SADC MINIMUM STANDARDS FOR CHILD AND ADOLESCENT HIV, TB AND MALARIA CONTINUUM OF CARE AND SUPPORT (2013-2017)

SADC Communicable Disease Project

Component 5: Scaling-up Child and Adolescent HIV, TB and Malaria Continuum of Care and Support

DRAFT POST REGIONAL CONSENSUS AND VALIDATION MEETING
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Acronyms and Abbreviations

ACT	Artemisinin Combination Therapy
ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral therapy
ARV	Anti-retroviral
BCG	Bacille Calmette Guérin
CD4	Cluster of Differentiation 4
CHBC	Community Home-Based Care
CMAM	Community Management of Acute Malnutrition
COCS	Continuum of Care and Support
CPT	Cotrimoxazole Preventive Therapy
CRC	Convention of the Rights of Children
CXR	Chest X-Ray
DOTS	Directly Observed Treatment, short course
EID	Early Infant Diagnosis
ESARO	Eastern and Southern African Regional Office (UNICEF)
EWIs	Early Warning Indicators
HBMM	Home Based Management of Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HTC	HIV Testing and Counselling
iCCM	integrated Community Case Management
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPT	Isoniazid Preventive Therapy
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated bed Nets
IUATLD	International Union Against Tuberculosis and Lung Disease
LLINs	Long-Lasting Insecticide Nets
MDG(s)	Millennium Development Goal(s)
MDR-TB	Multi-drug Resistant TB
M&E	Monitoring and Evaluation
MNCH	Maternal, Neonatal and Child Health
MS	Member State
MTCT	Mother to Child Transmission
NGO	Non Governmental Organizations
NNRTI	Non Nucleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
OVC&Y	Orphans and Vulnerable Children and Youth
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PITC	Provider-Initiated HIV Testing & Counselling
PMTCT	Prevention of Mother to Child Transmission
PSS	Psychosocial Support Services
RDT	Rapid Diagnostic Test for malaria
SADC	Southern African Development Community
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
TST	Tuberculin Skin Test
UN	United Nations
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Key Definitions

Adolescent	This document uses the WHO definition of adolescent: "A person 10 to 19 years old" [1].
Adolescent-friendly services	Adolescent-friendly health services are defined in this document as health services which do not discriminate or intimidate and are accessible, acceptable, affordable and appropriate for adolescents and young people. This definition is founded on WHO Operational Guidelines on HIV testing of infants, children and adolescents for Service Providers in the African Region[2].
Caregiver	A **caregiver** is any person giving care to a child in the home environment. **Primary caregiver** is the main person who lives with a child and provides regular parenting care for the child in a home environment. This often includes family members, such as parents, foster parents, legal guardians, siblings, uncles, aunts and grandparents or close family friends. **Secondary caregivers** include community members and professionals, such as nurses, teachers or play centre minders, who interact with a child in the community or visit a child at home but do not necessarily live with the child. **Child and youth caregivers** include children and youth who are caring for other children, ill parents and relatives and/or heading households.
Child:	This document uses child definition of the *SADC Strategic Framework and Programme of Action (2008-2015) for Comprehensive Care and Support for OVCY*, taken from the UN Convention of the Rights of the Child: "Every human being below the age of 18" [3].
Child-friendly services	A system of care that focuses on the physical, psychological, and emotional well-being of children attending health care facilities. A separate waiting area should be provided for children where they are contained and safe, and able to play and explore. Health-care workers who are identified as being good with children or have been specifically trained in paediatrics should staff the clinic. Counsellors may require special training to provide age-appropriate counselling and be sensitive to non-verbal communication. Children and their parents/caregivers should feel able to ask questions. Medical procedures (e.g. phlebotomy, injections) should be explained to the child to allay anxiety [4].
Comprehensive Care and Support	Intervention (s) or service delivery effort (s) that meets the complete set of basic needs or defined minimum standards across multiple services that addresses the survival, development, protection and participation rights of children and youth while addressing vulnerability.
Continuum of care and support	Integrated system of care for children from pregnancy to delivery, the immediate postnatal period, and childhood through adolescence. It guides and tracks patients over time through a comprehensive array of health services spanning all

[1] WHO. 2005. Child and adolescent mental health policies and plans. Document can be accessed at http://www.who.int/mental_health/policy/services/essentialpackage1v11/en/index.html

[2] WHO. 2010. Operational guidelines on HIV testing and counselling of infants, children and adolescents for service providers in the African Region.Document can be accessed at http://www.afro.who.int/en/clusters-a-programmes/dpc/acquired-immune-deficiency-syndrome/features/2883-operational-guidelines-on-hiv-testing-and-counselling-of-infants-children-and-adolescents-for-service-providers-in-the-african-region.html

[3] UN Convention on the rights of the child (CRC). Document can be accessed at http://www.unicef.org/crc/

[4] WHO. 2010. Operational guidelines on HIV testing and counselling of infants, children and adolescents for service providers in the African Region..

	levels of care: outpatient services, clinics and other health facilities, and by families and communities[5].
Harmonisation	All SADC Member States aligned to a common minimum standard of services holistically addressing HIV, TB and malaria in children and adolescents.
Holistic approach	A procedure for ensuring that different options or strategies are considered and applied flexibly in appropriate combinations that ensure comprehensive or optimal fulfillment of the well-being and development of a child.
Integration	This document uses the WHO definition of Integration: "The organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."[6] This requires a continuum of funding, administration, organisation, service delivery and clinical strategies designed to create connectivity, alignment and collaboration of HIV, TB and malaria programmes within the platform of Primary Health Care services towards improving patient outcomes, efficiency and cost-effectiveness [7,8].
Orphan	A child below the age of 18 years who has lost one or both parents. The concept of "social orphans" may be used to describe children whose parents may be alive but are no longer fulfilling any of their parental duties[9].
Palliative care for children	The WHO definition is used in this document : "Palliative care for children refers to the active total care of the child's body, mind and spirit, and also involves giving support to the family. It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease. Health providers must evaluate and alleviate a child's physical, psychological, and social distress. Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited. It can be provided in tertiary care facilities, in community health centres and even in children's homes."[10]
Paediatrics	The term as applied in this document, refers to the medical care of children.
Primary Health Care (PHC)	This document uses the definition from the Alma- Ata declaration of 1978: "Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing

[5] UNICEF. 2009. State of the World's Children. Maternal and Newborn Health. Document can be accessed at http://www.unicef.org/sowc09/

[6] WHO. 2010. Making Health Systems Work. Integrated Health Service Delivery. What and Why. Technical Brief No. 1. Document can be accessed at http://www.who.int/healthsystems/service_delivery_techbrief1.pdf

[7] Kodner DL, Spreeuwenberg C. 2002.Integrated care: meaning, logic, applications, and implications– a discussion paper, *International Journal of Integrated Care* – Vol. 2, 14 November

[8] Coker et al. 2010. A conceptual and analytical approach to comparative analysis of country case studies: HIV and TB control programmes and health systems integration, *Health policy and Planning,* - 25:i21-i31

[9] SADC. 2008. Comprehensive Care and Support for OVC&Y in the SADC: Strategic framework and programme of action 2008-2015. -. p. 5

[10] WHO.1998. WHO Definition of Palliative Care for Children. http://www.who.int/cancer/palliative/definition/en/

	health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."[11]
Psychosocial Support	A continuum of care and support that addresses the social, emotional, spiritual and psychological well-being of a person and influences both the individual and the social environment in which people live[12,13].
Task-shifting	A rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health[14].
Vulnerable children	Children who are unable or have diminished capacity to access their basic needs and rights to survival, development, protection and participation as a result of their physical condition, or social, cultural, economic or political circumstances and environment and require external support because their immediate care and support system can no longer cope[15,16,17].

[11] Declaration of Alma-Ata. 1978. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.Document can be accessed at http://www.who.int/publications/almaata_declaration_en.pdf
[12] SADC.2008. Comprehensive Care and Support for OVC&Y in the SADC: Strategic framework and programme of action 2008-2015.. p. 5
[13] SADC. 2011. Regional Conceptual Framework for Psychosocial Support for OVCY..p. ix
[14] WHO. 2008. Task shifting. Rational redistribution of tasks among health workforce teams. Document can be accessed at http://www.who.int/healthsystems/TTR-TaskShifting.pdf
[15] SADC. 2011. Minimum Package of Services for OVCY.
[16] SADC.2011. Regional Conceptual Framework for Psychosocial Support for OVCY.
[17] UNICEF. 2004. Children on the brink. Document can be accessed at http://www.unicef.org/publications/index_22212.html

1. Background

The vision of the Southern Africa Development Community (SADC) is one of *"a common future, a future within a regional community that continue to ensure socioeconomic well-being, freedom, social justice and peace and security*". As the region moves towards achieving this vision, it has faced the continuing challenges of the HIV and TB epidemics and of continued high levels of malaria in some countries. Children and adolescents, who represent almost 50% of the total SADC region's population, are particularly vulnerable to these three diseases, not only in terms of direct morbidity and mortality but also because of orphan-hood and weakening of household economies where parents and caregivers are either infected or affected.

1.1. Overview of paediatric HIV, TB and malaria in the SADC region.

Impressive progress in child and adolescent HIV, TB and malaria has been achieved in the SADC region, however, important challenges and gaps remain apparent. In the HIV arena, mother to child transmission of HIV (MTCT) resulted in more than 175,800 new infant infections in 2010 within the region, with the percentage of MTCT across Member States ranging from 3 to 37%[18]. In 2009, there were more than 1 million children under the age of 15 years estimated to be living with HIV within SADC Member States[19], and the mean coverage of antiretroviral therapy (ART) for children remained low, at 34%, even though some Member States have achieved more than 85% coverage[20]. The impact of TB remains high in SADC, with five Member States being among the 22 global high-burden countries that together account for approximately 80% of all new TB cases recorded each year in the world[21]. Du Cros *et al* estimate that between 5 and 15% of TB cases are children[22], however, the true extent of TB-related paediatric morbidity and mortality is thought to be underestimated, due to the difficulty in confirming diagnosis of TB in children [23]. Approximately 35 million children under five years of age are estimated to be at risk of contracting malaria, which is responsible for 1 in 5 childhood deaths[24]. While for some Member States more than 50% of under five-years old were sleeping under ITNs in the 2006-2010 period[25], on average across the SADC malaria affected areas, the majority of children still have limited access to malaria prevention measures, diagnosis and treatment services.

1.2. Foundation for Developing Minimum Standards in the SADC region

SADC Member States have committed themselves to improve child survival and development and to respond to these diseases. To this end Member States have signed and

[18] WHO. 2011. Global HIV-AIDS Response. Progress Report. 2011. Document can be accessed at http://www.who.int/hiv/pub/progress_report2011/en/index.html
[19] SADC. 2009. HIV and AIDS Strategic Framework (2010 – 2015).
[20] WHO. 2011. Global HIV-AIDS Response. Progress Report. Document can be accessed at http://www.who.int/hiv/pub/progress_report2011/en/index.html
[21] DRC, Mozambique, South Africa, United Republic of Tanzania and Zimbabwe. WHO. 2011. Global Tuberculosis Control . Document can be accessed at http://www.who.int/tb/publications/global_report/en/
[22] Du Cros P, et al. 2011. Counting children: comparing reporting for paediatric HIV and tuberculosis. *Bulletin of the WHO*;89: 855
[23] Moore D.P., et al 2009. Childhood Tuberculosis guidelines of the Southern African Society for Paediatric Infectious Diseases.
[24] SADC. 2010. Regional Minimum Standards for the Prevention Treatment and Management of Malaria
[25] Malawi, Tanzania, Zambia. UNICEF. 2012. State of the World's Children. The document can be accessed at http://www.unicef.org/sowc/index_61804.html

ratified a number of regional and international declarations. These include the SADC Protocol on Health, which prioritises the control of communicable diseases and calls for harmonisation of policies and strategies aimed at disease prevention and control; the 2003 Maseru Declaration on the Fight Against HIV and AIDS in the SADC Region (Point 1e: Prevention and Social mobilisation by 'Rapidly scaling up the programmes for the Prevention of Mother to Child Transmission of HIV'; Point 2b: Improving care, access to counselling and testing services, treatment and support by: 'strengthening family and community based care as well as providing support to orphans and other vulnerable children'); the 2006 UNGASS Declaration of Commitment on HIV/AIDS (Point 32 "Address as a priority the vulnerabilities faced by children affected by and living with HIV); the 2006 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services; the 2006 Maputo declaration of the 55th Regional Committee of the WHO African Region, which declared TB as an emergency in Africa; and the Millennium Development Goals, specifically Goals 4 (Reduce child mortality) and 6 (Combat HIV/AIDS, malaria and other diseases).

1.3. Rationale for the Minimum Standards

Confronted with the ongoing challenges of child survival and development, in the context of SADC Regional integration agenda, as well as the move towards harmonisation of the response to HIV, TB and malaria outlined in the SADC Protocol on Health, the SADC Secretariat is mandated to support the "Scaling up of Child and adolescent HIV, TB and Malaria Continuum of Care in the SADC region". This regional effort, focusing on capacity enhancement of Member States in child and adolescent HIV, TB and malaria service provision, aims to bring Member States closer to meeting international and regional targets within the coming two years, and continue to improve child survival and development beyond these targets. Pivotal to this initiative was the development of these *Minimum Standards for child and adolescent HIV, TB and Malaria Continuum of Care in the SADC Region*.

To inform the development of these Standards, a *Regional Assessment of policies and programmatic frameworks on paediatric HIV, TB and Malaria in the SADC region* was undertaken in 14 Member States from October 2011 to July 2012 [26]. The Regional Assessment noted that delivery of HIV and AIDS, TB & malaria services among children and adolescents needs to be strengthened and tailored to children and adolescent specific needs in SADC Member States. In addition, it showed that the delivery of services for the 3 diseases is not always integrated into Primary Health Care (PHC) nor linked with the delivery of other basic services to address the needs of children and adolescents, particularly those that are vulnerable. This linkage would ensure comprehensive delivery of services necessary for their optimum development (e.g. nutritional and psychosocial support and child and social protection as outlined in the SADC Minimum Package of Services for OVC&Y). Strategic planning and service delivery is typically done in a sectoral, vertical and uncoordinated manner which does not take into consideration the interrelationships in the causes and effects of these major diseases on children, adolescents and communities. Finally, the assessment also noted that Member States are at different levels of offering services to children and adolescents for the three diseases and the priorities in policies, strategies and guidelines for the delivery of services also vary between Member States. In

[26] SADC. 2012. Regional Assessment Report of Policies and Programmes On Paediatric HIV, TB and Malaria. Draft.

the context of free movement of people between Member States, this makes it difficult for citizens of SADC to access standard and quality services in the region.

SADC Ministers of Health and those responsible for HIV have recognized these challenges and directed the development of regional *Minimum Standards for child and adolescent HIV and AIDS, TB and Malaria continuum of care*. These Standards aim to strengthen child and adolescent specific policies and programmatic frameworks in HIV, TB and malaria, to guide the integration of HIV, TB and malaria services/programmes within primary health care (PHC) and with basic child care services, and to facilitate harmonisation across Member States. This integration and harmonisation effort could provide improved access to standard child and adolescent services across the region and benefits in terms of pooled procurement processes and related savings (e.g. economies of scale in procurement of drugs and commodities for the whole region), as well as helping Member States to strengthen and scale up successes towards achieving the MDGs, and other regional and international commitments and continue to reinforce child survival and development beyond these targets.

2. Process for Developing Minimum Standards

These Minimum Standards were developed through a participatory process, which included Member States, the SADC Secretariat, development partners and various stakeholders.

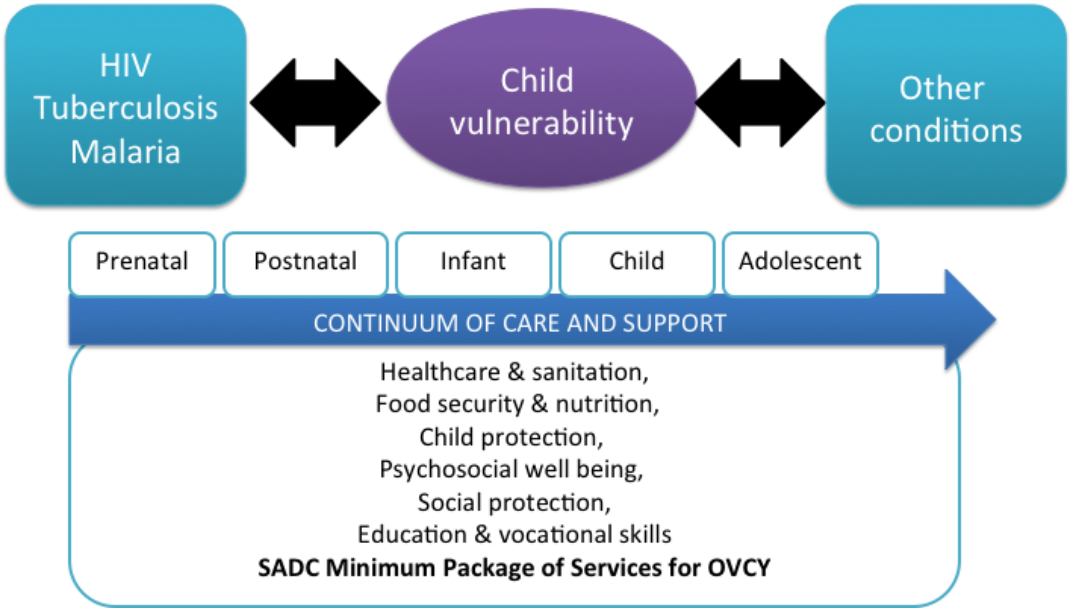
A Regional Assessment of 14 Member States, which included field interviews and a desk review of the most recent international, SADC, and development partners' strategic frameworks/plans and guidelines/standards on treatment and care of child and adolescent HIV, TB and malaria, was undertaken between October 2011 and July 2012 to clearly identify the status of policies, programme implementation and capacity gaps within the child and adolescent continuum of care in HIV, TB and malaria. The findings and recommendations were compiled into a *Regional Assessment Report,* which informed the development of these Minimum Standards.

The draft Minimum Standards document was reviewed for technical soundness by a team of regional experts during *Technical Working Group* meetings held in September 2012. The document was then presented to Member States and regional partners at a *Regional SADC Consensus Building and Validation Meeting* in October 2012.

3. Conceptual framework for the Minimum Standards: The Continuum of Care and Support approach

HIV, TB and malaria, create vulnerabilities in children by being direct sources of morbidity and mortality, but also because of weakening of household economies when caregivers are affected. These diseases also render children more vulnerable to other main child killers, such as pneumonia, diarrhea and malnutrition. In a bi-directional causal effect, vulnerabilities created by poverty, lack of access to essential services, and other main child killers, also render children more vulnerable to HIV, TB and malaria. As such, addressing one or a few among many vulnerabilities and deprivations faced by children and adolescents is neither adequate nor sustainable.

The SADC Minimum Package of Services for Orphans, and other Vulnerable Children and Youth asserts that children and adolescents require a minimum of essential interventions



and services in order to attain optimum development and become productive and responsible adults. These essential services include: (a) education and vocational skills; (b) health, clean water and sanitation; (c) food security and nutrition; (d) child and youth protection; (f) psychosocial support; and (g) social protection. These services should be delivered comprehensively, in a holistic manner, through a continuum of interventions at different stages of their life from birth to early adulthood. Of key importance is the fact that orphans and other vulnerable children and adolescents, because their households have diminished capacity to provide basic developmental services, often fall through the cracks of service delivery systems, even in cases where services are available, and thus require external support to guarantee access to all these essential services.

In view of the interrelatedness, magnitude and high impact of the triple effect of HIV, Tuberculosis (TB), and malaria epidemics on child vulnerability in the region, the *SADC Minimum Standards for Child and Adolescent HIV, TB and Malaria* adopt the comprehensive and holistic service delivery approach articulated in the SADC Minimum Package of Services for Orphans, and other Vulnerable Children and Youth. This approach, described as a Continuum of Care and Support (CoCS), promotes a collective and holistic address of child and adolescent health that includes prevention, diagnosis, treatment, care and support for these three diseases, within the broader platform of Primary Health Care (PHC). It also focuses on providing appropriate links to psychosocial support, food security and nutrition, child and adolescent protection services such as national registration and protection for those abused; family and community care and support systems, education and understanding of these diseases.

According to the SADC Minimum Package of Services for Orphans, and other Vulnerable Children and Youth, delivering comprehensive essential services and CoCS requires a shift from vertical, sector specific isolated service delivery to an approach that is holistic, taking into consideration the collective contributions of different service providers, children and

adolescents and communities. This can be achieved through mechanisms such as: (a) advocating and promoting inter-sector coordination and collaboration; (b) relevant policy, legislative and management instruments to foster coordination, collaboration and effective service delivery for children and adolescents; (c) establishing or strengthening and implementing effective service referral systems within and between service delivery sectors and stakeholders to ensure access to essential services for vulnerable children and adolescents; (d) empowering children and adolescents (consistent with their age and evolving capabilities), their caregivers and communities to seek and access services; and (e) establishing and implementing joint-sectoral planning, budgeting, and monitoring and evaluation activities for children and adolescents.

Thus, the continuum of care and support approach underlining these Minimum Standards recognizes that delivering the full spectrum of a child's needs beyond the biomedical or clinical ones is key to accelerating child survival and development in the SADC region.

4. Purpose and Scope

The Minimum Standards serve as a framework to guide the regional harmonisation of approaches for a continuum of care and support in HIV, TB and malaria for children and adolescents in the SADC region. This is necessary to improve the effectiveness of national and community efforts to accelerate child survival and achieve comprehensive developmental outcomes for children and adolescents.

These evidence-based standards set out the minimum requirements for all Member States which should be achievable by all, while not limiting the ambitions and continued progress of those Member States who are ahead of these requirements.

5. Expected Outcomes

Member States will incorporate these Minimum Standards into national policies, strategic frameworks and guidelines beginning in 2013. Member States will implement and operationalize the Minimum Standards over the next five years with a mid-term evaluation conducted in 2015 to ensure continued relevance of the standards and to address any challenges hampering implementation.

The implementation and operationalisation at Member State level of these Minimum Standards, through incorporation into national policies, strategic frameworks and guidelines should result in:

- Harmonisation of prevention, treatment, care and support for children and adolescents affected by HIV, TB and malaria across the SADC Region.
- Strengthening and scale-up of care and support of HIV, TB, and malaria in children and adolescents as part of a broader continuum of care on maternal-neonatal-child health within all Member States.

The ultimate outcome for the region is to achieve equity in the provision of health and support services to children and adolescents, thus decreasing morbidity and mortality and improving the well-being of children and adolescents in the SADC region, in line with global, continental and regional commitments.

6. Guiding Principles

These Minimum Standards are based on guiding principles defining the values that should be applied and upheld by all Member States in the delivery of paediatric HIV, TB, malaria and basic child services in the SADC region[27]. These principles are:

- **Child and human rights centred:** All service providers should fulfil their obligations and act in the best interest of the child, with a view to respecting, protecting, promoting and fulfilling their rights**.** Interventions should promote the child's understanding of his/her rights and responsibilities from an early age.
- **Integrated and holistic approach:** Policies and programmes should aim to provide comprehensive and integrated child health services within Primary Health Care that include HIV, TB and malaria, to ensure the well-being, growth and optimum development of the child and adolescent. Inter-sectorial partnerships and coordination is required, and all service providers –government, civil society, faith-based organizations and the private sector- should coordinate efforts to achieve this aim, ensuring appropriate referrals and complementing each other's efforts to avoid having children and adolescents fall through the cracks in the system.
- **Child and adolescent developmental perspective:** Interventions should help empower and build the capacities of children and adolescents to realize their full human potential (physical, intellectual, psychological, moral, spiritual, emotional, economic and political). Services should be adapted to age-specific needs (e.g. child and adolescent friendly services).
- **Equality, non-discrimination and gender sensitivity:** Policies, programmes and services should uphold non-discrimination practices in all situations, including age, sex, gender, sexual-orientation, language, religion, socio-economic status, cultural or ethnic group, and disability.
- **Involvement and participation:** Children, adolescents and their caregivers and communities should be consulted, involved and participate in the development, implementation, monitoring and accountability of policies and programmes that affect them in order to ensure relevance, appropriateness and ownership of their own treatment and care.
- **Partnerships:** Institutions, organizations, civil society and services providers, including the private sector should seek to establish working agreements and specific commitments, based on mutual respect, equality, shared responsibility and complementarity, to contribute to and reinforce the implementation of policies and programmes for children and adolescents.
- **Transparency:** All institutions, organizations and services providers, including the private sector, should operate in an open and accountable manner. Mechanisms should be in place and applied to safeguard transparency and accountability at the national, regional and international level, as well as to communities and children and adolescents who are service recipients and providers.
- **Evidence-based:** Programmes and interventions should be guided by evidence in a context-specific manner and operational research should be used to generate more evidence of effectiveness and cost-effectiveness of programmes. Communities and

[27] SADC. 2011. Minimum Package of services for OVC&Y.

children and adolescents should be educated on the importance of evidence-based strategies so they can be empowered to advocate for these.

- **Sustainability:** Policies, programmes and services should ensure long-term benefits to children and adolescents in a continuum of care over time. To ensure long term sustainability, the capacities of service providers as well as families and communities to provide care for children and adolescents should be strengthened. Children and adolescents should be empowered to advocate for their rights. They should be imbued with self-reliance and provided with opportunities to guarantee income generation as adults.
- **Equity and Universal Access:** Policies, programmes and services should aim to ensure that all children and adolescents, particularly If they are vulnerable, have the opportunity to attain their full health potential. In this regard, guaranteeing accessibility to health services for all children and adolescents is not enough. Economic barriers to equity and universal access to transport, food, shelter and water should also be addressed.
- **Do-no-Harm:** Programmes should ensure that interventions are providing benefit and are not generating negative effects that may harm the child or adolescents, his/her family, or the community.

7. Minimum Standards for Child and Adolescent HIV, TB and Malaria Continuum of Care

The following Minimum Standards should be clearly incorporated into national strategic frameworks/plans and clinical guidelines for treatment/management of the disease. These Minimum Standards exist within the broader context of essential services for the child and adolescent as outlined in the SADC Minimum Package of Services for Orphans and other Vulnerable Children and Youth and as articulated in the conceptual framework section above.

These standards are evidence-based and have taken into account international recommendations. They do not replace these international recommendations, but add value to them by rendering them appropriate to the SADC context.

7.1. Standards for HIV Prevention, Diagnosis, Treatment and Care in children and adolescents

HIV Prevention

HIV Testing and Counselling (HTC)[28]*.*

- Member States should strengthen efforts to ensure comprehensive knowledge of HIV in children and adolescents.
- All children and adolescents presenting to a health facility should be offered routine HIV testing and counselling regardless of signs or symptoms of disease or risk factor for infection. This is referred to as Provider Initiated HTC (PITC).

[28] Also refer to the SADC.2010. Regional Minimum Standards for HTC.

- HTC services for children and adolescents should be available at all testing sites and effort instituted to increase access for children and adolescents to ensure equitable access for all.
- The principles of voluntarism, informed consent, counselling and confidentiality, correct test results and linkage to care should be observed during HIV testing[29].
- Children and adolescents who are married or living together, pregnant or are parents; have STIs or are sexually active; those who are heads of households, or have been trafficked should be allowed to provide their own consent for HTC.
- HIV tests performed on a child or an adolescent under the age of consent or who is mentally incapacitated should be conducted with the consent of the parents or the legal guardian of the child or adolescent.
- All HTC services provided should be in the best interest of the child or adolescent.

Prevention of Mother-to-Child Transmission (PMTCT)

Refer to the SADC 2010 Regional Minimum Standards for PMTCT [30] and the Global Plan towards Elimination of MTCT[31].

Prevention of Sexual Transmission of HIV and enhancement of Adolescent Sexual and Reproductive Health and Rights (SRHR)

- Child and adolescent-friendly sexual and reproductive health services and age-appropriate information, including family planning, counselling, condoms and other contraceptives should be available at all levels of care.
- Child and adolescent SRH services should be integrated into Primary Health Care (PHC), and available in centres for treatment of Sexually Transmitted Infections, HTC, HIV care and treatment centres, schools and youth centres.
- Positive prevention for children and adolescents living with HIV should be available.

Post-Exposure Prophylaxis (PEP)[32]

- Child and adolescent -friendly PEP guidelines should be in place in all Member States.
- Child and adolescent -friendly PEP services should be available at all levels of health care.
- PEP services should be linked to psychological and legal services.

Male Circumcision

- Adolescent medical male circumcision, with relevant informed consent, should be made available according to national guidelines.

HIV Diagnosis[33,34]

- All children and adolescents should have access to definitive diagnostic testing for HIV.

[29] WHO. 2012. Service Delivery Approaches to HIV Testing and Counselling: A strategic policy framework. Document can be accessed at http://www.who.int/hiv/pub/vct/htc_framework/en/index.html.
[30] SADC. 2010.Regional Minimum Standards for PMTCT.
[31] UNAIDS. 2011. Global Plan towards de elimination of Mother to Child Transmission of HIV by 2015 and keeping their mothers alive. Document can be accessed at http://www.unaids.org/en/targetsandcommitments/eliminatingnewhivinfectionamongchildren/
[32] Also refer to the SADC.2011. Minimum Package of Services for OVCY
[33] Also refer to the SADC.2010. Regional Minimum Standards for HTC
[34] WHO. 2010. Recommendations on the Diagnosis of HIV infection in Infants and Children. Document can be accessed at http://whqlibdoc.who.int/publications/2010/9789241599085_eng.pdf

- An HIV virological test should be used to determine HIV infection in infants younger than 18 months.
- Early Infant Diagnosis (EID) should be performed in all HIV-exposed infants at 4-6 weeks after birth.

HIV Treatment and Care

Antiretroviral treatment and prevention of opportunistic infections

- All children under 2 years of age with confirmed HIV infection, irrespective of CD4 count or WHO clinical stage, should be started on ART.
- All children living with HIV between 2 and 5 years of age should be started on ART if CD4 count is ≤750 cells/mm^3 or %CD4+ ≤25, whichever is lower, irrespective of WHO clinical stage.
- All children and adolescents living with HIV who are more than 5 years of age should be started on ART if CD4 count is ≤350 cells/mm^3, irrespective of WHO clinical stage.
- All children and adolescents living with HIV with WHO clinical stages 3 and 4, irrespective of CD4 count, should be started on ART.
- Children living with HIV with no exposure to maternal or infant non-nucleoside reverse transcriptase inhibitors (NNRTIs), or whose exposure to maternal or infant antiretroviral is unknown, should have 2 NRTI + 1 NNRTI in the first line regimen.
- For children living with HIV with exposure to maternal or infant non-nucleoside reverse transcriptase inhibitors (NNRTIs), the first line regimen should be 2 NRTI + 1 protease inhibitor.
- All Member States should ensure access to paediatric fixed-dose combinations.
- All HIV-exposed infants should be started on Cotrimoxazole Preventive Therapy (CPT) at 4–6 weeks after birth and continue this treatment until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding.
- All children under 2 years of age with confirmed HIV infection should be started on CPT, irrespective of CD4 count or WHO clinical stage.
- All children living with HIV between 2 and 5 years of age with WHO clinical stage 2, 3 or 4 or CD4 ≤750 cells/mm^3 or %CD4+ ≤25 should be started on CPT.
- CPT should be continued up to age of 5 years, at which time the need for CPT should be reassessed.
- All children over 5 years of age and adolescents living with HIV with WHO clinical stage 2, 3 or 4 or CD4 <350 cells/mm3, should be started on CPT, according to adult guidelines.

Routine follow up and care for children living with HIV

- Regular follow up and pre-ART care services should be made available to all children and s who are not yet eligible for ART.
- Monitoring of growth, development and nutrition of children living with HIV should be routinely done monthly until the age of 18 months, and every 3 months thereafter.
- A transition plan from child to adult services should be in place in all Member States for adolescents living with HIV.

- CD4 routine monitoring should be made available and performed as a minimum at the time of HIV diagnosis and every 6 months thereafter.
- Targeted viral load testing should be in place to be initially used for children and adolescents that are suspected of failing treatment.
- All children and adolescents living with HIV should have access to services for disclosure, sexual and reproductive health needs and psychosocial support.
- A functional patient monitoring system that includes tracking of children and adolescents lost to follow up should be put in place.
- All terminally ill children and adolescents living with HIV should receive holistic palliative care; and appropriate pain and symptom control medication should be made available at all levels of health care service delivery.

Drug resistance monitoring for HIV[35]

- Member states should have a system in place to monitor and address HIV drug resistance among children and adolescents experiencing treatment failure and among recently-infected populations.
- Children and adolescents failing a second-line drug regimen should have access to drug-resistance testing. Laboratory services may be provided at national or supranational level.
- Member states should put in place quality tracking systems, including use of Early Warning Indicators (EWIs) to prevent emergence of HIV drug resistance.

HIV and TB coinfection

- All children and adolescents living with HIV:
  - should be actively screened for TB at each visit.
  - who are exposed to TB through household contacts, but with no evidence of active disease, should be provided with isoniazid preventive therapy (IPT).
  - who are diagnosed with active TB should begin TB treatment immediately, and start ART as soon as tolerated in the first 8 weeks of TB therapy, irrespective of CD4 count.
  - who are receiving ART and who develop TB should start TB treatment immediately while continuing ART and adjusting ART regimens as recommended for TB co-infection.

7.2. Standards for TB Prevention, Diagnosis, Treatment and Care in Children and Adolescents[36]

TB Prevention

BCG immunisation

- All children should receive BCG vaccination at birth as part of routine immunisation.
- Children with symptomatic HIV should not receive BCG vaccination.
- Infants born to a mother with smear-positive pulmonary TB should receive BCG immunisation after completing 6 months of IPT or TB treatment.

TB infection control

[35] WHO. 2012. HIV Drug resistance report. Document can be accessed at http://www.who.int/hiv/pub/drugresistance/report2012/en/index.html

[36] Also refer to SADC.2010. Harmonised Minimum Standards for the Prevention, Treatment and Management of TB.

- TB infection control guidelines should be in place and operationalised in all health facilities[37].
- All children and adolescents in household contact with a newly diagnosed case of pulmonary TB should be evaluated for TB disease.
- All children and adolescents in household contact with a newly diagnosed case of MDR-TB case should receive appropriate clinical follow up for two years.
- All children and adolescents with prolonged productive cough (> 2 weeks), fever, night sweats, weight loss or failure to thrive should be evaluated for TB.
- Children and adolescents living with HIV should be screened for TB at each visit, using a clinical algorithm.
- Pregnant women should receive antenatal testing for HIV and screening for TB using a clinical algorithm.

Isoniazid Preventive Therapy (IPT)

- All children under 5 years of age, and all children living with HIV (irrespective of age), without symptoms of active TB, that have been in close contact with a source case should be provided with IPT according to WHO guidelines.
- All infants breastfeeding from a mother with smear-positive pulmonary TB should be provided with IPT according to WHO guidelines.
- Neonates born to mothers with pulmonary TB who have received less than two months of TB treatment should be evaluated for active TB. Once active TB is excluded, the neonate should receive IPT.

TB Diagnosis

- Diagnosis of TB in children and adolescents should be based on clinical evaluation and the following investigations: 1) Tuberculin Skin Test (TST) using the Mantoux method, 2) Chest radiography (CXR) and 3) Sputum (in children old enough to produce it) or gastric aspirate for smear microscopy and culture.

TB Treatment and Care

TB treatment

- Directly Observed Treatment, short course (DOTS) should be provided for the care of children and adolescents with TB disease.
- Pyridoxine should be made available for all children and adolescents receiving isoniazid.
- TB drug resistance monitoring systems should be in place.

Routine follow up and care for children with TB

- Children and adolescents:
    - should be followed monthly during intensive phase of treatment and bi-monthly during continuation phase as a minimum.
    - with suspected treatment failure should be referred for further assessment, including evaluation for MDR-TB.

[37] WHO. 2009. WHO policy on TB infection control in health care facilities, congregate settings and households. Document can be accessed at *whqlibdoc.who.int/publications/2009/9789241598323_eng.pdf*

  - should be monitored for growth, development and nutrition status during treatment of TB.
- All children and adolescents diagnosed with TB (suspected, probable or confirmed) should be tested for HIV.
- All children and adolescents terminally ill, should receive holistic palliative care; and appropriate pain and symptom control medication should be made available at all levels of health care service delivery.

7.3. Standards for Malaria Prevention, Diagnosis, Treatment and Care in children and adolescents[38]

Malaria Prevention

- Malaria-free countries should prevent reintroduction of malaria through strengthening of mechanisms to manage imported malaria cases.
- Screening of malaria in other children, adolescents and adults (contact tracing) in same household should be performed in malaria pre-elimination countries.

Insecticide Treated Nets (ITNs)

- In Member States with malaria control programmes children and pregnant women should be priority recipients of LLINs (Long Lasting Insecticide Nets), although the whole population should be protected.
- LLINs should be provided free of charge in malaria endemic areas to pregnant women and children under five through antenatal clinics (ANC) and maternal, neonatal and child health (MNCH) clinics. Such provision should be accompanied by adequate counselling on the importance of regular and correct use of the LLINs.
- Universal coverage of ITNs should be maintained in malaria endemic countries

Indoor Residual Spraying (IRS)

- High quality annual IRS should be provided and maintained.
- Adequate monitoring, quality assurance and quality control of IRS programmes should be ensured.
- Regular surveillance of mosquito resistance should be instituted.

Malaria Diagnosis

- Every suspected malaria case, including children, should be confirmed by microscopy or RDT prior to treatment.
- In countries with malaria control programmes, if parasitological confirmation is not available, clinical diagnosis of malaria in children should be performed according to the latest WHO guidelines.
- Microscopy should be the preferred option in cases of suspected severe malaria or non *Plasmodium falciparum* malaria.
- Scale-up of malaria diagnostic testing should be integrated with efforts to improve the management of other febrile illnesses.
- All diagnostic tools should be quality-assured across all levels of the health system.

[38] Also refer to the SADC Minimum Standards for the Prevention, treatment and management of Malaria

Malaria Treatment and Care

Anti-malaria treatment

- Antimalarial treatment solely on the basis of clinical suspicion should only be considered in cases where parasitological diagnosis is not accessible, in countries with malaria control, but not malaria elimination programmes.
- The results of parasitological diagnosis should be available within a short time (less than two hours) of the patient presenting. In the absence or delay of parasitological diagnosis, patients with suspected severe malaria, and other high risk groups, should be treated immediately on clinical grounds.
- The first-line treatment for children with uncomplicated malaria should be Artemisinin based Combination Therapy (ACT) in fixed-dose combinations, according to the latest WHO guidelines.
- The first line treatment for children with severe *P. falciparum* malaria should be intravenous/intramuscular artesunate (given within 24 hours), followed by a full course of oral ACT, as soon as the patient recovers as recommended in the latest WHO guidelines.
- Use of quinine as first line treatment for children with severe *P. falciparum* malaria should be reserved for cases where intravenous artesunates are contraindicated, or unavailable.
- Strong referral systems for children with severe malaria to the highest level of care should be in place.
- Pre-referral treatment with intramuscular artesunate, artemether or quinine or rectal artesunate should be made available, according to the latest national guidelines.
- Where referral is not possible, intramuscular/rectal treatment should be continued until the patient can tolerate oral medication, then administer a complete course of an effective ACT.
- Regular monitoring of parasite resistance every two/three years should be undertaken to ensure use of efficacious medicines.
- Malaria prevention and treatment in malaria-affected areas should be prioritized for HIV-infected children.
- Malaria diagnosis and treatment at community level should be implemented and expanded in countries using integrated Community Case Management (iCCM) and Home Based Management of Malaria (HBMM) approaches.

Follow up and Care for children and adolescents with malaria

- Children and adolescents treated for uncomplicated malaria should be followed up to ensure adherence to treatment and for any additional support that may be required.
- Children and adolescents with severe malaria should be immediately hospitalized for intensive management.
- Children and adolescents treated for severe malaria should be followed for proper management of sequelae after treatment.

7.4. Cross-cutting standards on Care and Support for Children and Adolescents

Nutritional Assessment, Counselling and Support

- At each visit, all children and adolescents should be monitored for growth, development and nutrition.

- Nutritional assessment, counselling and support should be provided to caregivers, children and adolescents to enhance treatment effectiveness and adherence, retention in care and quality of life in children and adolescents.
- Children and adolescents who have severe acute malnutrition should receive therapeutic feeding, while children and adolescents with moderate acute malnutrition should receive supplementary feeding.
- Member States should adopt Community Management of Acute Malnutrition (CMAM) as a strategy for implementation.

Social protection

- HIV, TB, and malaria services for children and adolescents should be provided free of charge.
- Member States should put in place social protection mechanisms to support orphans and other vulnerable children and youth to have access to services.

Psychosocial support (PSS)

- Age-appropriate PSS should be provided to children and adolescents to ensure adherence to HIV and TB treatment and care, and to encourage positive living for those living with HIV.
- Child and adolescent-friendly PSS should be provided to all acute and chronically ill children and adolescents.
- Adolescent-friendly PSS should be provided to adolescent parents.
- Caregivers should receive counselling, care and support to avoid burnout and maximize adherence to ART, TB and malaria treatment for the affected children and adolescents.

Child and adolescent protection

- All children and adolescents presenting to health facilities or health care providers without birth registration should be treated and immediately referred for birth certification.
- Children and adolescents crossing borders, including migrants, refugees and Internally Displaced Populations (IDP) should be treated free of cost, irrespective of birth registration and then referred for birth registration.
- Unaccompanied children and adolescents and victims of trafficking presenting to health facilities or health care providers should be treated free of cost and referred immediately for social support or home affairs services.

Child- and adolescent- friendly services

- All health facilities should provide integrated, gender-sensitive, child and adolescent-friendly health services.

Community Home-Based Care (CHBC)

- CHBC programmes should include specific provisions for children and adolescents: 1) living with HIV, HIV/TB coinfection, TB or malaria; 2) living in households where

there is a person living with HIV, HIV/TB, TB or malaria; 3) who are caregivers, heads of households and other vulnerable children.

- Caregivers from the school environments, communities, faith-based organisations and health facilities should receive capacity strengthening on best practices that target needs of children and adolescents living with HIV.
- All terminally ill children, adolescents and their caregivers should receive holistic palliative care including through CHBC; and appropriate pain and symptom control medication should be made available at all levels of health care service delivery.

Advocacy, Communication and Social Mobilization (ACSM)

- Member States should develop appropriate Information, Education and Communication (IEC) material that address the diseases in children and are child and adolescent-oriented.
- Member States should develop capacity in the communities, among caregivers, older children and adolescents, to apply skills in prevention, treatment, care and support (e.g. adherence to DOTS and correct use of ITNs).
- Member States should ensure establishment of linkages between communities, child and youth-led organisations and health facilities for effective community, child and adolescent participation in service delivery.

Care and treatment across Member States borders

- Formal agreements, mechanisms and tools should be established for referral and transfer of children and adolescents living with HIV, TB and malaria across borders within the SADC region.

7.5. Standards on Health Systems Strengthening and Integration

Health Systems Strengthening[39]

Member States should have:

- Effective, safe and quality HIV, TB and malaria health services for children and adolescents right down to the community level and fully integrated into the PHC system.
- Policies and strategies for recruitment, distribution and retention of appropriate and adequate human resources for health.
- Pre-service and in-service training in child and adolescent HIV, TB and malaria.
- A national framework and policy for task-shifting/task-sharing in HIV, TB and malaria prevention, diagnosis, treatment and care for children and adolescents.
- A comprehensive training programme that includes supervision and support to health care workers carrying out task-shifting/sharing activities for children and adolescents.
- Health information systems that collect, generate, analyse and use reliable information on child and adolescent health determinants, status and health system performance.

[39] WHO. 2007. Everybody's Bussiness : Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action. Document can be accessed at http://www.who.int/healthsystems/strategy/en/

- Equitable access to effective, safe and quality medical products and technologies for children and adolescents.
- Funds allocated for child and adolescent health that ensure they have universal access to health, raised through a strong health financing system.
- Leadership and governance to strengthen health systems for comprehensive child and adolescent care that include oversight, partnership building, regulation and accountability.

Supply Chain Management

- A procurement and supply chain management system should ensure regular provision of drugs and commodities for child and adolescent HIV, TB and malaria treatment, prevention and control.
- Member States should explore the use of mobile health (mHealth) technology towards facilitating procurement and minimising stock outs.
- Policies that prioritise regulatory approval of new and generic medicines and diagnostics and which expedite their marketing should be developed.

Monitoring and Evaluation (M&E)

- Health Management Information Systems (HMIS) should capture data from all levels, including community level, and should include key indicators disaggregated by sex and age.
- Routine and additional data collection mechanisms should include key indicators on HIV, TB and malaria that allow for regular reporting to the relevant stakeholders of quality data on children and adolescents.
- Member States should ensure that child and adolescent data on HIV, TB and malaria are analysed and used for policy and operational decision-making.
- Conclusions of evaluations on service delivery for children and adolescents should represent the perceptions of children and adolescents, caregivers and communities.

Integration

- Member States should ensure the integration of child and adolescent HIV, TB and malaria prevention, diagnosis, care and treatment down to the primary health care level, including in the community.
- Member States should establish interrelationships between HIV, TB and malaria in the funding, planning, policies, strategic frameworks and guidelines of each of these diseases.
- Member States should establish and strengthen effective referral linkages to reinforce the quality of comprehensive service delivery for children and adolescents in HIV, TB and malaria programmes.
- Member States should develop a mechanism to harmonise the M&E systems to ensure common reporting of progress in the delivery of services for children and adolescents for HIV, TB and malaria.

8. Implementation process/mechanisms

Implementation mechanisms are critical to ensuring that the expected outcomes of these Minimum Standards are achieved. After adoption by Member States, these Minimum Standards need to be operationalised and implemented by incorporating them into national policies, frameworks and guidelines. To ensure this incorporation and domestication, the document needs to be disseminated to key stakeholders who can advocate for this process to take place. This section defines the key stakeholders and their roles in the implementation of these minimum standards. It also provides guidance on financing mechanisms, strategies to achieve widespread dissemination, and identifies critical monitoring areas to ensure integration of these Standards into national paediatric HIV, TB and malaria frameworks of Member States and harmonised implementation across the SADC region.

8.1 Stakeholder roles and responsibilities

The successful implementation of these Minimum Standards will depend on the involvement of all key stakeholders at regional, national and local level. This section outlines their roles.

8.1.1. SADC Secretariat

The SADC Secretariat will:

- Disseminate and popularise these Minimum Standards to all stakeholders at national, regional and international levels.
- Promote and support the domestication of the Minimum Standards into national policies, strategic frameworks and guidelines for effective operationalisation.
- Facilitate documentation, sharing and exchange of best practices on delivery of HIV and AIDS, TB and malaria services for children and adolescents.
- Facilitate inter-country and cross border prevention control and management of the three diseases including referral systems.
- Mobilise resources for regional coordination of the implementation of the Minimum Standards
- Monitor progress of Member States towards the implementation of the Minimum Standards.

8.1.2. Member States

- Member States will adapt, domesticate and implement these Minimum Standards within their national policies, strategic frameworks/plans and guidelines.
- Ministers of Health will oversee the implementation of these Minimum Standards in their countries.
- Ministers of Health will identify and coordinate partners to support the implementation of the Minimum Standards at national and community levels.
- Member States will mobilise and allocate resources for the full implementation of the Minimum Standards.

8.1.3. Other stakeholders

Other stakeholders include UN Agencies, bilateral donors and development partners, local and international Non-Governmental Organisations (NGOs), community and faith-based

organisations, the private sector, research and training institutions. Their roles are essential at the regional, national and local levels to ensure successful implementation by:

- Providing technical support to the SADC Secretariat and Member States for the implementation and M&E of the Minimum Standards.
- Popularising, advocating and promoting the recognition and prioritisation of these SADC Minimum Standards at national, regional and international levels.
- Supporting resource mobilisation for the implementation of the Minimum Standards at regional and national levels.

8.2. Financing mechanisms

Implementation of these Minimum Standards may require additional financial resource allocation by Member States, if these activities are not currently provided for in current budgets for HIV, TB, malaria and children programmes. Member States shall ensure that:

- Areas requiring additional financial resources are identified, and that participation and input of all relevant stakeholders, including UN agencies, donors, development partners and NGOs, is obtained in this process.
- Each area requiring additional support is costed, and a budget plan for additional resources receives endorsement by the relevant Ministries.

8.3. Dissemination strategies

The Minimum Standards document should be systematically disseminated across all Member States. Within Member States, dissemination should include key stakeholders at Ministries of Health, Ministries and Departments working with children and adolescent welfare and social protection, and other key stakeholders in government and development partners. This will ensure harmonised policies, programmes and services for child and adolescent HIV, TB and malaria along a continuum of care in the SADC Member States.

Dissemination strategies may include:

- Distribution of printed and/or soft copy versions of these Minimum Standards to key stakeholders in Member States.
- Regional training of trainers and in country training workshops for key stakeholders.
- Utilising webinars, e-platforms and mHealth technology to prompt regular dialogue and consultation in and between Member States on the adoption and implementation of the Minimum Standards, enabling cross-sharing of experiences and success stories.

8.4. Monitoring and Evaluation

Implementation of these Minimum Standards at the Member State level and harmonisation at the SADC level needs to be monitored. Monitoring will help identify progress, as well as gaps and bottlenecks that need to be addressed at the national and regional levels, and will allow key stakeholders to evaluate the extent to which they are making progress in operationalising these standards. Monitoring and evaluation results will provide evidence to inform management decisions aimed at fine-tuning and scaling up the response to HIV, TB and malaria in children and adolescents. Monitoring and evaluation of the Minimum Standards should be integrated in existing M&E systems for Health and those of other relevant sectors for children and adolescents.

8.4.1. Monitoring and Evaluation at Member State level

Member States should collect information on implementation based on the broad areas outlined in these Minimum Standards in order to systematically assess progress in each one of the following:

- **Minimum Standards in Child and Adolescent HIV:** Prevention, Diagnosis, Treatment and Care.
- **Minimum Standards in Child and Adolescent TB:** Prevention, Diagnosis, Treatment and Care.
- **Minimum Standards in Child and Adolescent Malaria:** Prevention, Diagnosis, Treatment and Care.
- **Minimum Standards on Cross Cutting Care and Support:** Nutritional assessment, Counseling and Support, Social Protection, Psychosocial Support, Child and Adolescent Protection, Child and Adolescent-friendly services, CHBC, ACSM, Care and treatment for children and adolescents across Member States borders.
- **Minimum Standards on Health Systems Strengthening and Integration:** Strengthening of health systems for children and adolescents, supply chain management of paediatric drugs and commodities, M&E, integration of funding, planning, policies, strategic frameworks and guidelines, referral linkages and M&E of HIV, TB and malaria for children and adolescents within PHC and with and basic child services.

Member States will collect information on an annual basis and prepare a report. The detailed variables and indicators on the information that will be collected are available in a separate document, which complements the *SADC Harmonised Surveillance Framework for HIV and AIDS, Tuberculosis and Malaria in the SADC region.*

8.4.2. Monitoring and Evaluation at the SADC regional level

At the SADC regional level, tracking progress on implementation of these Minimum Standards will focus on monitoring the incorporation of these Minimum Standards into national policies, strategic frameworks/plans and guidelines in each Member State. This incorporation is expected to occur in the next 5 years, and a midterm evaluation is envisaged in 2015. Moreover, to evaluate how Member States are implementing each of the aspects articulated in these Standards, the SADC Secretariat will collate the data from the annual reports from Member States. This will allow the monitoring of progress in the SADC region, reporting on successful models and best practices, as well as stumbling blocks and gaps. This regional report should be shared and discussed among key stakeholders at the regional and national levels. It should also provide feedback to countries on areas of improvement and serve as a basis for the SADC Secretariat to provide tailored technical support to Member States in order to ensure successful implementation and harmonisation across the region.

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