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Sadc Regional Advocacy Strategy on Hiv & Aids, Tuberculosis and Sexually Transmitted Infections

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Acronyms & Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
BCC	Behaviour change communication
CDC	Centre for Disease Control
CSO	Civil society organization
DOTS	Directly observed treatment short-course
DRC	Democratic Republic of Congo
HIV	Human immunodeficiency virus
IEC	Information education communication
IOM	International Organization for Migration
IPT	Isoniazid preventive therapy
MCP	Multiple concurrent partnership
MDG	Millennium Development Goal
MDR	Multi-drug resistant
NGO	Nongovernmental organisation
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission (of HIV)
SADC	Southern African Development Community
SBCC	Social behaviour change communication
SBC	Social behaviour change
SRH	Sexual and reproductive health
STI	Sexually transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	UN Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
XDR	Extensively drug-resistant

Executive Summary

This regional advocacy strategy on HIV and AIDS, tuberculosis (TB) and sexually transmitted infections (STIs) is intended for use by Southern African Development Community (SADC) Member States at a national level. This is an overall advocacy strategy highlighting the most important issues relating to HIV and AIDS, TB and STIs in the Southern African region. It provides a broad advocacy framework for each of the issues identified, along with key targets, messages, and interventions.

The regional advocacy strategy covers six main sections:

1. **Framing the strategy.** Constructing the strategy based on a coherent approach and evidence-based methodology.
2. **Baseline evidence.** Presenting a rapid assessment of priority issues and existing commitments in the responses to HIV and AIDS, TB and STIs at country, regional and global levels.
3. **Emerging Issues.** Trends, gaps and priorities emerging from the baseline review.
4. **Advocacy results.** Translating the identified priority issues into clear advocacy objectives for the region.

Cross-cutting issues

1. Strengthening national health systems as a way to effectively respond to communicable diseases, particularly HIV and AIDS, TB and STIs.
2. Communities fully engaged in the responses to HIV and AIDS, TB and STIs in the region.
3. Cross-border populations and other key populations with equal access to services, including prevention, care and treatment.
4. Children and young people actively engaged in the responses to HIV and AIDS, TB and STIs in the region.

HIV and AIDS

1. Create demand for prevention services, including condoms and testing, prevention of mother-to-child transmission of HIV (PMTCT), medical male circumcision and STI management.
2. Create and respond to demand for treatment services.
3. Accelerate HIV prevention and treatment services for injecting drug users.

Tuberculosis

1. Accelerate a fully integrated response to TB and HIV in the region.
2. Create demand for more TB diagnosis to reduce the number of missed cases.
3. Accelerate emergency management of drug-resistant TB in the region.

Sexually transmitted infections

1. Make STIs more visible through access and dissemination of more focused information.
2. Improve the management of STIs.
3. Increase specific funding for STIs.

5. **Advocacy strategies.** Identifying strategies for each of the identified advocacy.
6. **Implementation.** Highlighting important considerations for the implementation of the advocacy strategy.

The issues emerging from the baseline study prompted the following proposed key advocacy results:

The strategies proposed for each of these advocacy results are grouped into three main areas:

- **Evidence-based advocacy** through research and gaps assessments;
- **Action-oriented advocacy** by promoting consultative processes to agree on policy and programmatic change at all levels; and
- **Advocacy to create change** by focusing on public outreach and awareness raising.

A set of advocacy briefs has been developed for each of the priority issues, including: (i) cross-cutting issues for an integrated response (which should be viewed as pre-requisites for each of the individual epidemics), (ii) HIV and AIDS, (iii) TB, and (iv) STIs.

Lastly, considerations in implementing the strategy are addressed, and include: (i) planning, (ii) costing and identifying resources, (iii) assessing capacity, (iii) establishing collective ownership, and (iv) monitoring.

1

Framing a Regional Advocacy Strategy

This section examines the background and purpose of the strategy and defines its intended audience. It describes the methodology used to develop the regional advocacy strategy as well as how the advocacy strategy can be used.

1.1 Why a regional advocacy strategy?

As the Southern African region moves towards greater integration following the launch of the Free Trade Area, SADC recognises that major communicable diseases such as HIV and AIDS, TB and STIs threaten the achievement of development goals in the region. In response, the SADC Protocol on Health specifically advocates for the harmonisation of regional policies, strategies and guidelines on HIV and AIDS, TB and STIs. Advocacy is an important part of the response to HIV and AIDS, TB and STIs, and it requires harmonised priorities and messages in order to achieve improved results.

The purpose of the SADC Regional Advocacy Strategy on HIV and AIDS, TB and STIs 2015–2018 is to equip the SADC Secretariat and Member State Governments to:

- Achieve a stronger understanding of the common priority issues across the region;
- Identify the skills and resources that can be leveraged at a regional level to help Member States achieve more effective responses; and
- Acquire a clear and common framework for the entire region.

The SADC HIV Framework provides useful insight into the comparative advantages of a regional approach to the response to HIV and AIDS, TB and STIs.

1.2 Who is this advocacy strategy aimed at?

This regional advocacy strategy on HIV and AIDS, TB and STIs is intended for use by SADC Member State Governments at a national level. It is an overall advocacy strategy that highlights the most important issues relating to HIV and

[1] SADC. Health Protocol. Gaborone: SADC; 1999.

Value added by a regional approach

Experience has shown the power of unified regional approaches. Regional initiatives tend to have several comparative advantages over individual Member States initiatives when:

- An issue is difficult to tackle at individual Member State level, especially if it is of a trans-national nature, such as migration;
- It can deliver combined capacity, economies of scale or scope, or synergy of combined national efforts that are not feasible at Member State level. Examples include research into issues of common concern and good practices.

Member States can benefit from harmonising their approaches, such as the development of consistent guidelines, medicines registration, bulk purchasing of medicines and advocacy messages on key issues.

Source: SADC HIV Framework 2010–2015

AIDS, TB and STIs in the region. It provides a broad advocacy framework for each of those issues along with key targets, messages and interventions. Once the SADC Secretariat and the Member States validate the regional framework, they can expand it into specific detailed strategies that are based on each country's context and advocacy efforts.

The strategy aims to go beyond building awareness of key issues by creating change on the ground. It is expected to assist the SADC Secretariat, Member States and regional partners to start speaking with a united and strong voice in order to create the required macro-level changes in the responses of HIV and AIDS, TB and STIs in the region.

1.3 What methodology was used to develop a regional advocacy strategy?

The strategy is based on a rapid assessment of existing policies and plans, as well as interviews with selected key informants at regional level (see Annexes 1 and 2 for a full list of documents and key informants). Based on this research, the following criteria were used to prioritise regional advocacy outcomes and results:

- **Relevance to the region** – the extent to which the issues are relevant to the region;
- **Proportionality** – the extent to which issues contribute disproportionately to the risk or impact of the three diseases;
- **Practicality** – the extent to which the issue can be practically addressed.

It is important to note that the research did not include an exhaustive review of the political or financial implications of selecting specific advocacy issues.

A regional consultative process was arranged by the SADC Secretariat to workshop and validate the proposed strategy. Input from a Technical Expert Team was provided throughout the process, with the Team ensuring continuity across the various consultations.

1.4 How should this regional advocacy strategy be used?

For the purpose of this document, advocacy is defined as a concerted effort that seeks to change the factors that influence the personal health choices of individuals and change the environments in which those choices are made, such as laws, regulations, policies and institutional practices, prices and product standards.

In this regard, a set of practical advocacy briefs have been developed for each priority issue, including: (i) cross-cutting issues for an integrated response (which should be seen as pre-requisites for each of the individual epidemics), (ii) HIV and AIDS, (iii) TB, and (iv) STIs.

Each of the briefs includes advocacy outcomes and results, target audiences and partners, and specific strategies. The briefs are intended as strategic starting points for the SADC Member State Governments to take forward at country level.

2

Baseline Evidence on Key Emerging Issues

This section provides a summary of priority issues and trends emerging from commitments, recommended actions and latest evidence at global, regional and country levels. The first part examines the global landscape with which regional advocacy efforts need to be synergised, while the second part looks at regional trends and commitments. The third part reviews trends among Member States based on the relevant national frameworks that guide their response to the three epidemics.

Table 1 provides a snapshot of the key issues and trends emerging from the review at the various levels and for the three diseases.

	General health	HIV	TB	STIs
Global	• Sustainable well-being • Maximise healthy lives • Accelerate progress on the health Millennium Development Goals agenda • Reduce the burden of major non-communicable diseases • Universal health coverage and access	• Key populations at higher risk • Behaviour change programmes • Treatment, care and support for people living with HIV • Eliminate new HIV infections among children • Condom promotion and distribution • Voluntary medical male circumcision	• Pursue high-quality DOTS expansion and enhancement • Address TB/HIV, MDR-/XDR-TB • Contribute to health system strengthening • Engage all care providers • Empower people with TB, and communities • Enable and promote research	• Strengthen partner notification • Implement antenatal syphilis screening programmes • Deliver vaccines against STIs

	General health	HIV	TB	STIs
Regional	• Harmonise policies in case definitions of diseases, notification systems, inter-sectoral impact of the three diseases • Cooperate in standardisation of surveillance systems, advocacy efforts, information sharing • Provide services to high-risk and trans-border populations	• Universal Access to prevention targets by 2015 • Universal Access targets to achieve access to quality treatment for people living with and affected by HIV • Reduce the impact of HIV and AIDS and TB/HIV co-infection, especially among orphans, vulnerable children and youth • Mobilise sufficient resources for a sustainable, scaled-up, multi-sectoral response • Enhance institutional capacity for evidence-based programme design, implementation, monitoring, reporting and evaluation	• Address XDR-/MDR-TB • Develop regional emergency plan • Strengthen engagement between TB and HIV programmes, UN agencies, nongovernmental organisations, civil society organisations, and public-private partnerships • Strengthen and improve health delivery systems	• Enhance clinical approaches that include counseling for risk reduction, & encourage healthy sexual behaviour • Norms & standards that are required for benchmarking the quality of STI service provision • Strengthen the provision and management of equipment, medicines and supplies that are needed to support quality services, & • Improve the collection and management of STI-related information at health facility level to guide the strategic planning of STI control programmes
National	N/A	**HIV prevention priorities:** • Behaviour change communication • Testing • PMTCT **HIV treatment priorities:** • Access to ART • HIV/TB co-infection • Paediatric ART • Care and support / Palliative care	• TB diagnosis • Infection control • Drug-resistant TB • HIV/TB co-infection	• STI detection • STI management • Better integration with HIV and sexual reproductive health • Strong focus on young people

Source: CSI+ 2014

2.1 A global integrated health response

Health in the post-2015 agenda

- **Sustainable wellbeing** aiming for equity and recognising that health is influenced by non-health issues, including education, gender equality, sustainable energy and nutrition.
- **Maximising healthy** lives by ensuring interventions from all sectors.
- **Accelerating progress on the health Millennium Development Goals (MDG) agenda** by reaffirming the targets of ongoing initiatives such as: ending preventable maternal and child deaths; eliminating chronic malnutrition and malaria; providing universal access to sexual and reproductive health services, including family planning; increasing immunisation coverage; and realising the vision of an AIDS- and TB-free generation.
- **Reducing the burden of major non-communicable diseases** by focusing especially on cardiovascular diseases, cancers, chronic respiratory diseases, diabetes (the four non-communicable diseases causing the most deaths), and mental illness.
- **Universal health coverage and access** is suggested as a key contribution from the health sector for achieving health goals and targets, and for improving population health more broadly.

At a global level, a health-related advocacy strategy must be framed within the post-2015 health goals. At the time of writing, these were still being finalised, but they were expected to closely match the following outline.[2]

> "Health goals for an evolving world: universal, equitable, people-centred, and results-oriented"
>
> – Post-2015 Health Agenda

2.1.1 HIV and AIDS at global level

Within the post-2015 health agenda, HIV should be framed as part of an overall investment in health and transforming health systems and structures.[3] More specifically, the global response to HIV and AIDS is informed by ten specific targets, as outlined in the 2011 Political Declaration on HIV/AIDS and in the UNAIDS Investment Framework.[4] Those targets were developed to facilitate a more focused and strategic use of resources.

UNAIDS Investment Framework: Basic programme areas

- Key populations at higher risk (particularly sex workers and their clients, men who have sex with men, and people who inject drugs);
- Behaviour change programmes;
- Treatment, care and support for people living with HIV;
- Eliminate new HIV infections among children;
- Condom promotion and distribution;
- Voluntary medical male circumcision (in countries with high HIV prevalence and low rates of male circumcision).

[1] Task Team for the Global Thematic Consultation on Health in the Post-2015 Development Agenda. Health in the Post-2015 Agenda: Report on the Global Thematic Consultation on Health. The World We Want. April 2013. (Note that this process is a work in progress.)

[2] UNAIDS. AIDS Response in the Post-2015 Development Agenda. Geneva: UNAIDS; May 2013.

[3] UNAIDS. A New Investment Framework for the Global HIV Response. Geneva: UNAIDS; October 2011.

2.1.2 Tuberculosis at global level

The response to TB must be situated within the three, globally agreed priorities as outlined in the global Stop TB strategy:

- Integrated, patient-centred care and prevention (including early diagnosis and systematic screening, treatment, collaborative TB/HIV management, preventive treatment and vaccination);
- Bold policies and supportive systems (political commitment, community engagement, universal health coverage and social protection as a determinant of TB); and
- Intensified research and innovation.

More specifically, the Stop TB partnership has identified the following components for its Global Plan to Stop TB: [5]

- Pursue high-quality DOTS (direct observed treatment short-course) expansion and enhancement;
- Address TB/HIV, MDR-/XDR-TB and other challenges;
- Contribute to health system strengthening;
- Engage all care providers;
- Empower people with TB, and communities; and
- Enable and promote research.

In addition, TB priority actions have been developed to accelerate progress towards the MDGs and the post-2015 health targets:

- Reaching the "missed cases" (three million not in system);
- Address MDR-TB as a crisis;
- Accelerate an integrated response to TB/HIV;
- Increase financing to close resource gaps; and
- Ensure rapid uptake of innovations.

Accelerating an integrated response to TB/HIV has been identified as a special priority at regional level (see next section), and WHO has outlined the following global targets:

- Establish and strengthen the mechanisms for delivering integrated TB and HIV services;
- Reduce the burden of TB in people living with HIV and initiate early antiretroviral therapy (by implementing the "Three I's" for HIV/TB: (i) intensified case-finding, (ii) isoniazid preventive therapy (IPT) and (iii) infection control; and
- Reduce the burden of HIV in patients with presumptive and diagnosed TB.

2.1.3 Sexually transmitted infections at global level

According to the WHO[6], the four key objectives for the prevention and control of STIs globally are to:

- Increase the commitment of both national governments and international development partners to STI prevention and control activities;
- Promote both the reallocation of existing resources and mobilisation of funds to support those activities;
- Ensure that initiatives, policies and laws related to in-country provision of STI care are non-stigmatising and gender-sensitive; and
- Facilitate improved networking between all relevant partners and institutions in order to scale up and sustain interventions for STI prevention and control.

The advocacy component of WHO's global strategy addresses the need for an effective STI advocacy campaign to raise awareness and mobilise resources at the national and

[5] WHO Stop TB Partnership. Global Plan to Stop TB 2006–2015 and Operational Strategy to Stop TB 2013–2015. Available at www.stoptb.org

[6] WHO Department of Reproductive Health and Research. Global Strategy for the Prevention and Control of Sexually Transmitted Infections: 2006–2015. Geneva: WHO; 2007.

international level. In addition, the United States Centres for Disease Control's (CDC) STI Global Health Program includes five technical priorities (see box).

The five priorities of CDC's STI Global Health Program

- Elimination of congenital syphilis;
- STD control for HIV prevention;
- STD prevention in vulnerable populations;
- Rolling out STI vaccines in developing setting; and
- New surveillance and laboratory technologies of emerging concern (for example, highly-resistant gonorrhea).

According to the British Medical Journal[8], the top three global priorities for STI control are:

- Strengthen partner notification;
- Implement antenatal syphilis screening programmes; and
- Deliver vaccines against STIs.

2.2 A regional integrated health response

At a regional level, the *Abuja Declaration*[9] provides the overarching frame of reference. It calls on Governments to devote at least 15% public spending to health. In the SADC region, Malawi and Zambia are the only countries that have reached this target. In terms of how to allocate this spending around communicable diseases, the *African Union Roadmap on HIV, TB and Malaria*[10] outlines priority targets which need to be used as key advocacy messages.

SADC Health Protocol on Communicable Disease Control

1. State parties shall co-operate to harmonise, and where appropriate, standardise policies in the areas of:

   i) Case definitions for diseases;

   ii) Notification systems;

   iii) Develop regional polices and plans that recognise the inter-sectoral impact of HIV/TB/STDs and the need for an inter-sectoral approach to these diseases; and

   iv) Cooperate in the areas of

   - Standardisation of HIV/AIDS/STDs surveillance systems in order to facilitate collation of information that has a regional impact;
   - Regional advocacy efforts to increase commitment to the expanded response to HIV/AIDS/STDs; and
   - Sharing of information.

2. State parties shall endeavor to provide high-risk and trans-border populations with preventative and basic curative services for HIV/AIDS/STDs.

[7] CDC Division of Sexually Transmitted Disease Prevention. Available at http://www.cdc.gov/globalhealth/programs/std.htm.

[8] Low N, Hawkes SJ. Putting the magic in magic bullets: top three global priorities for sexually transmitted infection control. Sex Transm Infect. 2011;87 Suppl 2:ii44-6.

[9] Organisation of African Unity. Abuja Declaration on HIV/AIDS, TB and other Related Infectious Diseases. Abuja: OAU; April 2001.

[10] African Union Commission, and the NEPAD Planning and Coordinating Agency. African Union Roadmap on HIV, TB and Malaria: Shared Responsibility and Global Solidarity. Addis Ababa: AUC; July 2012.

African Union Roadmap on HIV, TB and Malaria: Shared Responsibility and Global Solidarity, 2012

- **More diversified, balanced and sustainable financing models:**
  - Investment targets for AIDS, TB and malaria met by 2015;
  - Financing sources for AIDS, TB and malaria diversified;
  - Financial sustainability achieved through predictable external resources and more domestic investments "on budget" in context of a compact of shared but differentiated responsibility.
- **Access to medicines – local production and regulatory harmonisation:**
  - Medicines security enhanced by facilitating and investing in local centres of excellence for innovation, research, development and manufacturing;
  - Medicines regulatory harmonisation mechanisms functioning within Regional Economic Communities and foundations laid for African Medicines Regulatory Agency;
  - Trade in medicines facilitated through concerted actions at global, continental, regional and national levels.
- **Leadership, governance and oversight for sustainability:**
  - Investments address most pressing needs and populations, are strategic, evidence- and rights-based, address discrimination and inequality and strengthen health and community systems;
  - AIDS, TB and malaria programmes developed through inclusive processes – participation of affected communities and civil society organizations;
  - African Union Member States demonstrate strong leadership and ownership for results with robust policy, oversight and accountability frameworks for investment in AIDS, TB and malaria.

In addition, the SADC *Protocol on Health* [11] addresses communicable disease control at a regional level in terms of standardising specific priorities and access to services for at-risk and cross-border populations.

Cross-border populations

The need for effective notification systems has been addressed in detail in the SADC *Framework on Population Mobility and Communicable Diseases*[12], which highlights the following key gaps:

- Inadequate harmonisation and coordination in the areas of disease-specific management guidelines, port health services, cross-border referral, and disease control across borders;
- Difficulty in accessing health services for communicable diseases when people cross borders;
- Inadequate disease surveillance and epidemic preparedness;
- Inadequate operations research and sharing of information; and
- Legal, and administrative barriers (legality of travel documents, contract employment, administrative delays and inadequate facilities, limited multi-sectoral structures).

> **"Across southern Africa, migrants often slip through the cracks of service provision and delivery. These highly marginalised and often invisible groups have limited access to social benefits and health, due to a range of legal, economic, language, social and cultural factors"**
>
> *– International Organization for Migration. Regional Assessment on HIV Prevention Needs of Migrants and Mobile Populations in Southern Africa, 2010*

[11] SADC. Health Protocol. Gaborone: SADC; 1999.

[12] SADC. Policy Framework for Population Mobility and Communicable Diseases. Gaborone: SADC; 2009.

Key populations

Cross-border populations are among the key populations which need to be integrated into key policies and programmes for responding to HIV and AIDS, TB and STIs, at both regional and country levels.

Key populations include both vulnerable and most-at-risk populations. The latter include men who have sex with men, transgender people, people who inject drugs and sex workers. Most-at-risk populations are disproportionately affected in most, if not all, epidemic contexts. Vulnerable populations are groups of people who are particularly vulnerable to infection in certain situations or contexts. They may include miners with TB , adolescents (particularly adolescent girls), orphans, street children, people in closed settings (such as prisons or detention centres), people with disabilities, and migrant and mobile workers.

Each country will define the specific populations that are particularly vulnerable and key to its epidemic and response based on its epidemiological and social context.

2.2.1 HIV and AIDS at regional level

The number of new HIV infections annually has declined substantially in the SADC region – from about 1.4 million in 2001 to 950 000 in 2011, a decrease of 32%. A combination of factors has contributed to this decline. In some countries, behaviour change may have contributed to the downward trend as countries stepped up their prevention efforts – including age-appropriate sex education, community-based behavioural prevention, condom use programmes and prevention programmes among sex workers.

The decline in new HIV infections has been strongest among adults and children, while progress among young people has been mixed. The percentages of young people living with HIV vary across the region. As shown in Table 2, HIV infection rates are significantly higher among young women than young men.

While unprotected sex is the main mode of HIV transmission in the region, injecting drug use is of particular concern in the Indian Ocean island countries (see box).

Injecting drug use and HIV transmission in Indian Ocean countries

Research suggests that as many as 10 000 people inject drugs in Mauritius, while in the Seychelles approximately 2.3% of the adult population is believed to inject drugs. In Mauritius, injecting drug use is one of the main risk factors for HIV infection, and in 2011 it was estimated that 52% of people who inject drugs in that country were living with HIV. Elsewhere in eastern and southern Africa, modelling of the epidemic indicates that people who inject drugs could account for an estimated 3.8% [2.3–5.4%] of new adult HIV infections in Kenya, 2.1% [0.3–5.6%] in Mozambique and 1% [0–5%] in South Africa. Reliable estimates are lacking for most other countries in the region.

Source: UNAIDS Getting to Zero in East and Southern Africa, 2013

SADC Member States have committed to, five priority objectives, which are outlined in the SADC HIV and AIDS Strategic Framework 2010–2015:[16]

[13] SADC. Declaration on TB in the Mining Sector. Gabarone: SADC; 2012.

[14] WHO. Consolidated ARV guidelines. Geneva: WHO; June 2013.

[15] UNAIDS. Getting to Zero: Epidemic Report for East and Southern Africa. Johannesburg; UNAIDS; 2013.

[16] SADC. HIV and AIDS Strategic Framework 2010–2015. Gaborone: SADC; 2010.

Table 2: HIV prevalence among youths in selected[17] SADC countries

Country HIV prevalence[18]	DHS year	Women - HIV prevalance (%)				Men - HIV prevalance (%)			
		15–17 years	18–19 years	20–22 years	23–24 years	15–17 years	18–19 years	20–22 years	23–24 years
DRC	2007	0.4%	1.2%	0.4%	0.2%	2.4%	0.5%	0.3%	0.3%
Mozambique[19]	2009	4.5%	9%	14%	15%	2%	4.2%	4%	7%
Tanzania	2011–2012	1.1%	1.5%	3.0%	6.6%	0.6%	1.1%	1.25%	2.8%
Zimbabwe[20]	2010–2011	4.8%	11%	20%	29%	4%	4.8%	10%	12.5%
		15–19 years	20–24 years	25–29 years	30–34 years	15–19 years	20–24 years	25–29 years	30–34 years
Lesotho[21]	2009	2.5%	23%	35%	41%	2%	7%	28.5%	40%
Malawi[22]	2010	4.0%	6.8%	19%	21%	1%	3.5%	6.8%	11%
South Africa[23]	2008	6.7%	21.1%	32.7%	29.1%	2.5%	5.1%	15.7%	25.8%
Swaziland	2006–2007	2%	38%	49%	45%	10%	12%	28%	44%
Zambia[24]	2007	6%	12%	20%	26%	4%	5%	12%	16.5%
Zimbabwe[25]	2010–2011	4.8%	11%	20%	29%	4%	4.8%	10%	12.5%

Source: CSI+, Consolidated data from national DHS and other relevant surveys from SADC countries.

Priority objectives of the SADC HIV Framework, 2010–2015

1. All Member States deliver on their Universal Access prevention targets by 2015.
2. All Member States deliver on their Universal Access targets for achieving access to quality treatment for people living with and affected by HIV and AIDS and TB/HIV co-infection by 2015.
3. Reduced impact of HIV and AIDS and TB/HIV co-infection on the socioeconomic and psychological development of the region, and on Member States, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015.
4. Sufficient resources mobilised for a sustainable, scaled-up, multi-sectoral response that channels resources efficiently to operational and community level.
5. Enhanced institutional capacity in the region supports evidence-based programme design, implementation, monitoring, reporting and evaluation at regional and Member State levels to ensure ongoing progress towards regional, continental and global commitments.

[17] Countries were selected based on comparable data available.

[18] No information available for the following SADC Member States: Angola, Botswana, Mauritius, Namibia, and Seychelles.

[19] Approximate figures: HIV prevalence rates situated as points on graphs with ranges such as 0–5, 5–10, 10–15, etc.

[20] Ibid

[21] Ibid

[22] Ibid

[23] HSRC. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008. Pretoria: South Africa; 2010.

[24] Ibid

[25] Ibid

Regarding population mobility and HIV and AIDS, SADC has outlined several priorities (see box).[26]

Priority regional action for HIV and AIDS and population mobility

- Universal implementation of the "Three I's" (intensive TB case finding, IPT and infection control) initiative for people living with HIV as part of broader collaborative TB /HIV activities;
- Strengthening and capacity building of networks of people living with HIV for cross-border collaboration;
- Information and education on gender-based violence and harmonised response measures such as post-exposure prophylaxis (PEP);
- Resource mobilisation for information, education and communication (IEC) material production and for ensuring dissemination to targeted populations;
- Involvement of all key partners at borders in programming, including people living with HIV;
- Mechanisms for effective logistic management of health commodities; and
- Review of regulations and laws that prevent people living with HIV from traveling to or entering other countries.

2.2.2 Tuberculosis at regional level

Five countries in the SADC region are among the 22 countries with the largest TB burdens in the world: Democratic Republic of Congo, Mozambique, South Africa, Tanzania and Zimbabwe. In 2011, the SADC region contained the majority of countries in Africa with an estimated TB incidence of more than 300 per 100 000 population.[27] WHO estimated that 50% of HIV prevalence in new TB cases in 2011 was located in the region.

Within Africa and the SADC region, there are significantly more HIV-associated TB deaths among women than men.[28] Evidence from South Africa suggests that children contribute 15–20% of the total TB disease burden, but reliable data is difficult to access.[29]

Many countries in the region have made good progress in reducing the number of TB deaths among people living with HIV. As a consequence, TB deaths among people living with HIV in eastern and southern Africa have decreased by about 30% since 2004–2006, when it peaked at an estimated 330 000 deaths per year. If this declining trend continues, the region could reach the 2011 Political Declaration target of reducing the number of TB-related deaths among people living with HIV by 50% by 2015, but this will require further progress in implementing the "Three I's" for HIV/TB, combined with early provision of antiretroviral therapy (ART).[30]

Table 3[31] illustrates the dramatic rise in new TB infections over the past ten years in several countries in the region, a trend that underlines the need for integrated TB and HIV prevention and care.

[26] SADC. Policy Framework on Population Mobility and Communicable Diseases. Gaborone: SADC; 2009.

[27] SADC Draft TB Report, 2013. Gaborone: SADC; 2013.

[28] WHO. Global Tuberculosis Report. Geneva: WHO; 2012.

Marais BJ, Hesseling AC, Gie RP, Schaaf HS, Beyers N. The burden of childhood tuberculosis and the accuracy of community-based surveillance data. Int J Tuberc Lung Dis. 2006;10:259–263.

[29] UNAIDS. Getting to Zero in Eastern and Southern Africa. Johannesburg: UNAIDS; 2013.

[30] WHO. Global Tuberculosis Report. WHO: Geneva; 2012.

Table 3: Estimated TB incidence rates, 2000–2012

Country	Incident TB cases, 2000	Incident TB cases, 2012	% change in estimated incidence, 2000–2012	Incident TB cases, (HIV-positive cases), 2000	Incident TB cases, (HIV-positive cases), 2012	% change in estimated incidence, 2000¬–2012
Angola	28,000	34,000	21%	25	86	244%
Botswana	16,000	8,200	-49%	11,000	5,100	-38%
DRC	150 000	210 000	40%	14,000	16,000	14%
Lesotho	10,000	13,000	30%	7,600	9,900	30%
Malawi	53,000	26,000	-51%	37,000	16,000	-57%
Mauritius	290	260	-10%	11	14	27%
Mozambique	93,000	140 000	50%	41,000	83,000	102%
Namibia	27,000	15,000	-44%	15,000	7,300	-51%
Seychelles	29	27	-7%	No data	No data	No data
South Africa	260 000	530 000	104%	140 000	330 000	136%
Swaziland	8500	17,000	100%	6300	13,000	106%
Tanzania	80,000	79,000	-1.25%	41,000	32,000	-22%
Zambia	72,000	60,000	-17%	52,000	35,000	-33%
Zimbabwe	91,000	77,000	-15%	79,000	55,000	-30%

Source: WHO Global Tuberculosis Report 2012

The SADC Strategic Plan for the Control of TB (2007–2015) identifies the following priority strategies for the region: [32]

- Address XDR-/MDR-TB;
- Develop regional emergency plan;
- Strengthen engagement between TB and HIV programmes, UN agencies, nongovernmental organisations (NGOs), civil society organisations (CSOs), SADC Member States, and public and private partnerships; and
- Strengthen and improve health delivery systems.

TB has increasingly become a cross-border issue in southern Africa. High rates of population mobility within the region are among the key drivers in the resurgence of TB, along with HIV and AIDS. Mobile populations – including miners[33] – are frequently at a higher risk for communicable diseases, due to poor integration with host country health services, language and cultural barriers, and generally lower levels of income. [34]

People experiencing forced migration, especially women, may be at an elevated risk for TB. In relation to TB, the risk experienced by mobile populations is further compounded by the length of time required to successfully administer DOTS and by differing cross-border standards of care for TB. The difficulty of supervising long-term treatment for unstable or mobile populations has been one of the factors associated with the rise of MDR-TB in the region.

The priority issues for addressing TB and mobility in the SADC region are listed in the box below.[35]

[32] SADC. Strategic Plan for the Control of Tuberculosis in the SADC Region, 2007–2015. Gaborone; SADC; 2007.

[33] SADC. Declaration of Tuberculosis in the Mining Sector. Gaborone: SADC; 2012.

[34] IOM. Regional Assessment on HIV Prevention needs of Migrants and Mobile Populations in Southern Africa. Geneva: IOM; 2010.

[35] SADC. Policy Framework on Population Mobility and Communicable Diseases. Gaborone: SADC; 2009.

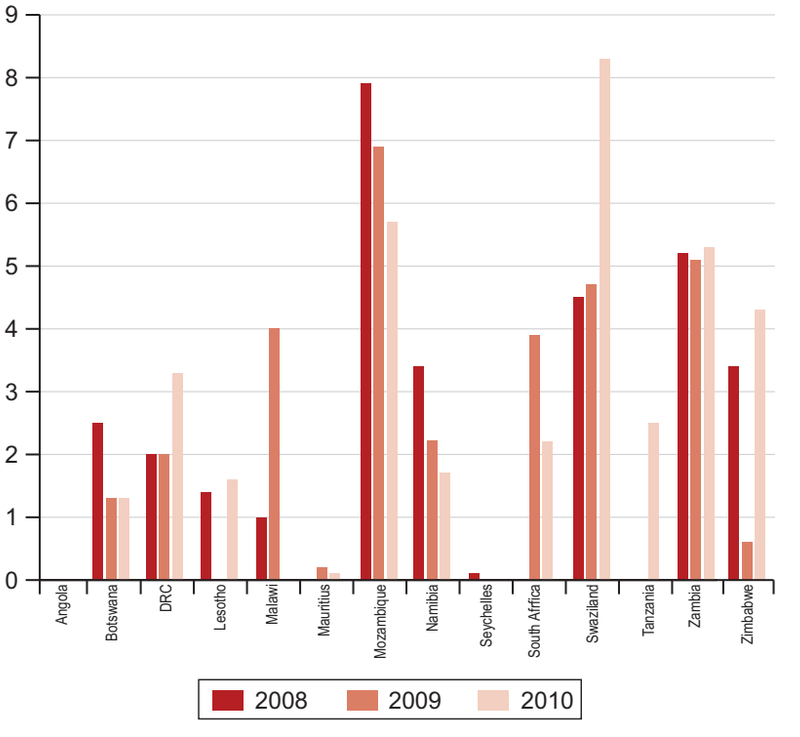
Priority regional action for TB and population mobility

- Coordination and service delivery linkages between TB and HIV and AIDS programmes in and between Member States in the context of collaborative TB/HIV activities.
- Periodic intensive TB case finding with full, supervised treatment in high-risk mobile groups such as refugees, mineworkers and farm workers.
- Community-based adherence support strategies among mobile communities such as refugees, mineworkers and farm workers.
- Regional harmonisation of treatment policies and clinical management guidelines for patients with TB, including MDR- or XDR-TB, and TB/HIV co-infection.
- Region-wide adoption and implementation of the "Three I's" for people living with HIV.
- Unfettered access to affordable TB diagnostic and treatment services for TB high-risk populations working in the private sector through appropriate public-private partnerships between national TB control programmes and private and corporate sectors such as the mining industry.
- Provision of adequate working and living conditions for employees that minimise the risk of TB transmission.
- Recruitment agencies should be required to provide information on TB risks (for example, with silicosis in the mining sector) to prospective migrant workers.
- Implementation of work place programmes that include entry and periodic screening for active TB, and workplace TB DOTS services for patients on treatment.
- Establishment of SADC-regulated cross-border notification and referral systems for drug-resistant TB cases, and a regional TB surveillance system.
- Establishment of regional TB reference laboratory facilities of excellence to support Member States with limited local capacity in diagnosing MDR- and XDR-TB, and to coordinate regional quality assurance and control of TB microscopy and microbiological services.

2.2.3 Sexually transmitted infections at regional level

The lack of consistent and accurate STI data in the SADC region is a major challenge. Proxy indicators, such as HIV transmission and unwanted pregnancies, however, point to significant rates of undetected and untreated STIs in the region.

Figure 1. Percentage of antenatal care attendees who tested positive for syphilis in the SADC region, 2008–2012

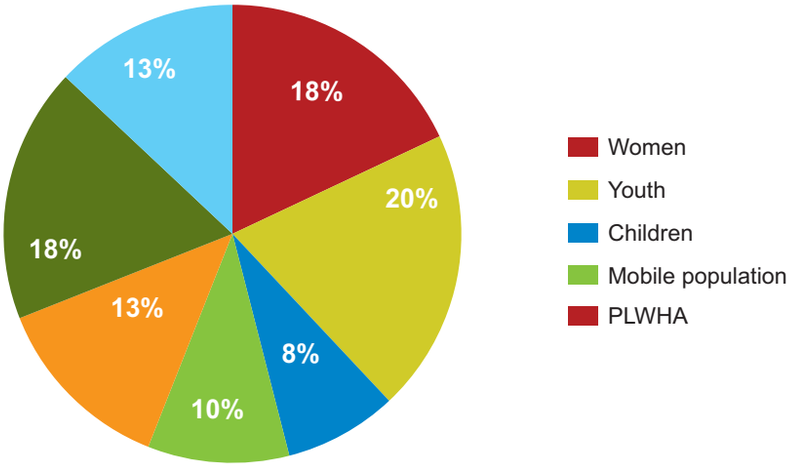


Source: WHO Global Health Observatory Data Repository [36]

[36] Available at http://apps.who.int/gho/data/node.main.A1359STI?lang=en

The experience of the SADC Project on STIs in High-Transmission Areas in Southern Africa, managed by the Health Systems Trust[37], suggests that STI control programmes across the SADC region are poorly managed and lack adequate surveillance systems.

Figure 2. Primary target audience of National HIV and AIDS frameworks among SADC Member States



Source: CSI+

The SADC HIV and AIDS Unit developed a Framework for the Control of Sexually Transmitted Infections in 2006, which provides standard guidance for Member States' STI responses.[38] It recommends that Member States:

- Enhance clinical approaches that include counseling for risk reduction and encourage healthy sexual behaviour;
- Adhere to norms and standards that benchmark the quality of STI service provision;
- Strengthen the provision and management of equipment, medicines and supplies that are needed to support quality services; and
- Improve the collection and management of STI-related information at health facility level to guide the strategic planning of STI control programmes.

2.3 Country-level response

This section provides a summary of the findings from a rapid assessment of relevant HIV and AIDS, TB and STI frameworks at national level (see Annex 1 for a full list of national-level documents) in order to identify trends across countries.

2.3.1 HIV and AIDS at country level

Based on a rapid assessment of national HIV and AIDS strategies available from Member States (see Annex 1), the following primary target groups for HIV interventions were identified across countries: youth, women and vulnerable groups.

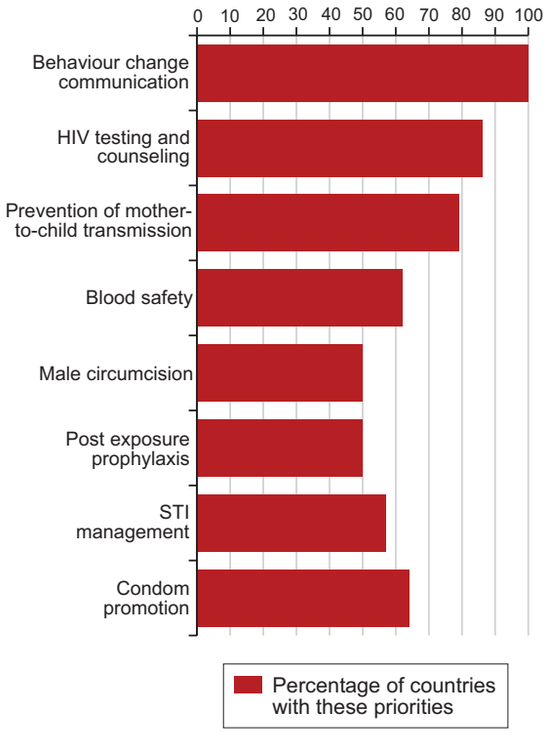
The three top HIV prevention interventions emerging from these national strategies included: behaviour change communication, HIV testing and counseling, and prevention of mother-to-child transmission of HIV.

Priority interventions related to HIV treatment included: access to ART, HIV/TB co-infection, paediatric ART, care and support services, and palliative care.

[37] The SADC Project on Sexually Transmitted Infections in High Transmission Areas, Health Systems Trust. Available at www.hst.org.za

[38] SADC. Framework for the Prevention and Control of Sexually Transmitted Infections in the SADC Region. Gaborone: SADC; September 2006.

Figure 3. Most common HIV prevention interventions across the SADC region



Source: CSI+

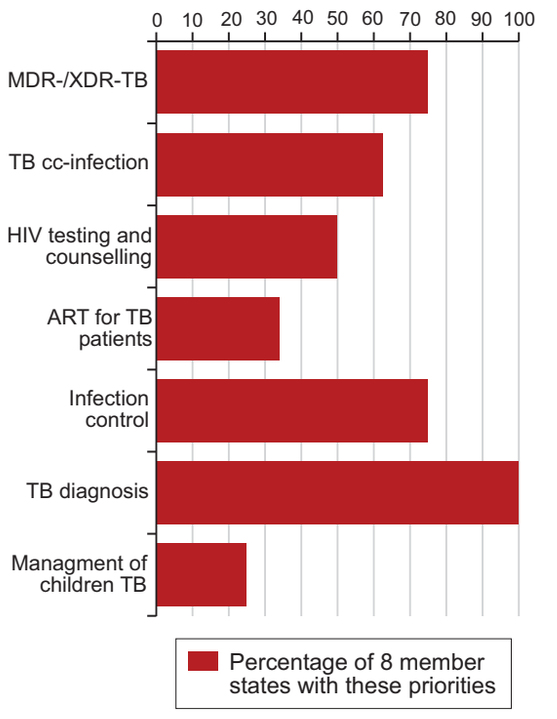
2.3.2 Tuberculosis at country level

The majority of national frameworks on communicable diseases in the region relate to HIV and AIDS. Some countries have specific strategic guidance on TB, while most address TB in relation to HIV and AIDS. The priority issues identified during the document review include: TB diagnosis, infection control, drug-resistant TB and HIV/TB co-infection.

2.3.3 Sexually transmitted infections at country level

Most countries in the SADC region do not have specific strategic frameworks on STI. Instead, STIs are addressed mainly within national HIV and AIDS plans. Based on the reviewed documents, the most common STI priorities involved the detection, management and improved integration of STI responses with HIV and sexual and reproductive health (SRH) programmes, as well as a strong focus on young people.

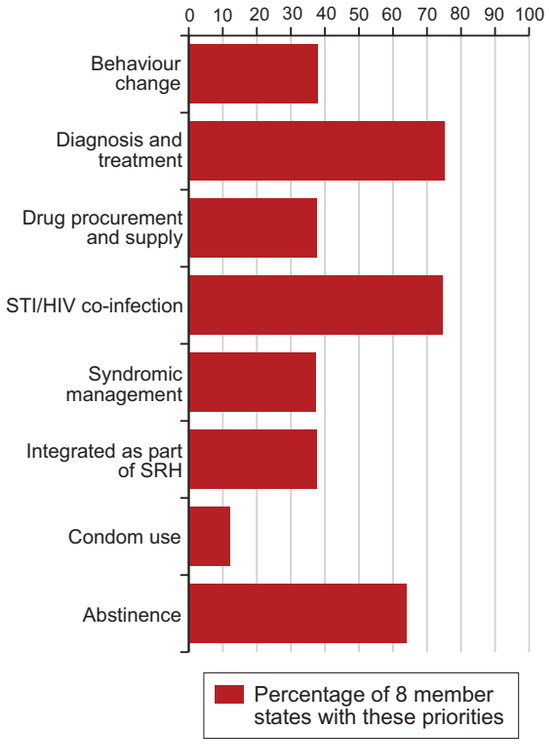
Figure 4. Most common TB interventions across the SADC region



Source: CSI+

During the consultation SADC regional consultation on advocacy and social behaviour change communication (SBCC) for HIV and AIDS, TB and STIs (9–10 October, 2013), health communication specialists representing Member States deliberated on what they felt were advocacy priorities for each of the three diseases. The box below outlines these priorities.

Figure 5. Most common STI interventions across the SADC region



Source: CSI+

Advocacy priorities according to Health Communications representatives of SADC Member States

STIs

- Place STIs higher on the SRH agenda;
- Clearly articulate the linkages between HIV and STIs – they deserve a similar approach since they are transmitted in the same way;
- Prioritise STIs based on both morbidity and mortality;
- Generate specific STI funding as STIs tend to get lose in overwhelming HIV funding;
- Apply human rights approach to services for at-risk populations.

HIV and AIDS

- Improve the integration of medical and traditional male circumcision;
- Improve advocacy and mainstreaming of SBCC in HIV prevention and treatment programmes;
- Strengthen community participation in HIV prevention programmes and regional campaigns;
- Make more domestic financing available.

TB

- Address TB in hard-to-reach and challenging settings;
- Improve collaboration at bilateral and regional levels for funding, implementation of a harmonised approach, and reduce diagnostic and treatment costs;
- Re-energise interest in TB among communicators;
- Lobby for funds to prevent stock-outs and shortages.

3

Emerging issues for regional advocacy

The evidence and commitments outlined in Part 2 point to important trends, gaps and priorities in the SADC region. These issues inform the regional advocacy priorities and form the basis for the development of priority advocacy results and strategies for advocacy in the region. These have been categorised as a set of cross-cutting and disease-specific issues, as illustrated in Figure 6.

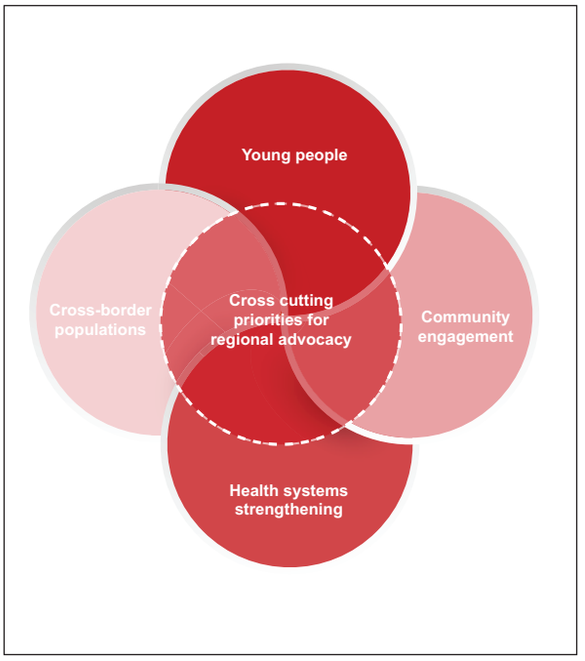
3.1 Cross-cutting emerging issues for regional advocacy

In order to effectively respond to key communicable diseases in the SADC region, fundamental cross-cutting issues must be addressed in an integrated manner. This is one of the key messages emerging from the reviewed literature, both at global and regional levels – effective responses need to be part of an integrated health approach.

Cross-cutting issue 1: Health systems strengthening

- In most countries, health spending still falls short of the agreed target;
- The quantity and quality of health professionals do not meet the required needs;
- Costs and processes are not facilitating better procurement of drugs and commodities (including condoms) across the region;
- Linkages in the management of SRH, HIV/TB and STIs and maternal and child health services are still weak; and
- There is inequity in access to services for various segments of the population, including gender inequality, young people and mobile populations.

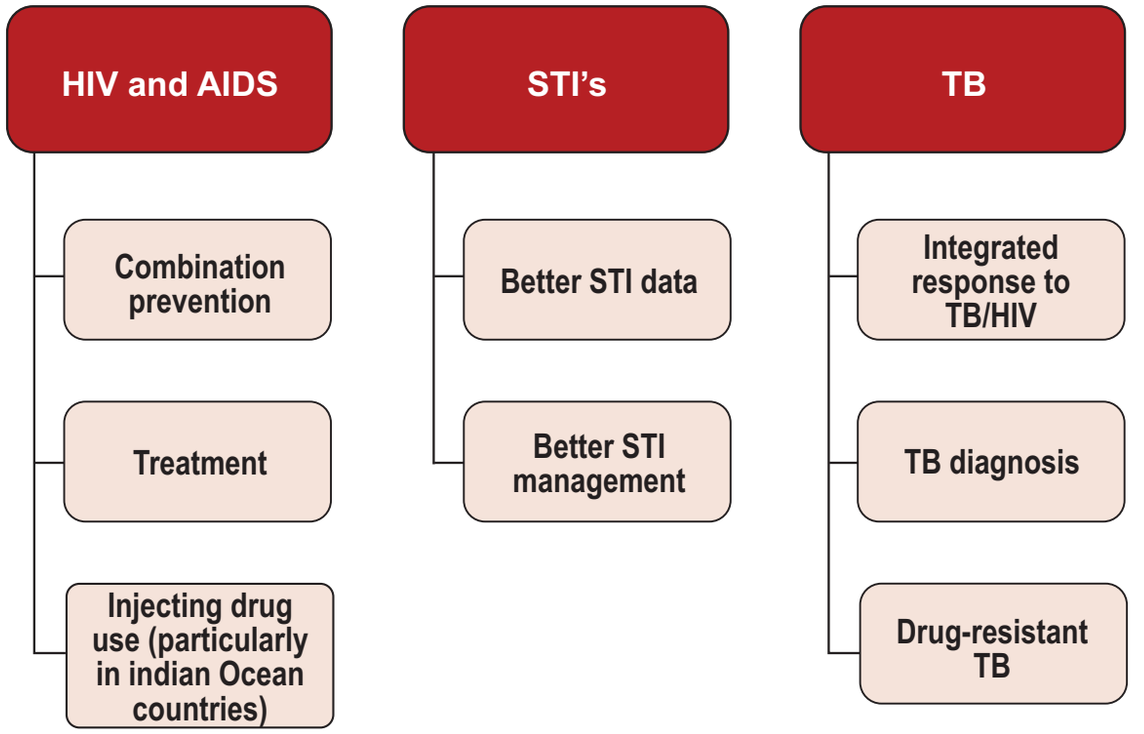
Figure 6. Proposed SADC advocacy priorities



Cross-cutting issue 2: Community engagement

- Community engagement continues to be weak and fragmented and lacks a mainstreamed policy and programmatic approach to ensure its institutionalisation. There is a need for stronger policy, guidance, resource allocation and monitoring around community engagement. Citizens, communities and local government officials must be able to engage with budget processes and strategic planning, and to monitor budget allocations and implementation of HIV and AIDS, TB and STI services;
- Social behaviour change communication needs to be promoted regionally as a framework for community engagement through standard minimum guidelines (See draft SADC SBCC Guidelines for HIV and AIDS, TB and STIs); and

Figure 6. Proposed SADC advocacy priorities



- There is a need for community participation within advocacy efforts including in the implementation of this strategy.

Cross-cutting issue 3: Cross-border populations and other key populations

- There is inadequate harmonisation and coordination in the areas of disease-specific management guidelines, port health services, cross-border referral, and disease control across borders;
- People who cross borders face difficulties accessing health services for communicable diseases, due to legal and administrative barriers;
- There is inadequate disease surveillance and epidemic preparedness, as well as operations research and sharing of information among cross-border populations; and
- Key populations must be better integrated into national policies and programmes on HIV and AIDS, TB and STIs.

Cross-cutting issue 4: Children and young people

- Children and young people, particularly young women and girls, continue to bear the direct and indirect consequences of HIV and AIDS, TB and STIs. There is an urgent need for revitalised efforts to prevent new infections in children and young people by using family-centred approaches;
- Those efforts should focus on integrating paediatric services into national responses for HIV and AIDS, Tb and STIs; and
- The efforts should also focus on creating demand for prevention services among young people, such as condom provision, HIV testing, STI management, male circumcision and prevention of mother-to-child transmission.

3.2 HIV and AIDS emerging issues for regional advocacy

HIV and AIDS interventions have evolved significantly over the past decade. There is more information available about which interventions are effective, and a strong evidence base for advocacy has been built.

The priority advocacy issue for HIV and AIDS is a revitalisation of prevention by increasing demand for effective HIV prevention, especially among young people. Efforts around treatment need to be continued and sustained. Both prevention and treatment are addressed within the context of sexual transmission of HIV. A distinct epidemic involving injecting drug use exists in some of the Indian Ocean countries, and this is addressed as a third, geographically specific advocacy priority.

HIV and AIDS issue 1: Combination prevention

- Stigma and discrimination remain major obstacles to increasing the demand for HIV prevention services, including HIV testing;
- Condom availability and consistent condom use remains low in the region, including among adolescents despite high HIV prevalence among 15–19 year olds;
- There are high levels of undetected STIs despite the strong links between untreated STIs and the risk of HIV transmission;
- Uptake of medical male circumcision is still relatively low in the region despite its effectiveness in preventing HIV acquisition; and
- There are opportunities to capitalise further on the gains in preventing mother-to-child transmission of HIV, which saw a 50% reduction in new infections among children between 2001 and 2011 in the region.

HIV and AIDS issue 2: Treatment

- There is a need for strengthened capacity of service providers to deliver comprehensive, quality treatment services (see health systems strengthening);
- Access to local production and regulatory harmonisation of medicines is still weak; and
- There is a need to revitalise efforts to ensure adherence to treatment, including paediatric treatment (see community engagement through SBCC).

HIV and AIDS issue 3: Injecting drug use

- There is a lack of essential prevention measures for people who inject drugs, including the promotion of safer sex, and availability of sterile drug injecting equipment remain limited in most countries in eastern and southern Africa.[39] Provision of these services needs to be accelerated in countries where injecting drug use is a significant mode of transmission.

3.3 Tuberculosis: emerging issues for advocacy

Tuberculosis issue 1: Integrated response of TB/HIV

- Despite the high HIV and TB co-infection rates in the region, integrated management of HIV and TB remains insufficient and does not meet demand.

Tuberculosis issue 2: TB diagnosis

- TB diagnosis remains inadequate across the region, despite high transmission rates.

Tuberculosis issue 3: Drug-resistant TB

- The region has some of the highest levels of drug-resistant TB, with SADC Member States accounting for half of all MDR-TB cases in Africa;
- The extent of MDR- and XDR-TB in the region reveals significant gaps in relation to TB treatment, case management, infection control and diagnostic capacities, and in some cases also highlights weaknesses in overall health systems.

3.4 Sexually transmitted infections: Emerging issues for regional advocacy

STI issue 1: Strengthen awareness of STIs

- Prevalence of STIs appears to be high, but accurate data that can inform more effective policies, programmes and resource allocation are lacking.

STI issue 2: Improved management of STIs

- STI detection rates are low;
- Capacity and awareness of STIs are weak; and
- Treatment of STIs is inadequate.

STI issue 3: Increased funding of STIs

- Funding for STI prevention and control services needs to increase.

[39] UNAIDS. Getting to Zero Epidemic Report Eastern and Southern Africa. Johannesburg: UNAIDS; 2013.

4

Proposed strategic framework for action

The proposed advocacy strategic framework is organised into a set of advocacy briefs for (i) cross-cutting issues for an integrated response that should be seen as prerequisites for advocacy efforts, and for (ii) each epidemic in the region. Specific sections have been developed in each brief, and these are described in more detail below.

Focusing on outcomes and results

In developing the strategy, specific and measurable outcomes and related results that can be achieved within a reasonable, defined timeframe were identified.

Identifying target audience and advocacy partners

It is useful to distinguish between primary and secondary audiences. The primary target audiences of this strategy are leaders and decision makers within government and other key institutions, such as the SADC Secretariat. The secondary audiences, or "advocacy partners", are individuals and structures that are best placed to contribute to the advocacy efforts. They include politicians, public servants, the SADC Secretariat, the media, development agencies, community-based organisations, influential NGOs, youth groups and so on.

Selecting advocacy strategies

The strategies proposed for each of the advocacy results are grouped into three main areas:

- Evidence-based advocacy through research and gap assessments;
- Action-oriented advocacy by promoting consultative processes to agree on policy and programmatic change at all levels; and
- Advocacy to create change by focusing on public outreach and awareness raising.

CROSS-CUTTING ISSUE 1: Health systems strengthening

Advocacy outcome 1	**Strengthen national health to effectively respond to communicable diseases, particularly HIV and AIDS, TB and STIs**
Advocacy result 1.1	**Reach target of 15% of national public spending going to health**
Target audience	National Ministers of Finance and Health.
Advocacy partners	Members of Parliament, National AIDS Councils, civil society, UN (especially WHO, UNAIDS) and bilateral donors, professional medical bodies.
Advocacy strategy	● **Research:** Gather evidence and demonstrate impact in countries that have reached the 15% target. ● **Gap assessment:** Country-level assessment of gaps in spending and benefits of filling the gaps. ● **Stakeholder consultation:** High-level national and regional conferences to reinforce benefits of reaching 15% target and secure commitment. ● **Public outreach:** Traditional and social media to raise awareness about importance of fulfilling obligation to meet target.
Advocacy result 1.2	**Low-cost procurement of medicines and commodities (including commodities) in the region**
Target audience	National Ministers of Health, and Trade and Industry.
Advocacy partners	Civil society, pharmaceutical companies, UN (WHO, UNAIDS) and bilateral donors.
Advocacy strategy	● **Research:** Gather evidence about the impact of unaffordable medicines and commodities, and the scope for cost-savings and impact of low-cost procurement. ● **Stakeholder consultation:** High-level national conferences with key stakeholders to chart most effective ways forward. ● **Public outreach:** Traditional and social media to raise awareness about various benefits of low cost procurement.
Advocacy result 1.3	**Better integrated management of SRH, HIV/TB and STIs and maternal and child health**
Target audience	National Ministers of Health.
Advocacy partners	Professional medical bodies, other relevant line ministries, local government, civil society, UN (including WHO, UNAIDS) and bilateral donors.
Advocacy strategy	● **Research:** Gather evidence about current lack of integrated management in the region, as well as impact of improved integrated management elsewhere and the likely impact on the region. ● **Gap assessment:** Country-level assessment of gaps in integrated services and what filling these gaps would achieve and cost. ● **Stakeholder consultation:** High-level national and regional conferences to promote the most effective means for ensuring improved integration of services. ● **Public outreach:** Traditional and social media to raise awareness about improved integration of services, including SBCC at a community level.

CROSS-CUTTING ISSUE 2: Community engagement

Advocacy outcome 2	**Communities fully engaged in the response to HIV and AIDS, TB and STIs in the region**
Advocacy result 2.1	**Institutionalise community participation in the national response through policy, guidance, resource allocation and monitoring**
Target audience	National Ministers of Health, and local Government.
Advocacy partners	Community-based organisations, civil society, community radio, professional medical bodies.
Advocacy strategy	● **Stakeholder consultation:** Community-level workshops and national conferences to institutionalise community participation. ● **Support establishment of community health platforms:** Identify relevant community health organisations. ● **Public outreach:** Use local media, including community stations, to raise awareness about importance of meaningful community engagement.
Advocacy result 2.2	**Invest in community-led interventions, such as SBCC programmes, and platforms to promote community health engagement**
Target audience	National Ministers of Health and Finance
Advocacy partners	Community-based organisations, civil society, community radio, professional medical bodies, other relevant line ministries (such as education), teachers' unions.
Advocacy strategy	● **Promote SBCC:** Develop national guidelines on SBCC for effective community health engagement; establish district-level multi-sector task teams on SBCC (see SADC regional SBCC guidelines). ● **Stakeholder consultation:** Community-level workshops to train trainers on SBCC. ● **Public outreach:** Use local media, including community stations, to raise awareness about importance of SBCC.
Advocacy result 2.3	**Facilitate improved harmonisation and coordination of disease-specific management guidelines, port health services, cross-border referrals, and disease control across borders**
Target audience	National Ministries of Health, Transport and Home Affairs.
Advocacy partners	Regional NGOs (such as North Star Alliance), IOM, WHO.
Advocacy strategy	● **Research:** Consolidate evidence and demonstrate impact of lack of equal access to services for cross-border populations. ● **Gap assessment:** Regional-level assessment of gaps in relation to cross-border populations and potential advantages of filling these gaps. ● **Stakeholder consultation:** Regional conference – and community meetings in strategic locations (borders and major centres of migration) – to raise awareness of policy and programmatic changes to address gaps. ● **Public outreach:** Use media to raise awareness of importance of improved access to cross-border health services.

CROSS-CUTTING ISSUE 3: Cross-border populations and other key populations

Advocacy outcome 3	**Cross-border populations and other key populations have equal access to services including prevention, care and treatment**
Advocacy result 3.1	Ensure continuum of health services for communicable diseases when people cross borders (health systems strengthening)
Target audience	National Ministries of Health and other relevant line ministries.
Advocacy partners	Regional NGOs (such as North Star Alliance), civil society, members of parliament, IOM, WHO, professional medical bodies.
Advocacy strategy	● **Gap assessment:** National-level assessment of gaps in relation to a continuum of health services. ● **Stakeholder consultation:** National conferences to highlight need for policy and programmatic change to address gaps in continuum of health services. ● **Public outreach:** Use traditional and social media – and public education campaigns in key locations – to raise awareness of importance of developing full continuum of health services and ensuring access for cross-border populations.
Advocacy result 3.2	**Ensure that key populations most affected by HIV and AIDS, TB and STIs are included in policies and programmes**
Target audience	National Ministries of Health.
Advocacy partners	National AIDS Councils, civil society, UN bodies (especially WHO and UNAIDS), bilateral donors, professional medical bodies.
Advocacy strategy	● Research: Gather and disseminate information on key population groups and on benefits of fully including them in policies and programmes. ● Gap assessment: National-level assessments of gaps in relation to key populations and how the gaps can be filled. ● Public outreach: Traditional and social media – and public education – to raise awareness of importance of including key populations and tackling stigma and discrimination faced by key populations.

CROSS-CUTTING ISSUE 4: Children and young people

Advocacy outcome 4	**Children and young people are actively engaged in the response to HIV and AIDS, TB and STIs in the region**
Advocacy result 4.1	**Fully integrate paediatric services into relevant policies and programmes related to communicable diseases – including HIV and AIDS, TB and STIs – using a family-centred approach**
Target audience	National Ministries of Health.
Advocacy partners	Civil society, professional medical bodies, UN bodies (WHO and UNAIDS) and bilateral donors.
Advocacy strategy	● Research: Gather and publicise evidence to highlight benefits of fully integrating paediatric services into relevant policies and programmes. ● Gap assessment: National-level assessments of gaps in relation to paediatric services. ● Stakeholder consultation: Regional conference to secure commitment to full integration of pediatric services.
Advocacy result 4.2	**Institutionalise children and youth-friendly health services that create demand for prevention and treatment services of communicable diseases**
Target audience	Ministries of Health, and of Children and Youth (where applicable).
Advocacy partners	Civil society, youth groups, community-based organisations, UN bodies (UNFPA, UNAIDS) and bilateral donors.
Advocacy strategy	● Research: Gather evidence to highlight the challenges and opportunities of involving youth in the response. ● Gap assessment: County-level assessments of gaps in youth-friendly health services, including factors that perpetuate gender inequity. ● Stakeholder consultation: National-, local- and community-level conferences and workshops, involving youth and youth groups, to identify policy and programmatic changes. ● Public outreach: Use social media and youth radio stations – including the support of celebrity champions from worlds of music, sport and TV – to raise awareness of need for youth engagement and to mobilise youth.

HIV and AIDS ISSUE 1: Combination prevention

HIV advocacy outcome 1	**Create demand for prevention services, including testing, condoms, prevention of mother-to-child transmission, medical male circumcision and STI management**
HIV advocacy result 1.1	Greater demand for innovative testing and counseling services, including by addressing obstacles related to stigma and discrimination, by using a variety of approaches, including SBCC
Target audience	Ministries of Health.
Advocacy partners	National AIDS Councils, civil society, UN bodies (WHO, UNAIDS, UNFPA), youth groups.
Advocacy strategy	● **Research:** Gather and publicise information about impact of innovative testing and counseling services, and impact of ongoing stigma and discrimination. ● **Gaps assessment:** National-level assessment of gaps relating to testing and counseling services, and how those gaps can be filled. ● **Stakeholder consultation:** National conferences to agree upon best applicable testing and counseling services and methods for overcoming obstacles related to stigma and discrimination. ● **Public outreach:** Use community radio stations and social media to raise awareness about importance of innovative services and how to demand them.
HIV advocacy result 1.2	**Greater demand for condom availability and distribution in strategic areas**
Target audience	Ministries of Health and Youth.
Advocacy partners	NACs, civil society, UN bodies (UNFPA), bilateral donors, youth groups.
Advocacy strategy	● Gaps assessment: National-level assessment of gaps in condom availability and distribution, and what needs to be done to overcome the gaps. ● Stakeholder consultation: National conferences to address challenges related to condom availability, distribution and use. ● Public outreach: Use events at high schools and universities, social media, celebrity campaigns, and community radio stations to spark calls by youth for wider availability of condoms.
HIV advocacy result 1.3	**Earlier detection and improved management of STIs**
Target audience	Ministries of Health.
Advocacy partners	Civil society, UN bodies (WHO, UNFPA), bilateral donors, professional medical bodies, community-based organisations.
Advocacy strategy	● **Research:** Gather and publicise information on impact of late detection of STIs on individuals and communities. ● **Gaps assessment:** National-level assessment of the gaps in detection and management of STIs and what would be needed to fill them. ● **Stakeholder consultation:** Regional and national conferences, and local workshops on early detection and management of STIs. ● **Public outreach:** Use traditional and social media to highlight importance of early detection of STIs and use of SBCC.

HIV advocacy result 1.4	**Greater demand for male circumcision by addressing ethical and cultural issues through SBCC, and by increasing capacity and resources to scale up male circumcision campaign**
Target audience	Ministries of Health and Finance.
Advocacy partners	National AIDS Councils, civil society, UN bodies (WHO, UNAIDS), bilateral donors, youth groups, traditional leaders, community-based organisations.
Advocacy strategy	● Research: Collate and disseminate information on the impact of male circumcision on STIs. ● Stakeholder consultation: National conferences to address challenges related to male circumcision (financial, cultural, etc.) and reflect on best approaches to encourage demand. ● Public outreach: Use traditional and social media as well as community radio stations to highlight benefits of male circumcision, along with public education campaigns involving community workshops, billboards, etc.

HIV advocacy result 1.5	**Reduce number of children newly infected with HIV by 90% and the number of mothers dying from AIDS-related causes by 50%**
Target audience	Ministries of Health
Advocacy partners	National AIDS Councils, civil society, UN bodies (WHO, UNAIDS, UNICEF), bilateral donors, community-based organisations, professional medical bodies.
Advocacy strategy	● Gaps assessment: National-level assessment of gaps in relation to PMTCT and services to support mothers. ● Stakeholder consultation: Regional conference to re-emphasise importance of PMTCT and ensure that Member States commit to targets. ● Public outreach: Use traditional media, community radio stations and public education campaigns to highlight success of PMTCT and ARVs in preventing infections in children and keeping mothers alive.

HIV and AIDS ISSUE 2: Treatment

HIV advocacy outcome 2	**Create and respond to demand for treatment services**
HIV advocacy result 2.1	**Reinforce capacity of service providers to deliver comprehensive quality treatment services (health systems strengthening)**
Target audience	Ministries of Health and Finance.
Advocacy partners	Civil society, people living with HIV.
Advocacy strategy	● **Gap assessment:** National-level assessment of gaps in capacity of service providers and what filling these gaps would achieve and cost. ● **Stakeholder consultation:** High-level national conferences to address current capacity constraints and chart way forward in relation to delivery comprehensive quality treatment services. ● **Public outreach:** Use traditional and social media to encourage community monitoring of service delivery to identify key bottlenecks and successful strategies.
HIV advocacy result 2.2	**SADC to facilitate access to local production and regulatory harmonisation of medicines**
Target audience	SADC Secretariat, Ministries of Health, Trade and Industry.
Advocacy partners	Civil society, people living with HIV, UN bodies (WHO, UNAIDS), pharmaceutical companies, business bodies, economists.
Advocacy strategy	● **Research:** Gather latest information on drug production, trade implications, legal issues and impact of greater local production. ● **Gap assessment:** Regional- and country-level assessment of gaps in procurement, delivery and national regulations and benefits of filling these gaps. ● **Stakeholder consultation:** High-level regional conference to be followed by national conferences to address bottlenecks in regional and local production and procurement, and to harmonise regulations. ● **Public outreach:** Use traditional media to highlight range of benefits of greater access to local production of medicines.
HIV advocacy result 2.3	**Greater community engagement around treatment adherence (using SBCC)**
Target audience	SADC Secretariat, Ministries of Health.
Advocacy partners	Civil society, community-based organisations, professional medical bodies.
Advocacy strategy	● Research: Gather data on importance of community engagement in ensuring greater treatment adherence. ● Stakeholder consultation: National conference to agree on best ways to use SBCC to promote greater community engagement. ● Public outreach: Use traditional and social media, particularly community radio stations, to encourage community engagement, as well as local-level workshops to promote effective SBCC.

HIV and AIDS ISSUE 3: Injecting drug use

HIV advocacy outcome 3	**Accelerate HIV prevention and treatment services for injecting drug users (particularly in Indian Ocean island countries where injecting drug use is the main mode of transmission)**
HIV advocacy result 3.1	Facilitate high-level political advocacy on injecting drug use
Target audience	SADC Secretariat.
Advocacy partners	Civil society, UN bodies (WHO, UNAIDS), professional medical bodies, youth groups.
Advocacy strategy	● **Research:** Gather information on injecting drug use in relation to HIV, TB and STIs. ● Gap assessment: National-level assessment of gaps in policy and programmatic responses to injecting drug use and benefits of filling the gaps. ● **Stakeholder consultation:** Regional conference for Ministers to highlight need for greater focus on injecting drug use. ● **Public outreach:** Traditional and social media to raise awareness among high- level politicians about injecting drug use and links to HIV.
HIV advocacy result 3.2	Promote the collection of reliable strategic information, including national integrated biological and behavioural surveillance surveys
Target audience	Ministries of Health, and Home Affairs.
Advocacy partners	Civil society, UN bodies (WHO, UNAIDS), bilateral donors, professional medical bodies, youth groups, National AIDS Councils.
Advocacy strategy	● **Research:** Conduct pilot integrated biological and behavioural surveillance surveys to showcase importance of national surveys. ● **Stakeholder consultation:** Regional conference to debate importance of reliable strategic information and how best to gather and use it. ● **Public outreach:** Use traditional and social media to raise awareness in general population about injecting drug use and links to HIV, and about importance of integrated biological and behavioural surveillance surveys.
HIV advocacy result 3.3	Address the needs of people who inject drugs in national AIDS strategies, while committing the required resources to comprehensive, evidence-based HIV programmes for this key population
Target audience	Ministries of Health and Finance, and National AIDS Councils.
Advocacy partners	Local government, civil society, UN bodies (WHO, UNAIDS), professional medical bodies, youth groups.
Advocacy strategy	● **Research:** Gather information on injecting drug use in relation to HIV, TB and STIs. ● **Gap assessment:** National-level assessment of gaps in policy and programme responses to injecting drug use and the benefits and costs of filling those gaps. ● **Stakeholder consultation:** Regional conference to identify best practices in relation to developing comprehensive, evidence-based HIV programmes for this key population. ● **Public outreach:** Traditional and social media to raise awareness about injecting drug use and the links to HIV, encourage people who inject drugs to demand health services that meet their needs, and ensure that health service providers deliver those services.

Tuberculosis ISSUE 1: Integrated response to TB/HIV

TB advocacy outcome 1	**Accelerate a fully integrated response to TB/HIV in the region**
TB advocacy result 1.1	Set up and strengthen a coordinating body for collaborative HIV/TB activities, which is functional at national and local health facility levels
Target audience	Ministries of Health.
Advocacy partners	SADC Secretariat, civil society, UN bodies (WHO, UNAIDS), professional medical bodies, National AIDS Councils.
Advocacy strategy	● Research: Gather information on TB/HIV and importance of integrated response. ● Gap assessment: National-level assessment of gaps in the integrated response to TB/HIV and how a coordinating body can help fill these gaps. ● Stakeholder consultation: National conferences to establish coordinating bodies for collaborative HIV/TB activities. ● Public outreach: Use medical journals to highlight need for integrated approach and for coordinating body to oversee collaborative activities. Use traditional and social media to raise awareness about TB/HIV and create public demand for more effective, collaborative and integrated responses.
TB advocacy result 1.2	SADC to lobby for access to regional GeneExpert technology to determine TB prevalence among people living with HIV
Target audience	SADC Secretariat, Ministries of Health.
Advocacy partners	Civil society, UN bodies (WHO, UNAIDS), professional medical bodies, academics, National AIDS Councils.
Advocacy strategy	● Research: Gather and disseminate information about impact of GeneExpert technology. ● Gap assessment: Regional- and national-level assessment of gaps in the use of GeneExpert technology and the benefits and costs of filling these gaps. ● Stakeholder consultation: High-level regional conference on more affordable and broader access to GeneExpert technology. ● Public outreach: Use traditional media and key medical journals to highlight need for wider use of GeneExpert technology. Use traditional and social media to raise awareness about impact of GeneExpert technology to increase public demand.
TB advocacy result 1.3	Carry out joint TB/HIV planning and monitoring to integrate and evaluate the delivery of TB and HIV services
Target audience	Ministries of Health.
Advocacy partners	Civil society, UN bodies (WHO, UNAIDS), bilateral donors, professional medical bodies, community-based organisations, National AIDS Councils.
Advocacy strategy	● Gap assessment: National-level assessment of gaps in the integrated response to TB/HIV, including planning, delivery and monitoring. ● Stakeholder consultation: National conferences to design more effective planning, delivery and monitoring of integrated TB/HIV services, and community workshops to monitor integrated response. ● Public outreach: Use traditional and social media – particularly community stations – to raise awareness about TB/HIV, need for integrated response and importance of local-level monitoring of services.

Tuberculosis ISSUE 2: TB diagnosis

TB advocacy outcome 2	**Create demand for more TB diagnosis to reduce the number of missed cases**
TB advocacy result 2.1	Increase awareness around TB diagnosis
Target audience	Ministries of Health.
Advocacy partners	Civil society, local government, people living with HIV, UN bodies (WHO, UNAIDS), bilateral donors, professional medical bodies.
Advocacy strategy	● Research: Gather information on missed cases in southern Africa. ● Gap assessment: Regional- and national-level assessment of gaps in TB diagnosis. ● Stakeholder consultation: Regional and national conferences on need to increase TB diagnosis, including broader use of GeneExpert technology. ● Public outreach: Use traditional, community and social media to raise awareness about TB, and urgent need for more diagnosis.
TB advocacy result 2.2	Increase capacity for TB diagnosis
Target audience	Ministries of Health and Finance.
Advocacy partners	Civil society, UN bodies (WHO, UNICEF), bilateral donors, professional medical bodies, youth groups, people living with HIV.
Advocacy strategy	● Gap assessment: National-level assessment of gaps in TB diagnosis and what filling them would achieve and cost. ● Stakeholder consultation: National conferences on need to increase capacity to conduct more TB diagnosis; and local-level workshops on how to utilise increased capacity, including GeneExpert technology. ● Public outreach: Use traditional, community and social media to raise awareness about TB, and stimulate public demands for more diagnosis.

Tuberculosis ISSUE 3: Drug-resistant TB

TB advocacy outcome 3	**Accelerate emergency management of drug-resistant TB in the region**
TB advocacy result 3.1	Promote MDR-TB and XDR-TB management as part of national TB control programmes
Target audience	Ministries of Health.
Advocacy partners	UN bodies (WHO), professional medical bodies, civil society, bilateral donors, Members of Parliament.
Advocacy strategy	● **Research:** Collate and publicise latest information about spread of MDR-TB and XDR-TB and potential impact of the epidemics. ● **Gap assessment:** Regional- and national-level assessment of gaps in management of drug-resistant TB and what filling these gaps would achieve. ● **Public outreach:** Use traditional, community and social media to raise awareness about threats posed by drug-resistant TB and about the ability to manage it successfully as part of national TB control programmes.
TB advocacy result 3.2	Adapt and promote specific guidelines for the "Management of Drug-Resistant Tuberculosis" according to WHO guidelines
Target audience	Ministries of Health.
Advocacy partners	SADC secretariat, civil society, professional medical bodies, WHO.
Advocacy strategy	● **Research:** Collate and publicise latest information about spread of MDR-TB and XDR-TB and potential impact of the epidemics. ● **Gap assessment:** Regional assessment of gaps in adapting WHO guidelines for specific regional context. ● **Stakeholder consultation:** Regional conference to agree SADC-wide guidelines on management of MDR-TB and XDR-TB, national conferences to ensure guidelines are incorporated into national TB control programmes. ● **Public outreach:** Use traditional, community and social media to raise awareness about threats posed by drug-resistant TB and ability to manage it successfully with adapted WHO guidelines.
TB advocacy result 3.3	Strengthen capacity to diagnose MDR-TB and XDR-TB (which requires facilities with culture and drug sensitivity testing)
Target audience	Ministries of Health.
Advocacy partners	Professional medical bodies, WHO, civil society.
Advocacy strategy	● **Gap assessment:** National-level assessment of gaps in diagnosis of drug resistant TB and what filling these gaps would achieve and cost. ● **Stakeholder consultation:** National conferences to agree on best way of increasing diagnosis capacity, and local-level workshops to make most effective use of increased capacity. ● **Public outreach:** Use traditional, community and social media to raise awareness about threats posed by drug-resistant TB and importance of early diagnosis.

Sexually Transmitted Infections ISSUE 1: Raise awareness about STIs

STI advocacy outcome 1	**Raise awareness through broader access to and dissemination of more focused information**
STI advocacy result 1.1	Improve basic data on STI prevalence
Target audience	Ministries of Health, and National Statistics Office.
Advocacy partners	SADC secretariat, UN bodies (WHO, UNAIDS), bilateral donors, private sector, professional medical bodies.
Advocacy strategy	● **Research:** Conduct and publicise relevant baseline research to improve understanding of STI situation in Member States (including statistics, trends, implications, challenges and opportunities). Conduct and publicise research into attitudes of general public and health service providers. ● **Stakeholder consultation:** High-level regional conference on factors driving STI epidemic, including gender inequality, and need for better management of epidemic. ● **Public outreach:** Use traditional, community and social media to raise awareness about STIs.
STI advocacy result 1.2	Collect and promote information to improve understanding what works and what does not in the response to STIs
Target audience	Ministries of Health.
Advocacy partners	UN bodies (WHO, UNAIDS), bilateral donors, private sector, professional medical bodies, civil society.
Advocacy strategy	● **Research:** Conduct and publicise research into effective responses to STIs in the region and elsewhere. ● **Gaps assessment:** National assessment into gaps in response to STIs. ● **Stakeholder consultation:** National conferences to identify best practices for management of STIs for each Member State. ● **Public outreach:** Use traditional, community and social media – and government advertising campaigns – to raise awareness about STIs (could include STI storylines in major TV soap operas) and about effective responses.
STI advocacy result 1.3	Increase awareness on STIs within the context of gender inequality, gender-based violence, stigma and discrimination, harmful cultural practices and multiple concurrent partnerships
Target audience	Ministries of Health.
Advocacy partners	Other relevant line ministries, UN bodies (WHO, UNAIDS), civil society, professional medical bodies, community-based organisations.
Advocacy strategy	● **Research:** Conduct and publicise relevant research on STIs within the context of gender inequality, GBV, stigma and discrimination, harmful cultural practices and MCP. ● **Stakeholder consultation:** National conferences on factors driving STI epidemic, including gender inequality, gender-based violence, stigma and discrimination, harmful cultural practices and MCP; and to identify best practices to address STIs in relation to each factor in specific national contexts. ● **Public outreach:** Use traditional, community and social media to highlight links between these factors and STIs.

Sexually Transmitted Infections ISSUE 2: Improved management of STIs

STI advocacy outcome 2	**Improve the management of STIs**
STI advocacy result 2.1	**Increase STI detection and screening**
Target audience	Ministries of Health.
Advocacy partners	UN bodies (WHO, UNAIDS, UNFPA), bilateral donors, professional medical bodies, civil society, SADC secretariat, National AIDS Councils.
Advocacy strategy	● Gap assessment: Identify gaps at national and regional level in relation to the detection and screening for STIs (including for cross-border populations) and what filling these gaps will achieve. ● Stakeholder consultation: Regional and national conferences on ways to increase detection and screening of STIs. ● Public outreach: Use traditional, community and social media (and events at high schools and universities) to promote awareness of STIs and how to detect them early.
STI advocacy result 2.2	**Increase STI management capacity and awareness, including surveillance and new laboratory technologies and systems**
Target audience	Ministries of Health, and Finance.
Advocacy partners	UN bodies (WHO, UNAIDS, UNFPA), bilateral donors, professional medical bodies, civil society, SADC Secretariat.
Advocacy strategy	● Research: Gather information on new technologies and systems. ● Gap assessment: Identify gaps at national level in relation to capacity, surveillance and new technologies. ● Stakeholder consultation: National conferences on ways to increase management capacity, and local-level workshops to ensure most effective use of new technologies and systems. ● Public outreach: Use traditional, community and social media to promote awareness of STIs and how to manage them.
STI advocacy result 2.3	**Increase treatment of STIs**
Target audience	Ministries of Health.
Advocacy partners	UN bodies (WHO, UNAIDS, UNFPA), bilateral donors, professional medical bodies, civil society, National AIDS Councils.
Advocacy strategy	● Gap assessment: Identify treatment gaps at national level (including for cross-border populations). ● Stakeholder consultation: National conferences on ways to increase treatment of STIs. ● Public outreach: Use traditional, community and social media to promote awareness of STIs and how to treat them.
STI advocacy result 2.4	**Increase STI prevention, particularly among young people, and address gender inequality, gender-based violence and MCP**
Target audience	Ministries of Health, and Women and Youth (where applicable).
Advocacy partners	UN bodies (WHO, UNAIDS, UNFPA, UNWOMEN), bilateral donors, professional medical bodies, civil society, youth groups, women's groups, National AIDS Councils.
Advocacy strategy	● Research: Conduct and publicise relevant research on STIs within the context of youth, gender inequality, gender-based violence, harmful cultural practices and MCP. ● Gap assessment: Identify prevention gaps at national level within the context of youth, gender inequality, gender-based violence, harmful cultural practices and MCP. ● Stakeholder consultation: National conferences on ways to tackle STIs within the context of youth, gender inequality, gender-based violence, harmful cultural practices and MCP. ● Public outreach: Use traditional, community and social media to promote awareness of STIs and how these factors drive STI epidemics.

Sexually Transmitted Infections ISSUE 3: Greater funding for STI services

STI advocacy outcome 3	**Improve the funding of STI prevention and control services**
STI advocacy result 3.1	**Mobilise specific funding for the prevention and control of STI**
Target audience	Ministries of Health, and Finance.
Advocacy partners	UN bodies (WHO, UNAIDS), bilateral donors, professional medical bodies, civil society, National AIDS Councils.
Advocacy strategy	● **Research:** Gather information on what has worked or not worked (for example, case reporting and elimination of syphilis in Mauritius). ● **Gap assessment:** Identify funding gaps at national level for prevention and control of STI services, and analyse benefits and costs of filling the gaps. ● **Stakeholder consultation:** Regional conference to ensure Member States commit to greater funding for STIs prevention and control, and national conferences to agree on specific funding proposals. ● **Public outreach:** Use traditional, community and social media to promote awareness of STIs and how to prevent and control them so that public demand helps to drive political process.

5

Implementation

This section outlines key steps and considerations for implementing the regional advocacy strategy.

Preparing a regional work plan

Effective advocacy requires good organisational planning. Having defined the overall results, target audiences, partners, key messages and strategies, it is important to systematically map the specific actions for the SADC Secretariat and Member States, including timelines, milestones, indicators and resources. This could be facilitated within the SADC Secretariat by establishing relevant task forces on specific advocacy issues.

At the level of Member States, a gaps assessment to identify key gaps and priority issues based on country contexts would be useful, along with identifying gatekeepers for each issue.

Collective ownership: Identifying champions and promoting partnerships

Effective advocacy tends to be driven by a "champion" (in this case, a Member State or a specific Ministry or institution) and brings together different players around a common cause.

At the SADC Secretariat level, there is an opportunity to facilitate such collective ownership by identifying and convening "champions" among Member States on specific issues and by promoting partnerships and linking with existing regional an global advocacy platforms.

At the Member State level, collective ownership could be facilitated by scanning existing advocacy initiatives and platforms and identifying gatekeepers for each advocacy issue.

Costing and identifying resources

Cost considerations are likely to influence the choice of approach. Funds and other resources will need to be sufficient to sustain advocacy for a chosen duration. The SADC Secretariat will need to mobilise adequate resources to implement the regional advocacy strategy. At country level, Member States will need to identify the existing and potential resources for specific advocacy issues.

Capacity assessment

It would be useful for Member States and the SADC Secretariat to undertake specific capacity assessments that identify existing resources and assets in order to capitalise on the advocacy results and corresponding strategies.

Monitoring and evaluation

During the planning stage, it is important to integrate monitoring and evaluation by identifying clear and measurable indicators and by establishing baselines and targets. This should translate into a clear monitoring plan for the regional advocacy strategy, which the SADC Secretariat would monitor.

At the level of Member States, monitoring should also take place during the planning phase and should be led by a gatekeeper that is selected for each issue.

Mechanisms are needed to track interventions and monitor results, such as media coverage and expressions of public support. Advocacy takes place in a dynamic environment. The policy terrain can change quickly and close monitoring of policy contexts and broader trends is needed so countries can react quickly and flexibly, identify opportunities and anticipate new challenges.

Some of the key implementation tasks at regional and country levels include:

At SADC Secretariat level:

- Establish relevant task force on specific advocacy issues;
- Convene Member States on specific advocacy issues; and
- Mobilise resources and strengthen capacity by linking up with regional and global advocacy platforms.

At Member State Government level:

- Gaps assessment to unpack key gaps and priority issues based on country context;
- Scan of existing advocacy initiatives and platforms, including stakeholder assessment, and identify gate-keepers for each advocacy efforts; and
- Identify existing and potential resources available for specific advocacy issues.

ANNEX 1: list of sources

Global documents

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Country documents

Angola	National Strategic Plan on HIV and AIDS, 2003–2008.
Botswana	The Second Botswana National Strategic Framework for HIV and AIDS, 2010–2016 Botswana TB/HIV and AIDS Collaborative Policy Guidelines, 2011.
Democratic Republic of Congo	Cadre Stratégique National de Lutte Contre le VIH/SIDA et les IST, 2009–2013
Lesotho	National HIV and AIDS Strategic Plan, 2006–2011. Kingdom of Lesotho National Tuberculosis Programme Policy and Manual draft, (2007 or later).
Malawi	National HIV and AIDS Prevention Strategy, 2009–2013. National Tuberculosis Control Programme Manual, 2012.
Mauritius	National Multisectoral HIV and AIDS Strategic Framework, 2012–2016.
Mozambique	National Strategic HIV and AIDS Response Plan, 2010–2014. National Strategic Plan for TB Control in Mozambique, 2008–2012.
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia, 2010/11–2015/16. Namibia National Health Policy Framework, 2010–2020.
Seychelles	The National Strategic Framework for HIV and AIDS and STIs, 2012–2016.
South Africa	National Strategic Plan for HIV and AIDS, STIs and TB, 2012–2016.
South African	National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.
Swaziland	The National Multi-sectoral Strategic Framework For HIV and AIDS, 2009–2014.
Tanzania	National Policy Guidelines for Collaborative TB/HIV Activities, 2008.
Zambia	National AIDS Strategic Framework, 2011–2015. National HIV/AIDS /STI/TB Policy, 2005.
Zimbabwe	National HIV and AIDS Strategic Plan, 2011–2015. Zimbabwe National Tuberculosis Control Programme, 2010.

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Regional Network on Equity in Health in Southern Africa (EQUINET)	www.equinetafrica.org
Health Economics and HIV and AIDS Research Division (HEARD)	www.heard.org,za
Health Economics Unit – University of Cape Town	www.heu-uct.org.za
Health Systems Trust (HST)	www.hst.org.za
Southern Africa AIDS Dissemination Service (SAfAIDS)	www.safaids.net
The Global Fund to Fights AIDS, Tuberculosis and Malaria	www.theglobalfund.org
STOP TB Partnership	www.stoptb.org
UNAIDS Regional Support Team for Eastern and Southern Africa	www.unaidsrstesa.org
USAID/ PEPFAR	www.hivsharespace.net
African Health Observatory – World Health Organization	www.aho.afro.who.int

ANNEX 2: List of selected key informants

Informants	Organisation	Title
Christine Chakanyuka-Musanhu	World Health Organization, Zimbabwe Country Office, Harare	National Professional Officer HIV/TUB
Eleanor Gouws	UNAIDS Regional Support Team for Eastern and Southern Africa, Johannesburg	Senior Strategic Information Advisor
Faith Mamba	UNAIDS Regional Support Team for Eastern and Southern Africa, Johannesburg	Regional Advisor – Strategic Investments
Kathleen Toomey	Centre for Disease Control and Prevention Botswana	Director
Kaymarlin Govender	HEARD – University of KwaZulu-Natal, Durban	Research Director
Lois Chingandu	SafAIDS – Johannesburg	Executive Director, Regional Office
Neway Fida	USAID – Pretoria	Regional Prevention Advisor
Sue Cleary	Health Economics Unit – University of Cape Town, Cape Town	Health Economist Professor
Themba Moeti	Health Systems Trust (HST) – Johannesburg	Chief Executive Officer
Sisonke Msimang	Former Executive Director, OSISA – Johannesburg	Gender and HIV & AIDS regional activist
Richard Lee	Open Society for Southern Africa (OSISA)	Communications and Campaigns Manager

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