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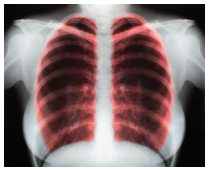

Regional Minimum Standards for the Harmonised Control of HIV and AIDS, Tuberculosis and Malaria in Militaries in the SADC Region

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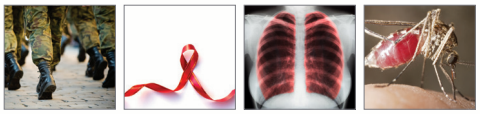

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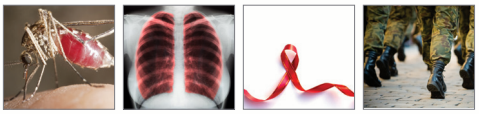
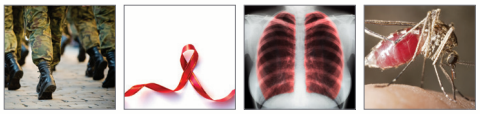
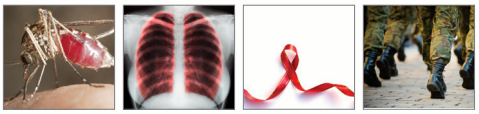




ACRONYMS & ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
DOTS	Directly-Observed Treatment, Short course
HIV	Human immunodeficiency virus
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
SADC	Southern African Development Community
STI	Sexually transmitted infection
SWOT	Strengths, weaknesses, opportunities and threats
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis



1. BACKGROUND

One of the aims of the Southern African Development Community (SADC) is to combat HIV and AIDS and other deadly communicable diseases. HIV and AIDS, tuberculosis (TB) and malaria are widespread in the region and have a serious impact on the general populations. Certain sub-populations, such as military personnel, are especially vulnerable to these diseases due to the nature of their work. For example, military personnel are often deployed for long periods away from their homes and families – elsewhere in their countries or beyond (as part of the SADC Standby

Brigade or the African Standby Force, for example). SADC militaries are sometimes also deployed as part of the United Nations Peace Keeping Force to countries in and beyond Africa. Military personnel therefore face exposure to different strains of communicable diseases in various theatres of deployment.

The military, however, are also unique in the sense that they typically are well-disciplined and –organised, and form a "captive audience" for public health interventions. This positions them well to respond positively to such activities and to serve as role models for wider communities in bids to control communicable and other diseases.

SADC Member States have committed themselves to the Abuja and United Nations General Assembly Special Session (UNGASS) on HIV and AIDS (2001) declarations to fight HIV and AIDS, and other communicable diseases such as malaria and TB. Those commitments were further affirmed by SADC Heads of State and governments, through the Maseru Declaration. The military and other uniformed services are specifically mentioned in the Maseru Declaration as a vulnerable population that requires special, targeted interventions and which is in a unique position to strengthen awareness and prevention initiatives among communities.Globally, the UN Security Council's Resolution 1308 of 2000 was a landmark in addressing HIV and AIDS as a security risk, and in proposing ways to address HIV and AIDS among peace-keeping personnel. The United Nations Department of Peace-Keeping Operations and UNAIDS have developed a detailed programming guide for the military in peace-keeping missions in the context of the AIDS epidemic, whereby voluntary counselling and testing (VCT) is encouraged as part of a holistic care and support programme for the military.

The development of these regional minimum standards therefore occurred in accordance with the Maseru Declaration and forms part of the operationalisation of the SADC Protocol on Health.

The Protocol prioritises the control of communicable diseases and calls for harmonisation of policies and strategies aimed at disease prevention and control.

For a more comprehensive situational assessment of HIV, malaria and TB in the military in the SADC region, please refer to the Assessment Report for the Harmonised Control of HIV/ AIDS, Malaria and Tuberculosis in Militaries in the SADC Region.

2. PURPOSE AND SCOPE OF REGIONAL MINIMUM STANDARDS

The regional minimum standards serve as a framework, which guides the regional harmonisation of approaches for preventing and controlling HIV and AIDS, TB and malaria in all SADC Member State militaries.

The guidelines provide minimum policy requirements for Governments, military health service managers and other policy development personnel in the SADC region in order to achieve harmony in the efforts to combat the three communicable diseases.

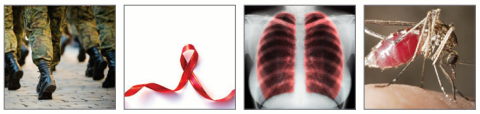
3. BASIS FOR REGIONAL MINIMUM STANDARDS

The regional minimum standards are informed by the SADC Protocol on Health, which prioritises the control of communicable diseases.

Various articles of the Protocol address key issues that can facilitate regional cooperation. For example, Article 9 on communicable diseases calls for the harmonisation of policies and sharing of information within the region. Articles 11 and 12 deal with malaria and TB, respectively, and call for cooperation and harmonisation of policies, guidelines, protocols, interventions and treatment regimens. The development of a framework of regional minimum standards for the military is important for strengthening the responses at national and regional levels.

The framework is aimed at instituting harmonised policies and standardised practices in SADC militaries for all three communicable diseases in order to decrease the incidence of national, cross-border and regional infections involving and affecting the military.

The specific focus on the military addresses a need identified in the Maseru Declaration: specific, targeted approaches for the military and other uniformed services that recognise and build on their unique position to strengthen awareness and prevention initiatives among communities. Specifically, the Declaration calls for:



Putting in place national strategies to address the spread of HIV among national uniformed services, including the armed forces, and consider ways of using personnel from these services to strengthen awareness and prevention initiatives.

The main purpose and objective of the framework is to guide and coordinate the regional response of the SADC militaries in relation to the three communicable diseases in a gender-sensitive manner. The framework thus aims to clearly articulate the regional minimum standards that should be implemented across all SADC Member State military health services.

The regional minimum standards also address the gaps and challenges revealed in the strengths, weaknesses, opportunities and threats (SWOT) analysis, and the assessment conducted for each of the three communicable diseases. Each communicable disease, according to the findings of the SWOT analysis and the assessment, has key policy and programmatic areas that must be taken into account in the implementation and institutionalisation of the regional minimum standards.

4. GUIDING PRINCIPLES

The following are the guiding principles for regional minimum standards that are in harmony with national, SADC regional and global policies for the three communicable diseases, HIV and AIDS, TB and malaria.

4.1 Involvement of leadership

In order to protect civilians, as well as military personnel, national Governments must lead the response and ensure the institutionalisation of the regional minimum standards as key policy prescriptions for the military.

SADC Governments' leadership and commitment to ensure the health of their citizens has been exemplary. Governments must continue to demonstrate this commitment and leadership in the adoption and ownership of these regional minimum standards. Commanders at all levels in the military hierarchy should also provide the necessary leadership in the implementation of these regional minimum standards within their organisations.

4.2 Context-specificity

The operationalisation of the regional minimum standards will need to take into consideration the specific contexts in each Member State.

4.3 Equality and non-discrimination

All initiatives that are implemented are to be guided by principles of non-discrimination and gender equality, in accordance with the SADC Treaty and SADC Gender and Development Protocol. The rights of all military personnel, their dependants and civilians are to be respected and safeguarded.

4.4 Inclusiveness

Joint participation is required of all partners (both civil and military) in the planning, implementation and evaluation of the regional minimum standards. Lack of inclusiveness may result in mutual distrust, as well as limited efficiency and efficacy in the implementation and sustainability of these guidelines.

4.5 Accountability

All partners and stakeholders are to be accountable to the military personnel and communities they serve.

4.6 Universal access

All military personnel, their families, civilians working closely with the military, refugees and internally-displaced people in contact with the military are entitled to access services from the military for the three communicable diseases when no other services are available.

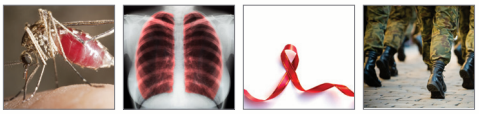
4.7 Monitoring, research and surveillance

Communicable disease responses in the military must be evidence-based and include appropriate prevention, care and treatment interventions. Monitoring of programmes, sample surveys and other data collection systems must be used to inform policy.

5. PROCESS FOR THE DEVELOPMENT OF MINIMUM STANDARDS

The process for the development of these regional minimum standards was participatory including Member States, the SADC Secretariat and various stakeholders. The process was also informed by internationally-recognised best practices.

Firstly, a desk review of the current national, regional and global policies relevant to –HIV and AIDS, Tuberculosis and Malaria among the militaries was conducted. This was followed by individual Member State Military specific assessments in each Member State, during which key informants within the respective programs, including development partners, civil society organizations and the private sector were consulted to



provide information on the state of programmes and policies. This assessment was done by the programme managers for the three communicable diseases mentioned above. The assessments also shed light on some challenges and best practices. Each military assessment culminated in a country level assessment report which was reviewed and validated by relevant remembers of each military.

The country reports were then compiled to inform a regional picture of the situation and response analysis. The draft regional assessment report was used as a basis for Regional Minimum Standards. Both the draft Regional assessment report and the draft regional minimum standards were then reviewed by a technical team for technical soundness in November 2008. The team comprised Military programme managers for the three communicable diseases from Member States, Technical Partners, and the SADC Secretariat. The purpose of the review team was to strengthen the quality of the documents.

Following the technical review and the incorporation of the comments, the documents were then presented to a regional workshop for validation of the situation and response analysis report and consensus building on the proposed regional minimum standards. All Member State Militaries and major stakeholders including regional partners and civil society organisations were invited to the validation and consensus building workshop. The workshop was held on 13-15 May 2009 at Victoria Falls, Zimbabwe. The meeting recommended the draft reports for approval through the SADC structures subject to the incorporation of suggested changes.

Accordingly, the revised reports were reviewed by the SADC National AIDS Authorities at their 7th Annual Forum held on the 12-14 October 2009 at the Democratic Republic of Congo for technical soundness and recommendation for approval by Ministers. Finally, the document was reviewed by Senior Officials in Ministries of Health and those responsible for HIV and AIDS before being submitted for approval by the joint ministerial committee of Ministers of Health and those responsible for HIV and AIDS. The Ministers approved the document at their meeting held on 9-13 November 2009 at Ezulwini, Swaziland.

6. REGIONAL MINIMUM STANDARDS FOR HIV AND AIDS

This section describes the key minimum standards components of the HIV and AIDS policy framework as derived from a review of the national, regional and global policies to combat the epidemic in the SADC region. The priority areas are prevention, and treatment, care and support.

6.1 Policy and programming

- In line with the “Three Ones Principle” (one coordinating authority, one strategic framework and one monitoring and evaluation framework), the military in each SADC Member State must actively participate and be involved in the development and implementation of the national strategic plans with their respective Governments.

- The minimum standards for the AIDS response must take into account the specific needs of men and women in the military (with the rank hierarchy and unique structure of the military kept in perspective). All programming must be gender-sensitive, and should encourage negotiating skills and respect for women’s rights.

- Member State militaries must develop their own broad-based HIV and AIDS policy document to guide their responses.

- There must be a policy on confidentiality assurance, and protection against stigmatisation and discrimination of HIV-positive military personnel.

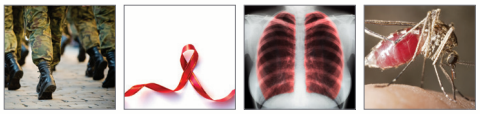
- HIV and AIDS committees should be set up within the military administrative system in a decentralised manner, and should be chaired by the command element of Member State militaries. This is to ensure command and leadership involvement in the response.

- There should be zero tolerance policy gender-based sexual harassment and violence or exploitation in Member States militaries.

- Member State militaries must include in their comprehensive HIV and AIDS policy the requirement for a comprehensive health assessment, including HIV testing during the recruitment process.

- Deployment of military personnel must be subject to a comprehensive health assessment and be based on an individual’s health status.

- The health status of military personnel who test HIV-positive, should be established based on WHO clinical criteria and should not be based solely on the HIV sero-positive test result.



- The competent (duly authorised) medical officer caring for HIV-positive persons will make the final recommendation on deployment, based on individual medication adherence, medical health status, anticipated duration and type of deployment, and health service support available within the area of deployment.

- Fitness for military duty (rather than HIV sero-status) must be the guiding principle for discharging personnel from the military on medical grounds.

6.2 Training

- HIV and AIDS education must be incorporated at all levels into military training in each Member State, as a part of education for prevention of sexually transmitted diseases (with one period per training cycle devoted to such training).

- Military personnel must regularly receive prevention education, and regular refresher orientation is therefore recommended.

- Members of military health services must be educated on the impact of HIV and AIDS on mental health, physical fitness and operational readiness of military personnel.

- Members of military health services must be trained to deal with the management of the various medical issues that arise from HIV infection.

- Military health service members must undergo formal, structured professional training and orientation on HIV and AIDS and its management within the military for at least one week, with periodic refresher courses on medical management.

6.3 Prevention

6.3.1 Behaviour change communication

- Communication strategies must be implemented to address the average military soldier's perception of invincibility to risks. Prevention education and AIDS awareness must motivate behaviour change.

- Behaviour change communication strategies in the military must include and encourage activities aimed at couples.

- The strategies must also address the issue of alcohol use, and other known risk factors for HIV transmission. All HIV and AIDS education material should include alcohol and substance abuse information.

- The interventions must specifically target those age groups in the military that are most at risk of infection.

- Every soldier must be sensitised to the issues of sexual harassment and gender-based violence, sexual exploitation and abuse. This should occur annually in formal groups and should managed by military superior officers or commanding officers.

- Militaries should encourage and constitute informal support groups within their structures, and arrange for training of peer educators who can influence behavioural change in military and civil communities and provide support to affected personnel. Such training or refresher programmes for peer educators should be organised at least annually.

6.3.2 Condom promotion and provision

Male and female condoms must be actively promoted and should be freely available in the military.

- Condoms must be made available in all barracks in military installations.

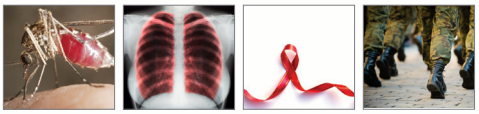
- All personnel must receive education on correct and appropriate use of condoms during basic military training, with demonstration on models.

- Refresher information on condoms and safe disposal of the same should be part of all military training courses in the subsequent career of personnel.

- Posters and pamphlets must be available in military health services to provide information on, and promote correct condom use.

6.3.3 Information education communication

- HIV and AIDS information, education and communication campaigns must target military personnel and their families, and should be conducted at least once a year.



- A pamphlet with summary information on HIV prevention should be provided during initial training and must also be given to all military personnel for quick and easy reference at the time of external operational deployment.

6.3.4 Routine comprehensive health assessment

Comprehensive health assessment is widely practised among SADC Member State militaries, and includes testing for HIV and other health conditions. This assessment is recommended for military personnel in the following situations:

- Pre-recruitment;
- Pre-deployment (for external deployments);
- Post-deployment;
- All pre-deployment and post-deployment HIV testing must be linked appropriately with counselling;
- Military health services must ensure universal access to continuous and confidential counselling, prevention, care, treatment and support for their personnel; and
- During military service every soldier must undergo routine comprehensive health assessments, including HIV testing, combined with continuous and confidential counselling, care and support. This may be done at intervals specific to the context of the Member States. However, soldiers younger than 30 years of age must undergo this at least every five years, those aged 30-40 years should receive the assessments every three years, and those in older age groups every two years.

6.4 HIV testing

- Routine HIV testing must be offered in all military health service healthcare facilities in accordance with the national health policy, where applicable.
- Military health service must provide facilities for confidential voluntary counselling and testing to members of their militaries at convenient locations at their bases and also during deployment.

6.5 Prevention of mother-to-child transmission

- Every Member state military health service must develop a structured approach to the prevention of mother-to-child transmission, based on its national guidelines, and ensure the availability of whatever modality is prescribed, to military personnel, including during operational deployment.

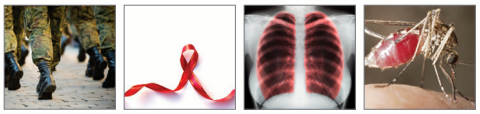
6.6 Safe male circumcision

- If safe male circumcision is endorsed by their Governments as an additional tool to prevent HIV transmission, military health services must develop their own internal action plans for providing the procedure in their settings, by making it available to all males who request it.
- Education campaigns must be implemented within SADC militaries to communicate the message that safe male circumcision is only an additional mode to prevent HIV, and is effective only when used as part of a package of prevention measures, including condom use.

6.7 Treatment, care and support

6.7.1 Counselling and support

- Counselling services must be readily available in military health services for those infected and affected by HIV and AIDS, as well as for victims of gender-based violence and sexual harassment, sexual exploitation and abuse.
- Support services for victims of sexual harassment and rape must provide access to post-exposure prophylaxis within the military health services health care system, based on medical assessment of the risk for acquiring HIV.
- Counselling services must include a mental health-screening component to assess depression and possibly also simple neuro-cognitive function.
- Individual and couple counselling must be provided to military personnel and their partners, especially in relation to status disclosure and adherence to treatment.



- Social service support must be provided to all personnel proceeding on deployments.

6.7.2 Medical management

Every military health service must develop and document a medical management or treatment plan for HIV-positive personnel, taking into account their resource constraints. This should also address the issue of prevention and management of opportunistic infections.

- A structured antiretroviral (ARV) programme is recommended for Member State military health services, and should be introduced in a phased manner to cover all military personnel and their families.

- Because some sexually transmitted infections (STIs) may increase the risk of HIV infection, routine medical care for military personnel by military health services should include syndromic management of STIs.

- There must be standardised operating procedures for providing an evidence-based post-exposure prophylaxis regimen for military health services personnel in healthcare settings.

- The risk of TB and HIV co-infection must be recognised at all levels of the integrated healthcare delivery system. Patients in military health services healthcare systems presenting with conditions that indicate possible infection must be tested for TB and HIV.

- Home-based care must be encouraged in order to help military personnel and their families to be cared for in the comfort of their own homes. Military personnel and their dependants must be guaranteed the required resources and expertise in order to provide care and support to their families effectively, irrespective of their gender and rank.

7. REGIONAL MINIMUM STANDARDS FOR MALARIA PREVENTION AND CONTROL

The framework is contextualised to the military, and is in line with many of the recommendations provided by the WHO global and regional responses to malaria. Although SADC militaries may originate from non-malaria endemic areas, they may be deployed to malaria risk areas. Thus, all Member State militaries must heed minimum standards for malaria prevention and control. The minimum standards cut across the different stages of malaria control: control, pre-elimination, elimination, certification and prevention of re-introduction.

7.1 Health intelligence

- Member State military health service must utilise geographical information systems, meteorological data, and satellite imagery, where available, to develop malaria health intelligence. This could be achieved by obtaining, collating, analysing and interpreting data for malaria and other diseases of military significance. This would include malaria mapping and the development of a “malaria early warning system” to enable formulation of health countermeasures.

7.2 Information, education and communication

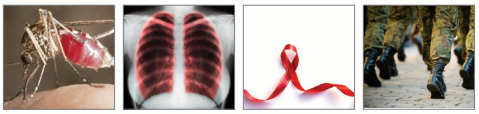
Routine information, education and behaviour change communication for malaria prevention must be provided to all personnel, irrespective of whether they are deployed in malaria areas.

- It is recommended that monthly lectures be conducted on malaria prevention and control when troops are deployed in malaria areas.

- In non-malaria areas, troops may be educated on malaria annually.

- Member State military health services must prepare a pamphlet on the military paradigm of malaria prevention and control, which needs to include relevant facts pertaining to malaria-endemic zones in the SADC region. This pamphlet must be provided to all military personnel at the time of basic training and again prior to deployment to malaria areas.

- A health education lecture with distribution of the above pamphlet on preventive measures must be included in the pre-deployment briefing for personnel being deployed to malaria areas.



- Military personnel must be sensitised to seek treatment as soon as possible when showing signs and symptoms of malaria. Education must be given to ensure that personnel comply with, and adhere to malaria chemoprophylaxis and treatment (wherever required).
- Sustained health education on preventive measures (in the form of lectures) must be continued in areas of deployment in malaria regions.

- Health education measures specifically focusing on healthcare-seeking behaviour and continuance of chemoprophylaxis with adoption of personal protection measures must be given to all personnel deinducting from malaria areas.

7.3 Personal protection

For military personnel deploying to malaria areas, Member State militaries must ensure availability and provision of the following:

- DEET-based repellents (liquid- or cream-based) and insecticide-treated nets for each soldier.

- Military health services must ensure provision of long-lasting nets for dependents of military personnel when based in malaria areas.

- All insecticide-treated nets issued to troops must be retreated periodically, as specified for the particular insecticide being used. A record or log of such treatment must be maintained for the duration of the insecticide-treated nets' use.

- Wherever considered appropriate, Member State militaries must consider utilising insecticide-impregnated or -treated uniforms for soldiers who are deployed to malaria areas.

7.4 Chemoprophylaxis

Military health services must decide on a standardised and effective chemoprophylaxis regimen with regional harmonisation at least three weeks prior to deployment of troops to malaria areas.

- Chemoprophylaxis, with due attention to all contraindications, must be commenced for troops at a minimum of two weeks or otherwise (as indicated for the specific drug) before deployment. Adequate generic health education messages for this must be developed.

- Military health services must conduct supervisory checks on compliance with chemoprophylaxis during deployments.

- During the post-deployment phase, troops must be sensitised to continuation of the chemoprophylaxis regimen for the duration indicated.

7.5 Testing for malaria

Pre- and post-deployment testing using peripheral blood smears must be done on all symptomatic military personnel.

- Microscopy (for peripheral blood smears) must be available in all major military healthcare facilities.

- Malaria rapid diagnostic tests must be available at all medical support detachments, even during deployment, in malaria areas.

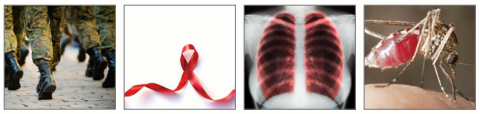
- Pregnancy tests must be done for female military personnel prior to deployment to malaria areas to guide in the selection of appropriate chemoprophylaxis.

7.6 Case management

Healthcare workers must be trained and oriented to develop a high index of suspicion for malaria for military personnel being deployed to, and de-inducting from a malaria-endemic zone.

- Early diagnosis of malaria must be achieved by making available rapid diagnostic tests and slides for peripheral blood smears at all detachments in malaria areas (microscopy can be made available at higher medical echelons).

- All personnel experiencing fevers must be tested for malaria by utilising rapid diagnostic tests on site and peripheral blood smear (on- or off-site).



- Prompt treatment in malaria areas must be ensured by prescribing Artemisinin-based Combination Therapy to all personnel who require it, either on diagnosis through use of rapid diagnostic tests or peripheral blood smears, or based on clinical suspicion.

- There must be timely notification of the occurrence of malaria to the military health services and relevant health support system in the area of deployment.

- All of the above (including chemoprophylaxis) should be documented in a treatment guideline specific to the military health service, and this must be disseminated to all clinicians within those services.

7.7 Vector control

Upon arrival in a malaria area, indoor residual spray with an appropriate insecticide must be carried out on all structures that are temporarily or permanently occupied by troops. This must be repeated at intervals specified for the particular insecticide, and based on the vector bionomics of the region.

- Regular indoor knockdown space spray with an appropriate insecticide must be done in all screened structures occupied by military personnel.

- Environmental management, including manipulation (where feasible) for control of mosquito breeding sites in the vicinity of deployment, must be done, using chemical anti-larval control in an environmentally friendly manner.

- Supervisory visits to the area of responsibility for deployed detachments in malaria areas by environmental health personnel must be done periodically.

- Space spray with a knockdown insecticide must be done inside all vehicles and containers at designated points of entry into non-malaria areas at deinduction.

- Compliance with pertinent international health regulations, especially with reference to disinfection of military aircraft, must be ensured.

7.8 Role of military leadership

The success of malaria control in the military depends on the enforcement of personal protective measures by commanding officers. Part of the responsibility for enforcing personal protective measures is to ensure that personnel are adequately trained and can employ protective measures. Member State militaries must therefore ensure command involvement and accountability for the prevention and control of malaria. The command element of militaries must obtain advice from their military health services to recommend and ensure that personal protective measures are employed, to select optimum locations for bivouacs and base camps, and to recommend safe times for training and field exercises.

8. REGIONAL MINIMUM STANDARDS FOR TUBERCULOSIS CONTROL

The framework addresses the minimum policy standards for the different components of a TB control programme. The following minimum standards for the military in the SADC region cut across the various components of a TB control framework.

8.1 Prevention of TB infection

Military health services must ensure that adequate administrative, environmental, and personal protection protocols are practiced at all levels in their militaries.

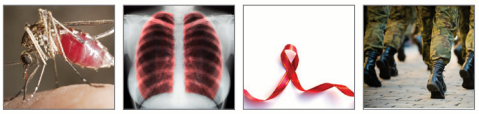
8.1.1 Administrative measures to prevent TB infection

- All military health services must institute systems and practices for early recognition of TB suspects by suitable triage at the Out Patient Department level and separation of TB suspects from general clinic attendees by “social distancing”.

- All military health services must undertake periodic and ongoing patient education campaigns on respiratory (cough) etiquette.

8.1.2 Environmental measures to prevent TB infection

- Member state militaries must undertake measures to reduce overcrowding in barracks and other military accommodation and must ensure that barracks are kept clean and are properly ventilated.



- Military health services must have isolation facilities in their health care system for individuals with smear positive and pulmonary TB.

8.1.3 Personal protective equipment

- Personal protection equipment must be accessible to the healthcare personnel of military health services working in areas with high risk for transmission of TB.

- There must be supervisory oversight within the military health services to ensure that personnel adhere to standard precautions, as applicable.

- Children of military personnel must be provided with TB (BCG) vaccination at birth, or at the first point of contact with the military health services, if not vaccinated at birth. All personnel must be educated on the importance of this preventive measure.

8.2 Case-finding and diagnosis

- Pre- and post-deployment sputum testing among other modalities of diagnosis of TB infection or disease must be done on all symptomatic military personnel, as part of the comprehensive health assessment.

- All “chest symptomatics” must be screened for TB by military health services, and HIV testing should also be offered in the military setting:

- Military health services must ensure availability of quality-assured laboratory services for diagnosis of TB (microscopy and/or culture), including during deployment;

- Military health services must provide ongoing counselling and support to TB patients and their families; and

- If a soldier is diagnosed with TB, contact tracing within the military setting is required in order to monitor people who have been in contact with the individual.

8.3 Information, education and communication

- All military personnel must be provided with information on TB prevention, diagnosis and treatment at regular intervals during military service.

- Pamphlets with summary information on TB should be given to all military personnel during military training courses.

8.4 Training of military health service personnel

- Healthcare personnel of military health services must be trained in all aspects of TB prevention, diagnosis, treatment and care through periodic structured capsules and continuing medical education programmes.

- Health care personnel must be oriented to provide information, education and communication on TB to all military personnel and their dependents.

8.5 Treatment, care and support

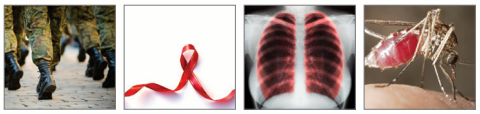
Member State militaries must ensure access to quality-assured diagnostic services to effective, standardised and adequate TB treatment (for the entire duration of the prescribed regimen) for all military personnel, their families, civilians working closely with the military, refugees and internally displaced people in contact with the military where there are no other services available.

- Military health services must have a standard TB treatment policy in line with their national policies, based on multi-drug therapy. DOTS is recommended in the military setting.

- Member State militaries must create systems and protocols to ensure soldiers and their dependents diagnosed with TB complete a prescribed anti-TB treatment course. Adherence support should be available to every patient.

- Member State militaries must have a personnel management policy for TB so that military personnel diagnosed with TB, after completing a prescribed course of anti-TB treatment (of at least six months duration) and after being deemed fit by a medical officer, will be eligible for external deployment and training.

- Military health services must provide individual and couple counselling to infected military personnel and their partners to ensure treatment compliance through support within the family for proper management of TB.



8.6 Disease surveillance

Military health services must develop and strengthen TB surveillance and health information systems within their organisations.

- A registry of TB cases detected and treated in the military (with sex and age disaggregated data) must be maintained by military health services.
- Military health services should utilise WHO case definitions and indicators for maintaining disease surveillance.
- Military health services must support and ensure participation in the expansion and strengthening of civil military and inter-country and cross-border collaboration for disease surveillance and control.

9. IMPLEMENTATION MECHANISMS FOR THE REGIONAL MINIMUM STANDARDS

The implementation mechanism defines the key stakeholders and their roles in the implementation of the Regional Standards. Furthermore, it provides guidance on how the agreed Standards will be financed. Lastly, it identifies the critical indicators to be monitored to ensure that the Standards are fully integrated in the work of the Member States. To this end, this section is intended to map out the path to the domestication of the regional standards, including how it will be financed and monitored.

9.1 Stakeholder roles and responsibilities

The successful implementation of the regional Minimum Standards for the harmonised control of HIV and AIDS, TB and malaria in the militaries of the SADC region requires the involvement of all key stakeholders at both national and regional levels. To this end, it is important to provide an outline on their roles.

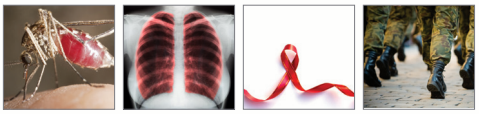
9.1.1 Member States

- The SADC Ministers of Defence in collaboration with Health Ministers will oversee and monitor the implementation of these regional standards.
- Military Health Services shall take a lead role in ensuring that the minimum standards are integrated to the annual work plans of their military health programmes.
- Military Health Services shall ensure that military health programmes involve Ministries of Health and key stakeholders in the public and private sectors (for example, donors, WHO, partners, community-based organisations, Private Sector and training institutions) to identify their roles in the implementation of the various activities articulated in the minimum standards.
- Military Health Services shall identify challenges to implementation of each standard, and ways of overcoming them. They will also identify opportunities for each standard.
- SADC Military Health Services shall develop a detailed financial plan and avail resources for supporting the implementation of the harmonised minimum standards.

9.1.2 SADC Secretariat

The SADC Secretariat will coordinate the overall implementation and monitoring of these minimum standards on behalf of the Ministers of Defence and Health. Specific responsibilities will include:

- Advocating for implementation of effective Military Health programmes in the region in relation to the commitments made by Member States (such as the SADC Protocol on Health, and the Maseru Declaration on HIV and AIDS);
- Facilitating domestication of the minimum standards ;
- Facilitating skills transfer and sharing of good/ innovative practices, benchmarking of Member States among each other and provide a platform of sharing of good practices;
- Coordinating partners for resources mobilisation and technical support in the region; and
- Coordinating regional training programmes on the implementation of the minimum standards for the control of HIV and AIDS, TB and Malaria in the military;



9.1.3 Other stakeholders

Other stakeholders include UN Agencies, bilateral donors and development partners, local and international NGOs, community-based organisations and communities, the private sector and research and training institutions. All are essential for the successful implementation of the Minimum Standards.

9.1.3.1 UN Agencies and other development partners

Their roles will vary but will include:

- Assisting in updating and developing new programmatic/clinical guidelines.
- Linking Member States militaries with new technologies and tools for diagnostics.
- Supporting resource mobilisation to assist in implementing activities for the control of HIV and AIDS, TB and Malaria in the military;
- Assisting with inputs in harmonising the management protocols to support implementation of health programmes in the military.

9.1.3.2 Local and international donors and NGOs shall:

- Assist in implementation of agreed on minimum standards.
- Advocate for strengthening of communicable disease control in the military.
- Augment resources to ensure implementation of the minimum standards.
- Assist in disseminating best practices within the region.
- Provide additional human resources as needed to support implementation of minimum standards.
- Support integration of HIV and AIDS, TB and malaria in the overall military health care services.
- Provide feedback to MS on the progress or otherwise in the implementation of the minimum standards.

9.2 Financing mechanisms

Implementation of these minimum standards may require additional financial resource allocation by each Member State. Funding for the activities required to meet the minimum standards will be allocated within the national budget of each Member State, if these activities are not currently provided for in the Military Health budgets.

Member States shall ensure that:

- Areas that need additional financial resources are identified, with the participation of all relevant stakeholders, including UN agencies, donors, development partners, and NGOs.
- Each area that needs improvement is costed. Examples could include the costing of implementing the advocacy, communications and social mobilisation strategy.
- Military Health programmes receive endorsement from their Ministries of Defence where additional finances are required.

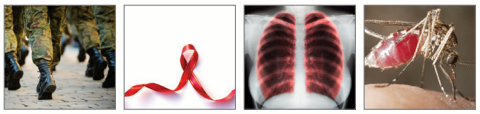
9.3 Monitoring and evaluation

9.3.1 Role of Monitoring and Evaluation in Implementation of Minimum Standards

These minimum standards need to be monitored in order to enable both Member States and the SADC Secretariat to objectively assess progress in implementing the regionally agreed on Minimum Standards for the Harmonised Control of HIV and AIDS, TB and Malaria. Monitoring is an important management tool that helps to indentify implementation progress, challenges and bottlenecks that should be addressed for enhanced impacts.

Effective monitoring shows programme managers the extent to which they are making progress in institutionalising the minimum standards into the national health programme. Furthermore, results from monitoring implementation of the minimum standards will inform management decisions aimed at fine-tuning the response to communicable diseases in the Militaries at the MS level.

At the same time, results from monitoring will show progress that the region is making in the implementation of the SADC Protocol on Health as it relates to communicable diseases and the Militaries.



9.3.2 Monitoring and Evaluation at MS Level

There are broad areas that are articulated in the Minimum Standards for the Harmonised Control of HIV and AIDS, TB and Malaria in Militaries that if fully implemented, will lead to realization of communicable disease and the militaries commitments and harmonisation of responses to communicable diseases among the militaries across MS. These are the areas that MS are expected to collect data on as a way of systematically assessing progress in each of the areas articulated in the minimum standards. Member States will collect information to track progress on the following areas:

9.3.2.1 HIV and AIDS

- Development and implementation of relevant policies;
- Training of military personnel;
- Prevention of HIV transmission;
- HIV Testing and Counseling;
- Prevention of Mother-To-Child Transmission (PMTCT);
- Safe Male Circumcision;
- Treatment, Care and Support
- Participation of the military in the development of national strategic plans for HIV and AIDS, TB and Malaria;
- Comprehensive Health assessment;

9.3.2.2 Malaria

- Development and application of Malaria health intelligence;
- Provision of routine information, education and behaviour change communication on malaria to military personnel;
- Personal protection;
- Chemoprophylaxis;
- Testing for Malaria;
- Vector Control
- Diagnosis and case management;
- Comprehensive Health assessment;

9.3.2.3 Tuberculosis

- Prevention of TB infection;
- Case finding and diagnosis;
- Development and implementation of Information, Education and Communication (IEC) for TB;
- Training of military health service personnel;
- Treatment, care and support; and
- Development and implementation of TB surveillance and health information systems
- Comprehensive Health assessment;

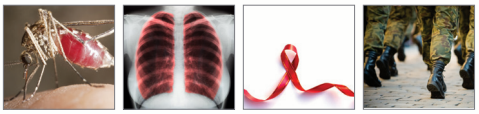
Member States Militaries will collect information on the broad areas above on an annual basis and prepare an annual report. The detailed variables on which information will be collected are in a separate document “Framework for monitoring progress in implementing Regional Policies and Frameworks”.

9.3.3 Monitoring and Evaluation at the SADC Regional Level

At the SADC regional level, tracking implementation progress for the minimum standards for the Harmonised Control of HIV and AIDS, TB and Malaria in Militaries will focus on issues relevant at that level. It should be noted that the aspects of communicable diseases and the militaries to be monitored at the regional level are exactly the same with those monitored at the MS level. The difference is that at the regional level, interest will be to know the number of MS whose Militaries are implementing each of the aspects articulated in the Minimum Standards Thus, more specifically, at the regional level monitoring will focus on identifying the number of MS implementing the following:

9.3.3.1 HIV and AIDS

- Development and implementation of relevant policies;
- Training of military personnel;
- Prevention of HIV transmission;
- HIV Testing and Counselling;
- Prevention of Mother-To-Child Transmission (PMTCT);



- Safe Male Circumcision;
- Treatment, Care and Support
- Participation of the military in the development of national strategic plans for HIV and AIDS, TB and Malaria;
- Comprehensive Health assessment;

9.3.3.2 Malaria

- Development and application of Malaria health intelligence;
- Provision of routine information, education and behaviour change communication on malaria to military personnel;
- Personal protection;
- Chemoprophylaxis;
- Testing for Malaria;
- Vector Control
- Comprehensive Health assessment;

9.3.3.3 Tuberculosis

- Prevention of TB infection;
- Case finding and diagnosis;
- Development and implementation of Information, Education and Communication (IEC) for TB;
- Training of military health service personnel;
- Treatment, care and support; and
- Development and implementation of TB surveillance and health information systems
- Comprehensive Health assessment;

Specific details on the information to be collected are contained in the "Framework for monitoring progress in implementing regional Policies and Frameworks" document.

9.3.4 Reporting Mechanisms

Member States Military Health Services (MHS) will prepare three annual national reports on the implementation of Minimum Standards for the Harmonised Control of HIV and AIDS, TB and Malaria in Militaries based on the information on the areas to be monitored at the MS level.

The national Military HIV and AIDS reports will be submitted to the Regional SADC Military HIV and AIDS Coordinator while the National Military reports for TB and Malaria reports will be submitted to the Regional SADC Military Coordinators for TB and Malaria respectively.

The three Regional SADC Military CDs Coordinators will compile regional reports for the three diseases and share them with MS MHS for their review and comments. MS MHS will share their comments with the three Regional SADC diseases coordinators to enable them finalize the draft regional reports.

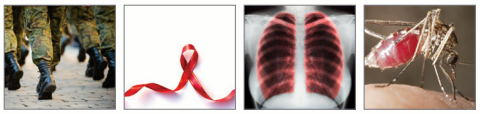
The Regional disease-specific Coordinators will share the three reports with the overall SADC MHS Coordinator who will use these reports to prepare a consolidated Draft SADC Military CD (HIV and AIDS, TB and Malaria) Report.

The consolidated report will be prepared by the overall regional MHS coordinator to reflect items for both decision and information of the Military Health Chiefs. Once ready it is shared with the SADC MHS Chairperson and all MS Military Health Services Chiefs. The Overall MHS Coordinator will then present the document at the SADC MHS Annual General Meeting for review, endorsement and decisions.

Minutes of the MHS AGM and the decisions are sent to the SADC Secretariat's Organ on Defence and Security for information (ORGAN) in preparation for the Defence Chiefs meeting where final review and approval is made.

Once approved by the Defence Chiefs, the document will be distributed to the SADC Secretariat's Organ on Defence and security and Social Human development and Special Programs for information and to the Military Health Services chairperson and MS MHS Chiefs for implementation.

The consolidated report on communicable diseases and the Militaries will be analysed to identify implementation challenges and recommend concrete solutions to the identified bottlenecks. Thus, the report will be used for decision making and policy reviews at both the national and regional MHS levels.



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