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Regional Minimum Standards and Brand for HIV and other Health Services along the Road Transport Corridors in the SADC Region

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
ASH	African Strategies for Health
BBSS	Behavioural and Biological Sero-Prevalence Survey
BLC	Building Local Capacity for Delivery of HIV Services in Southern Africa
CSO	Civil society organisation
HIV	Human immunodeficiency virus
HCT	HIV counselling and testing
IOM	International Organisation for Migration
LDTD	Long distance truck drivers
M&E	Monitoring and evaluation
MoH	Ministry of Health
MOU	Memorandum of understanding
MS	Member States
NAC	National AIDS Council
NCD	Non-communicable disease
NSP	National Strategic Plan
PMTCT	Prevention of mother-to-child transmission
PEP	Post-exposure prophylaxis
RMSB	Regional minimum standards and brand
SADC	Southern African Development Community
SBCC	Social and behaviour change communication
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SW	Sex workers
TB	Tuberculosis
TWG	Technical working group
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WHO	World Health Organisation

EXECUTIVE SUMMARY

A recent HIV Sero-Prevalence Survey by the World Health Organisation in three border sites in southern Africa identified HIV prevalence rates of 53% among sex workers (SW) and 26% among long distance truck drivers (LDTD).[16] This disproportionate vulnerability among SW and LDTD along transport routes in the region is fuelled by high levels of mobility; poor access to HIV, sexually-transmitted infections (STIs), tuberculosis (TB) and other essential health services; and limited coordination of service providers along the transport corridors. This situation leaves behind priority key populations and continues to be a source of HIV transmission in the region. Furthermore, it poses challenges to case detection, retention in care, and management of communicable and non-communicable diseases.

Member States in the Southern African Development Community (SADC) are committed to the identification, adoption and implementation of evidence-based best practices, harmonization of standards, and revitalization of prevention strategies to achieve the UNAIDS 90-90-90 targets by 2020. In order to reach the ambitious goals of an AIDS free-generation, the region must apply an inclusive approach targeting marginalized populations including SW and LDTD.

In response, the SADC Secretariat developed the **Regional Minimum Standards and Brand for HIV and other Health Services along the Road Transport Corridors in the SADC Region** (RMSB) in 2014.

Approved by the SADC Council of Ministers of Health in November 2015, the standards harmonize prevention, treatment and care provided throughout the region's transport corridors, starting from the existing Cross Border Initiative roadside wellness centers.

These standards seek to complement existing services, guiding SADC Member States and implementers to more effectively target high-risk geographic areas and improve the quality and reach of current HIV prevention and health services to meet the needs of LDTD and SW. The RMSB will serve as a platform to strengthen regional and national partnerships among relevant ministries, the private sector, donors, and civil society in the delivery of health services to these populations. They emphasise the specific needs of LDTD and SW, and align to existing global and regional standards, guidelines and frameworks for disease prevention, diagnosis, and management.

The RMSB outline a minimum package of services and appropriate service delivery models. They define roles and responsibilities for key stakeholders, including the SADC Secretariat, Member States, the private sector, employer and workers' organisations, academia/research institutions, donors/ international cooperating partners and the media. They also address management mechanisms, including financing, quality assurance, and monitoring and evaluation to facilitate sound and sustainable implementation.

A community health outreach

The RMSB advocate for improved access to prevention, diagnostic and treatment services for the following conditions:

Communicable diseases

- HIV
- TB
- STIs
- Malaria

Non-communicable diseases

- Hypertension
- Diabetes

Other

- Sexual and reproductive health services, including family planning and cervical cancer screening and referral
- Occupational health-related conditions

SADC and its partners expect that the implementation of the RMSB will significantly enhance the quality and reach of prevention and treatment services to vulnerable populations in the region.

BACKGROUND AND RATIONALE

The establishment of the Southern African Development Community (SADC) and the promotion of trade, commerce, and regional infrastructure—especially transport networks—to achieve SADC's economic development and integration objectives has resulted in an increase in the number of people and goods moving among countries, as well as internally from one region of a country to another.[1] This increase in movement has been reinforced by the introduction of the SADC Free Trade Agreement of 2008.[1] Twelve of the fifteen SADC Member States (MS) are mainland countries and rely heavily on regional surface transport networks—particularly roads—for the transportation of goods to and from ports or between Member States. Over 80 percent of intra-SADC and international trade and traffic occurs via road.[1]

Transport routes in the Southern African Development Community

Mobility has been acknowledged as an important factor that impacts health vulnerability and is a challenge for public health management.[1] In addition, communicable diseases such as human immunodeficiency virus (HIV), tuberculosis (TB), sexually transmitted infections (STIs) and malaria place a heavy burden on the MS public health systems. Mobile populations that frequently use the SADC road transport corridors include labour migrants in the road transport, construction, mining and commercial, agricultural, ports and maritime sectors as well as informal cross border traders, domestic workers and sex workers (SW).[2]

These regional minimum standards and brand (RMSB) focus on the road transport sector and aim to improve access to HIV and other health services for long distance truck drivers (LDTD), SW and communities along transport corridors in the SADC region.

Health vulnerabilities for LDTD and SW stem not only from individual risk factors, but also from environmental factors specific to a location.[2] Spaces of vulnerability are those areas where mobile populations live, work or pass through. The presence of migrants and mobile populations and their interaction with local communities at border posts, ports, construction sites, informal settlements, farm compounds and mines creates a fluid social environment that may increase sexual risk behavior and reduce access to health care services.[2] Poverty and limited job opportunities in these communities may induce women (both migrants and locals) to engage in transactional and commercial sex with those who have resources or disposable income.[3]

These factors must be taken into consideration when designing programmes for these target groups, and interventions should include both the communities with which they interact and their own families.[4] The SADC Guidelines for Driver Health Management define the workplace of a professional truck driver as the truck itself and the transport corridors they use, including the road, truck stops, and border posts, sea ports and company premises.[5] LDTD are away from their families and social networks for extended periods of time, with trips often lasting between a few days to a few months. This exposes them to the potential to engage in risky behaviour and practices such as substance abuse and unprotected sex.[1] Relatively low risk perception, limited prevention knowledge and the complex web of travel and sexual mixing all increase the risk of contracting HIV and STIs.[6]

LDTD are a major client group of SW along the transport corridors.[7] They also engage in transactional sex with other groups, including female traders, married women and adolescents.[8] These complex sexual networks and poor risk reduction practices may fuel the spread of HIV and other communicable diseases beyond LDTD and SW.

SW are a heterogeneous population and may include female, male or transgender sex workers.[9] SW carry a disproportionate burden of HIV and STIs. There are numerous reasons for this, including the nature of their work, unsafe working conditions and barriers to negotiating consistent condom use. Structural factors such as stigma, discrimination, the criminalization of sex work in many countries and violence against SW all increase their vulnerability to HIV and STIs. In addition, these factors hamper access to essential HIV prevention, testing, and treatment services and commodities.[10,11] Evidence has shown that effective HIV prevention packages for SW that include biomedical, behavioural, and structural interventions tailored to local contexts result in improved health outcomes.[12]

In Africa, SW were reported to be 12.4 times more likely to contract HIV than the general population.[13] HIV prevalence among SW as reported in the Behavioural and Biological Sero-Prevalence Survey (BBSS) in the SADC region ranges from 1.3-70.3 percent. A 2014 survey of truck drivers and SW along the major road between Durban and Johannesburg in South Africa revealed an overall HIV prevalence of 16.7 percent among truck drivers and 88.4 percent among SW.[6] A baseline HIV Sero-Prevalence Survey conducted by the World Health Organisation (WHO) among SW and LDTD in three border sites in 2013 revealed that the HIV-1 prevalence among SW was 53 percent, and 18-26 percent among LDTD. This study also showed poor uptake of HIV and STI services at border sites by the two target groups (20 percent). Individuals living in communities along road transport corridors were also vulnerable to STIs.

TB prevalence in the region is high, with reports ranging from 174-1,287/100,000 persons in 2010.[14] The region's high HIV rates result in high TB and HIV co-infection.[15] There is limited data on TB among LDTD and SW; however, given their high mobility and exposure to overcrowded and poorly ventilated environments, this group may be at increased risk of contracting TB.

Globally, there has been an increasing burden of non-communicable diseases (NCDs),[16] including within the SADC region. There have been increases in the prevalence of cardiovascular diseases, diabetes, and cancers, and Member States are consequently scaling up interventions to address NCDs. The prevalence and risk of NCDs among LDTD and SW in the region is poorly documented, but could be attributed to limited exposure to health information and education.

Despite the high disease burden among LDTD and SW, the region still lacks comprehensive health services for these populations. Both groups are highly mobile with poorly defined places of work, which presents significant challenges for service providers who seek to reach them. The situation is exacerbated among migrants, who move to or transit through a country where they are not citizens. MS have varying policies on service provision to non-citizens, and as a result, the continuum of care may easily be interrupted.[5] Disruptions in the continuum of care prevent LDTD and SW from accessing continuous, high-quality health services. As a result, case detection and management of both communicable and non-communicable diseases is more difficult, and progress towards sound disease management in the region is compromised.

Disease management interventions for LDTD, SW and communities living along the road transport corridors across the region have focused largely on the provision of HIV and AIDS services. Global good practices such as the Avahan AIDS Initiative, implemented from 2003 to 2012 in India before being transitioned to government, have demonstrated how a data-driven, comprehensive approach can significantly reduce population-level HIV prevalence in high-prevalence provinces through large-scale prevention interventions focused on high-risk groups such as SW, men who have sex with men, LDTD and their helpers. It has been estimated that in Phase 1, the Initiative averted more than 100,000 new HIV infections in a five-year period (between 2003 and 2008). The proportion of STIs diagnosed among female SW decreased from 39 percent in 2005 to 11 percent in 2009, while STIs diagnosed among men who have sex with men decreased from 12 percent to 3 percent.[17]

The majority of SADC Member States have prioritised services for key populations, particularly SW, in their National Strategic Plans (NSPs) for HIV, and have introduced a range of interventions to address vulnerable populations, with promising results. These include the SADC Cross Border Initiative (a regional Global Fund project which aims to establish wellness clinics for SW and LDTD at 32 border sites in the SADC region), North Star Alliance, Corridor Empowerment Project, Walvis Bay Corridor project, African Sex Workers Alliance and South Africa's Red Umbrella National Sex Work Programme, which have demonstrated the feasibility of establishing health services along selected transport corridors. However, there is a need to strengthen and improve the quality and reach of these interventions to these target groups.

The development of the RMSB is in line with SADC's overall vision of harmonizing interventions and practices across the region to improve health and development. This is established in the SADC Health Protocol of 1999 that draws from International Declarations such as the Alma Ata of 1978.[18]

The establishment of these standards is also in direct response to the evidence showing that LDTD and SW in hotspots along transport corridors are disproportionately affected by HIV and STIs and are not adequately reached by existing health services. These standards aim to provide guidance to MS and implementers in both the public and private sectors on the provision of high-quality health services to these target groups and other people living along the road transport corridors.

Finally, a coordinated response among MS and implementing partners in the region is critical to ensure that:

1. The management and control of HIV, TB, STIs, malaria, hypertension, diabetes, cervical cancer, and sexual and reproductive health is effective.
2. LDTD and SW have access to a standard set of health services as they move among countries.

1. PURPOSE AND SCOPE

The purpose of these standards is to provide guidance to MS and implementing partners from both the public and private sectors in delivering high-quality health services to LDTD, SW, and people living along road transport corridors in SADC. They are intended to improve access to HIV and other health services by these target populations, who are at greater risk of HIV infection. The standards describe service delivery models and the minimum package of services, and define roles, responsibilities, and management mechanisms to facilitate sound and sustainable implementation.

These standards will also serve as a platform to strengthen partnerships between relevant ministries and departments in the delivery of health services to the road transport sector at both regional and national levels. In addition, they will constitute a reference point for enterprises in the transport sector to formulate harmonised company policies and programmes.

The standards emphasise the specific needs of LDTD and SW and align to existing regional standards, guidelines and frameworks for disease prevention, diagnosis and management.

These standards advocate for access to the following prevention, diagnostic and treatment services:

Communicable diseases

- HIV
- TB
- STIs
- Malaria

Non-communicable diseases

- Hypertension
- Diabetes

Other

- Sexual and reproductive health services, including family planning and cervical cancer screening and referral
- Occupational health-related conditions

These standards build on existing SADC guidelines and frameworks that include:

- Harmonised Minimum Standards for the Prevention, Treatment & Management of TB in the SADC Region (2010).
- Regional Minimum Standards for Guidance on HIV Testing and Counselling in the SADC Region (2010).
- SADC Regional Minimum Standards for the Prevention, Treatment and Management of Malaria (2011).
- Sexual and Reproductive Health Strategy for the SADC Region 2006-2015 (2008).
- Framework for the Prevention and Control of Sexually Transmitted Infections in the SADC Region (2010).
- SADC HIV and AIDS Strategic Framework 2010-2015.
- SADC Minimum Standards on the Integration of HIV and SRH (2015).

2. GUIDING PRINCIPLES

The key guiding principles and values for these standards are outlined below.

2.1 Right to Health

All persons have a right to equitable, accessible and acceptable health services.

2.2 SADC Mandate on Harmonising and Integrating Regional Policies

SADC is mandated to harmonise regional policies, which promotes a continuum of care from one country to the next.

2.3 Sustained Political Commitment

Consistent up-to-date evidence is needed to support advocacy for LDTD and SW, and will create an environment for sustained political commitment.

2.4 Health-Promoting Workplace Environment

LDTD and SW should enjoy working environments that promote health through peer education, outreach, support groups and other methods.

2.5 Gender Mainstreaming

Gender dynamics are considered at all levels of development and implementation.

2.6 Empowerment of SW and LDTD

Empowerment of SW and LDTD is central to interventions to ensure that these groups are able to demand accessible and acceptable services.

2.7 Effective Partnerships

Stakeholders should collaborate to leverage partner's comparative strengths.

3. PROCESS OF DEVELOPMENT

In 2007, the International Organization for Migration (IOM), in partnership with SADC, the World Food Programme and North Star Alliance, facilitated a regional workshop on HIV in the road transport sector in southern Africa. Participants recommended the formation of a comprehensive HIV programme for the sector that included an integrated package of health care services; a multi-sectorial communication strategy with evidence-based behaviour change communication interventions tailored to the target group's needs; effective coordination, partnerships, advocacy and

policy development and quality assistance; and regional monitoring and evaluation frameworks and systems. A small task team was established, coordinated by the United States Agency for International Development (USAID) Regional HIV/AIDS Program (RHAP) and IOM, to explore development of regional minimum standards for mobile populations in the transport sector in anticipation of presenting a final package for review and approval by SADC structures.

In 2011, a sub-regional workshop on HIV and AIDS in the transport sector in southern Africa emphasised the importance of a more holistic approach to service provision. This was defined as integrated services that extend beyond HIV and AIDS, with consideration for TB, STIs, malaria, cholera, road safety and occupational health. The SADC Secretariat, with the support of GIZ, developed guidelines for Drivers Health Management in 2011. A situational analysis of TB, HIV, and occupational health and safety identified a lack of harmonisation in both the transport and health sectors across the region as a significant challenge to delivering effective health services.[5] The guidelines were developed to provide transport companies and road freight associations with information on workplace health and safety issues, employee wellbeing, social security and other work-related topics, such as decent work conditions.

In an effort to respond to recommendations from these earlier interventions and to improve existing services, the SADC Secretariat, with support from USAID and IOM, held a one-day consultation in 2012 with key stakeholders. Participants agreed to prioritize the development of a regional minimum package of HIV prevention and management services for interventions targeting the road transport sector in southern Africa.

In April 2014, SADC convened a technical working group (TWG) to achieve consensus on the RMSB. The group agreed that the standards should take a holistic approach and include HIV, TB, STIs, malaria, hypertension, diabetes, sexual and reproductive health, cervical cancer and other occupational health-related conditions.

SADC, with technical and financial support from the USAID-funded Building Local Capacity for Delivery of HIV Services in Southern Africa Project (BLC) and African Strategies for Health (ASH), developed the RMSB to improve access to HIV services for LDTD and SW in the SADC region. The RMSB were developed in a participatory manner, engaging representation from Member States, development partners, USAID/RHAP, UN agencies, regional transport federations, workers groups, associations of sex workers and key implementing and cooperating partners that provide health services to LDTD, SW and communities living along road transport corridors in the region. Development of the standards included a situational analysis conducted at eight cross border sites with input from service providers and clients, several TWG meetings, and a validation and consensus-building meeting with Member States' National AIDS Councils (NAC) and Ministries of Health (MoH), as well as other key stakeholders from across the region, including trucking companies, donors, service providers, and civil society.

The SADC Secretariat presented the RMSB to the SADC Health Ministers in January 2015

and was advised to revise the standards to promote a more holistic approach to LDTD and SW, incorporate lessons learned from global good practice such as the Avahan project, and expand the service delivery models for delivery of health services. The Health Ministers further advised SADC to ensure broad participation of all stakeholders such as the private sector and sex worker associations.

SADC facilitated the expanded TWG meeting to revise the RMSB from 15-16 September 2015. The meeting was well attended, with representatives from the African Association of Sex Workers, Sex Workers Education and Advocacy Taskforce (SWEAT), FHI360, Networking HIV/AIDS Community of South Africa (NACOSA), Federation of East and Southern Africa Transport Associations, the South Africa National Road Freight Association, development partners, service providers, and representatives from Botswana, Malawi, Mozambique, Swaziland, South Africa, Tanzania and Zimbabwe.
The TWG proposed that SADC update the background section to include most recent data on HIV prevalence among LDTD and SW and highlight the interface between mobility and HIV risk, provided input on appropriate service delivery models with criteria to guide decision-making regarding choice of model, suggested aligning the minimum package to these models and updating the roles and responsibilities section, and added proposed indicators for monitoring implementation of the RMSB and service provision to LDTD and SW in the region. The revision of the RMSB was also informed by a desk review on the status of sex work in the SADC region, identifying barriers SW face in accessing health care services, as well as country strategies and programs and global and regional good practices to improve access to services.

A SADC consensus-building meeting with Member States was held from 12-13 October 2015 to ensure collective ownership of the revised RMSB by Member States and relevant stakeholders, and reach a common understanding of the RMSB implementation, including processes for its domestication at country level. After this meeting, the final draft RMSB (with an implementation plan and proposed indicators for monitoring implementation of the RMSB and services) was approved at the SADC Health Ministers meeting from 9-13 November 2015.

RMSB Technical Working Group meeting in October 2015

4. REGIONAL MINIMUM STANDARDS AND BRAND

These regional minimum standards outline a minimum package of services and appropriate service delivery models for improving access to HIV and other health services for long distance truck drivers, sex workers and communities along transport corridors. Community members may include migrant workers, informal traders, and uniformed services such as customs, border police, and immigration officials.

4.1 Service delivery models

Member States should select a strategic mix of service delivery models and invest in community-based outreach services to increase access to and the uptake of HIV and other health services by LDTD and SW. Strong referral systems should be established among local health facilities, civil society organisations (CSOs) and other partners to ensure clients receive the required services and improve their health outcomes. Two options for the provision of health care service have been identified.

4.1.1 Option 1: Designated stand-alone clinics

Location: Specifically designed stand-alone clinics[a] located at border posts (within two km walking distance of border posts) and informal and formal truck stops along major transport corridors. These sites have been identified as spaces of vulnerability related to high levels of risk behaviour and have consistently high volumes of LDTD and SW passing through or residing in the area.

Walvis Bay Corridor Group stand-alone clinic

Target groups: Primarily LDTD and SW. Local community members may also access services and will be referred to government clinics for follow-up services.

Funding: Primarily funded by the private sector, but may also be supported through public-private partnerships.

Specifications:

- Health care workers must be suitably qualified and registered with the relevant nursing council in the country of operation.
- Health care workers must be sensitised to provide non-judgemental, appropriate HIV prevention, treatment and care, and other health services to LDTD and SW. This will enhance the quality and acceptability of health services to these populations.
- Clinics may extend operating hours to improve accessibility of health services by the target groups.
- Clinics should provide comprehensive health care services as defined in the minimum package of services.

[a] *These sites are also known as roadside wellness centres*

- Clinics should establish community outreach services through formal partnerships with CSO partners to increase uptake of available health services by LDTD and SW (refer to section below on community empowerment and outreach). Partnerships should be formalised through the use of memoranda of understanding (MOUs).
- Stand-alone clinics should establish close relationships with district health departments/facilities to ensure that clients access follow-up screening, diagnosis and treatment for health care services not provided at the site. Regular meetings should be held with district health facilities to monitor project implementation, coordinate referrals and address implementation challenges and bottlenecks.
- Stand-alone clinics must report on a monthly or quarterly basis to the MoH's district health management to enable government to monitor service provision to these target groups.
- Stand-alone clinics must display the RMSB signage and branding to ensure that they are easily identified by the target group.
- Stand-alone clinics must comply with national health standards and protocols, and should be licensed or accredited by the relevant health authority. Accreditation or licensing certificates should be prominently displayed at the stand-alone clinics.

4.1.2 Option 2: Integrated primary health services: government clinics

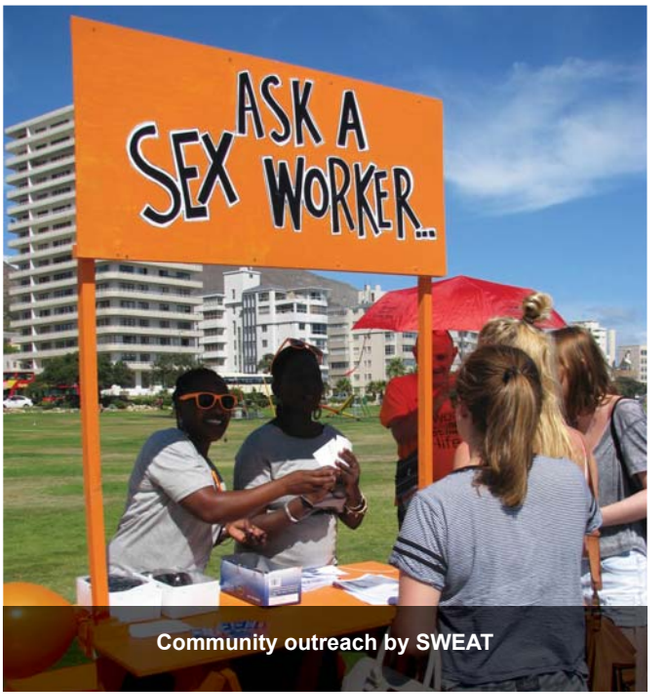
Location: Government health clinics located along major transport corridors which expand their services to provide non-judgemental and appropriate health services to LDTD and SW along the transport corridors.

Target groups: LDTD, SW and general population.

Funding: Government-funded.

Specifications:

- As in Option 1, health care workers must be sensitised to provide non-judgemental, appropriate HIV prevention, treatment and care, and other health services to LDTD and SW. This will enhance the quality and acceptability of health services to these populations.
- Clinics may have extended operating hours to improve accessibility of health service by the target groups.
- Clinics should establish community outreach services through formal partnerships with CSO partners to increase uptake of available health services by LDTD and SW (refer to section below on community empowerment and outreach). Partnerships should be formalised through the use of MOUs.
- Clinics must display the RMSB signage and branding to ensure that they are easily identified by the target group.



Community outreach by SWEAT

Community empowerment and outreach
Regardless of the chosen health care model, health care providers should establish partnerships with CSOs to implement community empowerment and mobilisation services for LDTD and SW.[b] This will increase ownership, accessibility, acceptability and uptake of health services by these target groups. Community empowerment and outreach services include one-on-one or small group educational sessions by peer educators; peer support groups; referrals to health, mental health and legal services; and targeted HIV counselling and testing (HCT) and other health campaigns using mobile clinics and tents.

Health care providers should partner with CSOs to conduct regular HCT and other health campaigns to increase the number of clients who know their HIV status and are enrolled in treatment and care.

These campaigns should be held at times and in locations where these groups congregate, such as taverns and truck stops. These campaigns should offer an integrated package of services, including HCT; screening for TB, STIs, cervical cancer and NCDs; and social behaviour change communication (SBCC). Referral and follow-up systems should be established to ensure that clients who test HIV positive or exhibit symptoms of TB and/or STIs receive treatment services and are enrolled in care.

4.2 Criteria for the selection of appropriate service delivery models

4.2.1 HIV prevalence and other data

Country epidemiological and BBSS reports confirm that HIV risk and prevalence are unevenly distributed among population groups and different geographic areas. For example, HIV prevalence is disproportionately high among key populations (SW, men who have sex with men and people who inject drugs) globally, and among young women and girls in sub-Saharan Africa. However, HIV prevalence alone is not sufficient to guide the design of effective programs for diverse target groups. Effective programs should be guided by an in-depth understanding of the epidemic, including analysis of HIV transmission dynamics, population diversity and geographic distribution of risk.

Data sources include population size estimates, district-level prevalence data, health statistics, and BBSS reports for SW and LDTD, as well as data on traffic flows along major transport routes and border

[b] *Community empowerment enables marginalised groups such as sex workers to take collective ownership of programs to achieve HIV outcomes and address the social and structural barriers to their overall health and human rights. Countries like Kenya, Brazil, Thailand, India and the Dominican Republic have proved that investing in community-led programs for sex workers results in improved reach, access, service quality, reduction of risk behaviour, as well as increased uptake of health care services.*

posts. Data from various sources should be triangulated to overcome limitations of individual data sources.

Service providers should also conduct local-level situational analyses and mapping to inform program planning. This includes geographic mapping of spaces of vulnerability where high risk behaviour occurs (hotspots). Different types of sex workers and clients (such as LDTD, border officials or others) must be identified, and areas where SW and LDTD live or temporarily stay and meet clients mapped. Programmatic mapping is then used to identify available services and gaps in current service delivery. Collectively, this data can be used to plan health care services, assign mobile services, recruit and deploy peer educators, target outreach activities and distribute condoms. Guiding questions include:

- How many people live within this geographic area?
- What is the geographic distribution of HIV prevalence, incidence and number of people living with HIV in this geographic area?
- Where are the health facilities?
- Where would the expansion of services increase coverage or equity?

4.2.2 Equity of access

Health equity is the principle or commitment to reduce and ultimately eliminate disparities in health and in its determinants.[c] LDTD are highly mobile and have difficulty accessing essential health services, while SW encounter structural barriers to accessing health services, with low service utilisation compared to the general population. Innovative approaches are therefore required to reach these target groups. Community empowerment and outreach strategies such as peer education and providing HIV and other health services via mobile clinics or facilities can increase coverage and reach these groups and clients in remote areas which are underserved by existing health facilities.

4.2.3 Cost effectiveness

Cost effectiveness relates to the feasibility, affordability and sustainability of different service delivery models. The service delivery models have different resource implications, including human resources and infrastructure. Ideally, service delivery models should take maximum advantage of the available resources while expanding services to reach those most in need. Finding additional resources to scale up HIV services for priority groups is a crucial part of the planning for overall scale-up of the national response to HIV.

The cost effectiveness of an approach varies with the nature of the epidemic in a particular area. For example, door-to-door visits may be productive in high-prevalence areas, but they may only reach a small percentage of infected people in a low-prevalence setting. Combining HCT with health screening and services in multi-disease campaigns may be cost-effective, offer broader health impact and reduce stigma.

4.3 Minimum package of services

The minimum package of services outlined below serves as the basis for the RMSB. It draws from existing international guidelines and regional standards that guide the provision of key services for HIV, TB, malaria,

[c] *Social determinants of health refers to the conditions in which people live and work which affect their health. Social and economic obstacles to health include factors such as race or ethnic group, religion, socio-economic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.*

and sexual and reproductive health. The proposed minimum package of services aims to contribute to increased case detection, capacity and awareness, and levels of treatment for communicable and non-communicable diseases at both regional and national levels. It responds to the health needs of LDTD, SW, and communities living near road transport corridors. Community engagement is vital for the success of these services and promotes the provision of high-quality, comprehensive services in a non-discriminatory environment.

The existing SADC guidelines and standards include the following:

- **Harmonised Minimum Standards for the Prevention, Treatment and Management of TB in the SADC Region (2010).** In this document, among others, standards are defined for TB diagnosis, case-definitions, treatment, and cross-cutting issues such as infection prevention and control.
- **Regional Minimum Standards for Guidance on HIV Testing and Counselling in the SADC Region (2010).** These minimum standards address the need for a conducive environment for HCT, and provide guidance on informed consent, the age of consent, and the various HCT approaches (including provider-initiated testing and counselling). It also covers capacity needs, the accreditation of HCT sites, and the provision of treatment and care for HCT service providers.
- **SADC Regional Minimum Standards for the Prevention, Treatment and Management of Malaria (2011).** In this document, among others, standards are defined for vector control measures, malaria in pregnancy and malaria case management.
- **Sexual and Reproductive Health Strategy for the SADC Region 2006-2015 (2008).** This document provides a framework for developing sexual and reproductive health (SRH) policies, and for harmonization for countries that do not yet have such policies. It also guides interventions by SADC Member States, the SADC Secretariat, donors and other stakeholders in the region.
- **SADC Minimum Standards on Integration of HIV and SRH (2015).** These standards seek to promote and support efforts by Member States to better integrate SRH and HIV into national policies and frameworks.
- **Framework for the Prevention and Control of Sexually Transmitted Infections in the SADC Region (2010).** This document outlines guidance for STI case management, behaviour change communication for STI management, quality assurance, STI surveillance and monitoring and evaluation (M&E) based on a set of core indicators.
- **Guideline for Drivers Health Management in the SADC Region (2011).** These guidelines are intended to provide transport companies and road freight associations with information on workplace health and safety issues, employee wellbeing, social security and other work-related topics, such as decent working conditions.

Service providers are required to be registered with the Ministry of Health, and licensed to operate as either health posts or clinics according to national health classification systems. This determines the scope of practice and competencies required to perform specific health functions.

All service providers must adhere to national HIV, STI, TB, malaria and other relevant health protocols in the provision of health services. In addition, service providers are required to develop and sign MOUs with the MoH and NAC at the national level and level closest to their point of service provision. Service providers will develop and maintain referral channels for the treatment and management of all health conditions beyond their scope.

4.3.1 Prevention services

Government and service providers should ensure that the following services and commodities for the prevention of communicable and NCDs are available at health facilities. The type, quality and timeliness of commodities and services should comply with existing national and regional standards.

Communicable diseases

- HIV counselling and testing
- Male and female condom promotion and distribution, and condom negotiation skills development
- Promotion and distribution of water-based lubricants
- TB education and prevention
- Malaria prophylaxis, including provision of nets
- Post-exposure prophylaxis (PEP) for both occupational and non-occupational exposure (HIV, STIs, and pregnancy)
- Prevention of mother-to-child transmission (PMTCT) referrals
- Voluntary medical male circumcision (VMMC) referrals
- Risk reduction counselling for LDTD and SW on communicable diseases (see SBCC services)

Non-communicable diseases

- Sexual and reproductive health services, including family planning and emergency contraceptives

Other

- Psychosocial support
- Vital signs examination

SBCC services

- Service providers identify champions from the target groups and build their capacity to serve as peer educators and agents of change.
- SBCC materials on HIV, TB, STIs and malaria are based on the SADC Regional Advocacy Strategy and SBCC Guidelines on HIV and AIDS, STIs, TB, and Malaria.
- SBCC materials should be evidence-based, gender-sensitive and culturally appropriate, and be developed in a participatory manner with input from LDTD and SW.
- SBCC materials should be available in local languages.
- SBCC topics include, but are not limited to the following: HIV; HCT; anti-retroviral therapy (ART); STIs; TB; Malaria; SRH and rights; benefits of VMMC; male and female condoms and lubricants; nutrition; behavior change; health risks associated with smoking, alcohol and drug abuse; gender-based violence and referrals; human and legal rights; stigma and discrimination; and economic strengthening/empowerment projects for SW, as well as basic information on NCDs.

Service delivery methods include:

- Education and awareness, group discussions and interpersonal communication

- Peer education and outreach, including door-to-door campaigns and edutainment
- Local advocacy

4.3.2 Screening services

Service providers will develop a directory and referral channels for those testing positive during screenings and who require follow-up beyond the scope of the health facilities.

Communicable diseases
- Regular symptomatic screening for STIs
- Symptomatic TB screening for all clients, including those who are HIV positive, as well as sputum collection
- Malaria screening

Non-communicable diseases
- Diabetes screening
- Cholesterol screening

Other
- Hypertension screening
- Body Mass Index screening
- Eye testing
- Screening for alcohol and drug abuse
- Screening for gender-based violence
- Cervical cancer screening through visual inspection of the cervix using acetic acid

4.3.3 Treatment services

The SADC Secretariat will advocate for the harmonisation of treatment regimens for communicable and non-communicable diseases across the region. Ministries of Health will train service providers on the use of flow charts to evaluate signs and symptoms and appropriate methods of case management. Service providers will adhere to national guidelines and treatment protocols on:

Communicable diseases
- STI syndromic treatment
- Malaria treatment and referral
- TB treatment and referral
- ART treatment (ART preparation, ART enrollment and refills/referrals)

Non-communicable diseases
- Diabetes treatment/management and referral
- Hypertension treatment/management and referral

Other
- Treatment of minor ailments (cuts and bruises, back pain, headaches, upper respiratory tract infections and others)
- Referral for other conditions beyond the scope of these facilities

4.4 Clinic design

To increase uptake of HIV and other health services among LDTD and SW, both stand-alone and government clinics along road transport corridors should be easily accessible and visible. Sites should comply with the RMSB branding (directional signage and signage on the building), which increases visibility and markets the available services to clients. The following section outlines minimum standards for clinic design, infrastructure, equipment, environment and staffing, as well as branding requirements to facilitate access to and increase uptake of the minimum package of services.

4.4.1 Option 1: Designated stand-alone clinics

Design and infrastructure

Stand-alone clinics along the road transport corridors may be permanent structures made of brick and mortar, timber, or portable homes.

Where containers are used, they must be insulated and properly ventilated. Clinics should have sufficient space for equipment, with adequate room for unhindered movement and comfort. They should include:

- A room for HCT
- Consultation or dispensing rooms
- A waiting area
- Ablution facilities for staff and clients
- A storeroom or lockable cabinets

Service providers will ensure that clinics have:

- Adequate ventilation and lighting
- A power supply
- Running water
- Infection control measures
- Waste management systems and sanitation facilities

Equipment

Clinics should be fully furnished and have relevant medical equipment and waste management systems as per national health protocols to provide the full spectrum of services in the minimum package. They should have the following equipment:

- Continuous supply of drugs and commodities as per government regulations
- Comfortable and durable furniture
- Lockable cabinets for files
- Lockable cabinets for drugs
- Security and confidentiality of records
- Back-up power system (i.e. solar power)
- Examination couch
- Paper register
- Functional examination light
- Disposable gloves
- Adequate sterile vaginal specula of different sizes
- Sharps equipment management system, including functional sterilisation instruments
- Sex organ models for demonstrating male and female condom use
- An adequate stock of male and female condoms and test kits, and containers for taking blood and other samples
- Male and female condom dispensers placed in locations for easy and confidential access
- Refrigerator for samples and drugs, and a proper log
- Fire extinguisher

External environment

Service providers will ensure that stand-alone clinics are located at or very close to truck stops and border posts, with adequate parking for trucks. Truck stop owners will ensure that facilities are surrounded by and include the following:

- Quarry stone or paved surfaces to minimize dust and mud
- Decent accommodation
- Clean toilets and showers
- A convenience store
- Canteen facilities
- Entertainment facilities such as a TV set, indoor games and board games
- Communication facilities such as cell phone charging and internet
- Money transfer facilities
- Vehicle maintenance and fuel
- Fitness facilities

Staffing

Staff recruitment and appointments must comply with local employment conditions and government standards regarding minimum qualifications, experience and salary levels.

Staffing requirements for the facilities along the road transport corridors include:

Mandatory:
- 1 registered nurse
- 1 trained counsellor
- 1 peer educator

Optional:
- Cleaner
- Security

The number of staff can be adjusted depending on the size and patient load of each facility. Staff will wear uniforms bearing the regional brand.

4.4.2 Option 2: Integrated primary health services: government clinics

All clinics should align and comply with approved government health service standards with regard to design and infrastructure, equipment, external environment and staffing.

4.5 Branding

The RMSB includes a brand, which is the visual representation of the minimum package of services, and will be used at all sites subscribing to the RMSB. The SADC Secretariat will provide guidance on brand management. Partner organisations and service providers will conduct activities to raise awareness of the RMSB brand among the target groups. Communications activities will include and not be limited to: awareness campaigns, dissemination of brochures, and directional and location signage. The following branding criteria shall be met:

- Brand application across all communication channels shall comply with the Brand Identity Controls
- Brand application will use quality materials
- Brand expression will use the appropriate language/s and be sensitive to the target groups
- Brand expression will use appropriate channels and media for the target groups
- Brand communication will reinforce consistent messaging and be on-going

The brand development process was highly consultative, including input from the TWG and field testing with LDTD and other clients in six sites and in three languages. The RMSB brand incorporates the SADC logo, with the name: **CROSSBORDER WELLNESS**, and the slogan: **Drive for Life.**

4.5.1 Directional and information signage

Minimum signage requirements include:
- 1 sign on the building with the name of the clinic
- 1 sign on the building with the RMSB brand and indicating the services offered
- 2 directional signs on either side of the road pointing in opposite directions, indicating how to reach the site
- 2 directional signs one km from the site on either side of the road pointing in opposite directions
- 1 sign at weigh bridges bearing the RMSB brand and indicating the nearest clinic
- 1 site disclaimer that includes any legal or truck stop requirements or acknowledgements

The following signage criteria shall be met:

- All signage designs will conform to the Brand Identity Controls
- All signage will be comprised of UV protected vinyl and Chromadek with steel frames, either permanently mounted on a robust surface or on steel poles no smaller than 50mm in diameter
- All directional signage on the road will comply with country or local by-laws in terms of design and location

5. IMPLEMENTATION MECHANISMS

Implementation of the RMSB will occur at both regional and national levels. Multiple stakeholders have been identified as key contributors to the effective implementation of these standards. These include the SADC Secretariat, National AIDS Councils, the Departments of Health and Transport and Immigration, private sector roleplayers such as National Transport Associations, employer and worker organisations, sex work associations and civil society.

5.1 Financing

Country NSPs and policies should be aligned to the RMSB to improve services to these target groups. Programmes for LDTD and SW should be included in annual, national, and district work plans and budgets to support implementation of the RMSB.

- Ministries of Health or NACs will ensure an adequate budget for clinics targeting LDTD, SW and communities living along the road transport corridors.
- Ministries of Finance will allocate resources for the provision of health services along the road transport corridors.
- MS will engage international cooperating partners to allocate funding for transport corridor facilities and activities that adhere to these standards.
- Trucking companies are encouraged to make contributions through their Corporate Social Investment.
- Service providers (private sector and CSOs) will seek alternative sources of funding to complement government efforts.
- Ministries of Health or NACs will ensure a budget for research and M&E relevant to the transport sector.
- Research institutions and academia should seek additional alternative sources of funding for research.

5.2 Monitoring and evaluation

Implementation of the RMSB and services to LDTD and SW should be monitored to assess progress and identify areas for improvement. Proposed indicators for RMSB implementation at the regional level include:

- Number of approved regional and national multi-sectorial implementation plans with relevant monitoring indicators
- Number of MS who submit regular reports on program implementation to the MoH/ NAC and SADC
- Number of MS who report disaggregated data for SW and LDTD
- Number of service providers sensitized on the RMSB
- Number of service delivery sites that adhere to the RMSB.

Government, in consultation with civil society and development partners, should develop disaggregated and sub-national level indicators to monitor service delivery and facilitate regional and international reporting.

Indicators should provide information on the size and coverage of the target group, as well as the treatment cascade. M&E systems should be harmonised to ensure that clients who cross borders can be effectively monitored. Proposed indicators include:

- Number/percentage of LDTD and SW reached with HIV prevention programmes.
- Number of condoms and lubricants distributed to LDTD and SW.
- Number/percentage of LDTD and SW who have received HCT in the past 12 months and were given their results.
- Number/percentage of LDTD and SW who are living with HIV.
- Number/percentage of LDTD and SW with STIs diagnosed and treated appropriately according to the respective guidelines.
- Number/percentage of LDTD and SW enrolled on ART.
- Number/percentage of LDTD and SW retained in care.

Countries should investigate the feasibility of using unique identifiers to protect the identity and confidentiality of clients, and should conduct regular surveillance assessments to monitor the implementation and impact of its programmes.

CSOs which implement HIV and related health services with donor funding should report on these services at the district level, as this provides essential information on coverage and uptake of services among these target groups.

5.3 Quality assurance

The SADC Secretariat, in collaboration with MS Ministries of Health or NACs will ensure quality assurance of services.

- The SADC Secretariat will appoint an independent third party to conduct an objective assessment of implementation. Assessment findings will be submitted to SADC, MoH and NAC.
- The clients will continuously rate services to inform technical assistance and capacity building requirements.
- Clinics should follow national standards and operating procedures for quality assurance of laboratory tests and equipment
- MS district health offices will conduct external quality control at clinics to ensure compliance with government protocols. The district health offices will also conduct supportive supervision and provide guidance to sites to address gaps in services. This includes training and on-site support to staff to promote adherence of national standards.
- MS Ministries of Health or NACs, academia and research institutions will ensure that research complies with ethical standards.

5.4 Roles and responsibilities

5.4.1 SADC Secretariat

The mandate of the SADC Secretariat in the implementation of the RMSB will be to harmonise and coordinate the development of the regional minimum standards, mobilise resources, monitor and evaluate implementation of the RMSB and provide regular progress reports to MS and stakeholders. In particular, the roles and responsibilities of the Secretariat will include the following:

- Coordinate priority setting for research in collaboration with academic and research institutions.

- Promote region-wide domestication of the standards and mobilize resources to ensure timely domestication across the region.
- Support efforts to ensure that it has adequate technical capacity to support MS in domestication and monitoring of implementation.
- Advocate for harmonisation of protocols for chronic disease management as well as health information systems across the region.
- Seek and establish mechanisms for pool purchases for pharmaceuticals and other medical supplies for the region.
- Encourage policies that allow migrants to access free medical treatment at host country primary health care facilities.
- Develop a dissemination and implementation plan for the RMSB.
- Support efforts to ensure that minimum standards to regulate truck stop facilities are developed and implemented across the region. The SADC Secretariat will establish information and knowledge sharing networks and platforms for best practices.
- Collaborate with MS Ministries of Health and implementing partners to establish an M&E Framework and plan with appropriate indicators, tools and guidelines.
- Ensure that documents and communications materials are in all three SADC official languages: English, Portuguese and French.

5.4.2 Member States

MS will provide the overall leadership for the implementation of the RMSB through the provision of enabling legislative and regulatory frameworks. This will include:

- MS will ensure that the legal and political environment is conducive to enable health care access by SW and non-citizens.
- MS will encourage international cooperating partners to align financial and technical support to SADC and country priorities.
- Ministries of Health or NACs will fast-track the domestication and adaptation of the RMSB to the local context.
- Ministries of Health will lead coordination and implementation of the RMSB. The MoH will collaborate with relevant ministries (Finance, Transport, Immigration and Labour), private sector and civil society to ensure that policies for the road transport sector are aligned with these standards.
- Ministries of Health will ensure that medicines and commodities, equipment and necessary data-collecting tools are provided to clinics as per national guidelines. Ministries of Health will institute corrective action in the event of non-compliance.
- Ministries of Health will ensure that staff is adequately trained and sensitised to diagnose, treat and manage LDTD and SW as per national guidelines. They will ensure that staff members receive on-going training with regular refresher courses on communicable and non-communicable disease management.
- Ministries of Health will ensure that strong linkages are created and maintained with other sectors, including transport associations and SW associations, for better design and implementation of interventions.
- Ministries of Labour will ensure that non-affiliated/individual LDTD are not excluded from health interventions.

- Ministries of Health or NACs will ensure that there are regular and joint performance reviews of health service provision to LDTD, SW and communities living along road transport corridors.
- Ministries of Health will ensure that capacity is developed at all levels for data collection, analysis, synthesis, quality assessment and dissemination as per the RMSB M&E Framework.
- Ministries of Health or NACs will ensure harmonisation and alignment to national and sub-national indicators, and quality assurance and reporting systems.
  In consultation with civil society and development partners, they will develop disaggregated national indicators for services to SW and LDTD in line with international, regional and national reporting guidelines.
- Ministries of Health or NACs will develop strategies to strengthen linkages and referrals of clients to ensure continuum of care.
- The Ministry responsible for immigration should ensure adequate capacity of immigration officials to support the implementation of these standards to enhance referral processes.

5.4.3 Civil society

Civil society, including CSOs, will participate and play an active role in advocacy, dissemination and support of the implementation of the RMSB. Their roles and responsibilities include:

- Design and implement specific health-promoting activities for LDTD and SW along road transport corridors.
- Support community empowerment and the strengthening of SW associations.
- Collaborate with MS and LDTD and SW representatives to develop targeted messages for LDTD and SW.
- Partner with government to sensitise service providers (i.e. police and health care workers) to ensure services adhere to human rights and meet the needs of the target groups.
- CSOs providing clinical services will ensure that they adhere to national health care standards and protocols as well as the RMSB, and report to Ministries of Health or NACs.
- Regional and national SW associations shall ensure that SW are not excluded from health interventions.

5.4.4 Private sector

The private sector will contribute to the implementation of the RMSB through participation in policy and legislation, social dialogue and constructive engagement of government and workers' representatives, and resource mobilization to support implementation. In particular, the role and responsibilities of the private sector will include:

- Trucking companies will ensure that they implement SADC's Driver Health Management Guidelines and the RMSB.
- Trucking companies will ensure that information on health and wellbeing, including health services available along the transport corridors, are part of the orientation process for new truck drivers.
- Truck stop owners will ensure that their facilities are in compliance with regional truck stop standards.
- Companies and regional and national transport associations engaged in cross border transport will ensure that their policies facilitate implementation of these standards and related guidelines.

They will disseminate the RMSB and facilitate awareness campaigns to ensure that all staff are aware of these standards and related guidelines.

5.4.5 Workers' organisations

Workers' organisations will contribute to the implementation of the RMSB through full and active participation in policy development and legislation, social dialogue and constructive engagement, and resource mobilization. Roles and responsibilities include:

- Advocate for their LDTD members to have access to comprehensive health services.
- Support the efforts of trucking companies to implement these standards.
- Monitor implementation of the RMSB, identify gaps and take them to the appropriate association/forum for remedial action.

5.4.6 Academia/research institutions

Academia and research institutions will contribute to the RMSB through strengthening the evidence base through research and documenting international and regional good practice on the implementation of HIV and other health services along the road transport corridors. They will:

- Collaborate with the SADC Secretariat on setting research priorities.
- Generate evidence to guide program design and implementation, as well as evaluate the impact of interventions to guide future programs. This will include generating strategic information for policy and program formulation.
- Collaborate with the SADC Secretariat to establish information and knowledge sharing networks and platforms for good practice.

5.4.7 International cooperating partners

International cooperating partners have an important supportive role in the implementation of the RMSB. These partners include bilateral and multi-lateral partners, development banks, foundations, and UN organisations. They will:

- Support regional and/or MS activities that are compliant with these standards.
- Support infrastructure development through investment funding to MS.
- Ensure that requests for proposals for projects along the transport corridors are compliant with the RMSB.
- Support evidence-based policy and program formulation.
- Support capacity building of implementers, including staff working at clinics.
- Support civil society organisations in the formulation of advocacy strategies.

5.4.8 The media

The media will work in collaboration with MS to disseminate information to a variety of targeted audiences.

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ANNEX A

ACTION PLAN REGIONAL MINIMUM STANDARDS AND BRAND FOR HIV AND OTHER HEALTH SERVICES ALONG THE ROAD TRANSPORT CORRIDORS IN THE SADC REGION								
Activities		**Outputs**	**Key performance indicators**	**Timeframe**	**Means of verification**	**Responsibility**	**Budget (USD)**	**Budget notes**
Strategic Action 1: DISSEMINATION AND DOMESTICATION OF THE APPROVED RMSB								
1.1	Disseminate the approved RMSB to SADC Member States and regional stakeholders	Approved RMSB disseminated to Member States and regional stakeholders	Number of relevant regional stakeholders aware of the RMSB and who have received a copy of the RMSB	Jan-March 2016	Distribution list	SADC Secretariat	10,000	Layout/design and printing
1.2	Disseminate the approved RMSB in Member States	Approved RMSB disseminated to national and sub-national stakeholders	Number of relevant national stakeholders aware of the RMSB and who have received a copy of the RMSB	Jan-June 2016	Distribution list	MOH/NAC	N/A	

ACTION PLAN REGIONAL MINIMUM STANDARDS AND BRAND FOR HIV AND OTHER HEALTH SERVICES ALONG THE ROAD TRANSPORT CORRIDORS IN THE SADC REGION								
Activities		**Outputs**	**Key performance indicators**	**Timeframe**	**Means of verification**	**Responsibility**	**Budget (USD)**	**Budget notes**
Strategic Action 1: DISSEMINATION AND DOMESTICATION OF THE APPROVED RMSB								
1.3	Facilitate the domestication of the approved RMSB in Member States	Approved RMSB domesticated at country level	• Number of Member States who conducted domestication/ sensitization meetings with key stakeholders at national and sub-national level • Number of national multi-sectorial implementation plans with indicators to domesticate the RMSB • Number of Member States who aligned policies and services with the RMSB • Number of Member States who included programmes for LDTD and SW in their NSP work plans and annual budgets	Jan 2016-Feb 2017	Records of domes-tication/ sensitization meetings, national implemen-tation plans, revised policies/pro-cedures, and NSP work plans and budgets	MOH/NAC	45,000	Domestication/ sensitization meetings

ACTION PLAN REGIONAL MINIMUM STANDARDS AND BRAND FOR HIV AND OTHER HEALTH SERVICES ALONG THE ROAD TRANSPORT CORRIDORS IN THE SADC REGION								
Activities		**Outputs**	**Key performance indicators**	**Timeframe**	**Means of verification**	**Responsibility**	**Budget (USD)**	**Budget notes**
Strategic Action 2: CAPACITY BUILDING FOR IMPLEMENTATION OF THE RMSB								
2.1	Conduct Mainstreaming HIV and AIDS training of trainers for service providers, including transport sector and border agencies	Services providers trained in Mainstream-ing HIV and AIDS, in-cluding the RMSB	Number of persons trained by sector	Jun-Dec 2016	Reports of training sessions conducted	SADC Secretariat/NAC/ MOH	122,000	Programme workshops
2.2	Conduct training of trainers for Member States' M&E experts in the disaggregate indicators on LDTD and SW	M&E experts trained in indicators on LDTDs and SWs	Number of M&E experts trained in indicators on LDTD and SW by Member States	Jul-Sept 2016	Reports of training sessions conducted	SADC Secretariat/NAC/ MOH	128,000	Programme workshops
Strategic Action 3: COORDINATION								
3.1	Convene an annual partnership forum for transport operators, programme implementers and stakeholders	Annual partnership forum for transport operators, programme implementers and stakeholders convened	Number and type of implementers and stakeholders attending the annual partnership forum	Oct 2016	Record of the partnership forum	SADC Secretariat/NAC/ MOH	50,000	Programme workshops

ACTION PLAN REGIONAL MINIMUM STANDARDS AND BRAND FOR HIV AND OTHER HEALTH SERVICES ALONG THE ROAD TRANSPORT CORRIDORS IN THE SADC REGION								
Activities		**Outputs**	**Key performance indicators**	**Timeframe**	**Means of verification**	**Responsibility**	**Budget (USD)**	**Budget notes**
Strategic Action 4: SUPERVISION - MONITORING AND EVALUATION - REPORTING								
4.1	Collate country data/ evidence on size estimation studies and hot spot mapping to improve planning of services for LDTD and SW along transport corridors	Data and evidence on size estimation studies and hot spot mapping is validated and disseminated	Number of studies validated and disseminated for better programming of services for LDTD and SW	Mar 2017	Reports on studies validated for better pro-gramming	SADC Secretariat/NAC/ MOH	25,000	Programme workshop
Strategic Action 5: RESOURCE MOBILISATION AND FUNDING								
5.1	Advocate for funding by private sector and international cooperating partners for expanded services for LDTD and SW	Advocacy meetings/ visits conducted	Number of public-private partnership (PPP) and international cooperating partner (ICP) agreements to support implementation	2016-2020	PPP and ICP agreements	Private sector stakeholders, MOH/NAC, transport sector	N/A	


CROSSBORDER
WELLNESS
Drive for life.

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