Policy Framework
for Population Mobility and Communicable Diseases
in the SADC Region

Final Draft

April 2009

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Abbreviations and Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ARV	Anti-Retroviral Drug
CSO	Civil Society Organisation
DOTS	Directly Observed Treatment – short course
DSHD&SP	Directorate Social and Human Development and Special Programmes
HIV	Human Immune Deficiency Virus
ICM	Integrated Committee of Ministers
IHR	International Health Regulations
IOM	International Organization for Migration
IPT	Isoniazid Preventive Therapy
ITN	Insecticide-Treated Net
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistant Tuberculosis
MS	Member State
NGO	Non-Government Organisation
PEP	Post Exposure Prophylaxis (against HIV infection after rape)
PLWHA	People Living with HIV and AIDS
SADC	Southern African Development Community
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNHCR	United Nations High Commissioner for Refugees
WHA	World Health Assembly
WHO	World Health Organisation
XDR-TB	Extensively/Extremely Drug Resistant TB

Definition of Terms

Population mobility refers to movement of people from one place to another, temporarily, seasonally or permanently for either voluntary or involuntary reasons. It is a broad term that describes the full range of mobility from short-term movement (e.g. truck drivers) to longer term or permanent relocation. ***Internal mobility*** refers to movement of people from their homes to other places within the same country e.g. from rural to urban areas. ***External mobility*** refers to movement of people who cross international borders to a foreign country.

Migration is a more specific term that is used for those mobile people who take up residence or remain in another place for an extended period of time, including seasonal migrants. Migration can also be internal or external.

External mobility can have ***legal status,*** which means the host government permits the migrants to stay or work, or it may be ***undocumented,*** which means the migrants do not have official documents to allow them to stay in the host country.

Mobility may be ***voluntary –*** *e.g. for* work, study or exploration purposes—or it may be ***involuntary;*** as a result of coercion, trafficking, or poverty (this includes most refugees).

People affected by mobility

People who are **not** mobile may also be vulnerable to the health consequences of population mobility. For example, those who live in places where mobile people pass through (**transit**) or settle (**destination**) may be at risk of infection through interactions with mobile people. When mobile people return home (**source**) with new infections, their **source** community may experience the impacts of the disease.

Communicable Disease: an illness due to a specific infectious agent or its toxic products which arises through transmission of the agent or its products from an infected person , animal or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or inanimate environment.
(Source: Control of Communicable Diseases in Man by A S Benenson, Editor, Fifteenth edition, 1990)

1. Introduction

The Southern African Development Community (SADC) is brought together by a common vision for economic integration with eventual free movement of capital, labour, goods and services across the SADC Member States (MS). As people move, they are likely to encounter communicable diseases with consequences on their health.

A number of factors have been advanced to explain the spread of communicable diseases, including poverty and economic marginalization. Population mobility has also been recognized as a factor in the spread of communicable diseases, which in turn led to the recognition of the need for cross-border collaborations. While some Member States may have successful public health programmes that are able to control communicable diseases, migration from high prevalence areas that are less able to control them becomes an important factor in defining local population cohorts at risk. Conversely, people can travel from low (or no) prevalence to high prevalence countries, with the risk of re-introducing diseases that had been controlled/eliminated in the source country. Furthermore, mobility may affect a person's ability to seek care and adhere to treatment.

The Sixty-First World Health Assembly (WHA) of May 2008, through the adoption of the Resolution on "health of Migrant" recognised that some categories of migrants experience increased health risks and called for the development of intersectoral policies to protect their health.

This Framework acknowledges that one of the risks mobile people encounter is communicable diseases. It has therefore been framed to form a basis for programming for mobile populations and communicable diseases in the SADC region. It was put together through various stages of consultations within the region, including consulting regional experts, MS programme managers, UN agencies working in the region, international and local organizations working with mobile populations and representatives of mobile populations. From these consultations and a review of relevant literature, a Situation Assessment document which accompanies this framework was developed. The document provides detailed analysis of the current situation and issues affecting communicable disease control and mobile populations in the region.

2. Current Situation

The control of communicable diseases is considered a priority health and developmental issue and a matter of great concern for the region. Communicable Diseases, especially HIV, TB and Malaria are the greatest causes of morbidity and mortality in the region.

2.1 Trends in Population Mobility

Cross-border movement of people in the Southern Africa is not a recent phenomenon. There is a long history of cross-border migration in the region with movements involving primarily either organized labour or individuals seeking employment opportunities in the

informal sectors of the economy. Evidence shows that it is increasing and will continue to increase when regional initiatives such as the Free Trade Area protocol promulgated in August 2008 and the Protocol on the Facilitation of Movement of Persons becomes operational.

Other noticeable trends include:

a) The feminisation of cross-border movement, with women and girls now crossing borders on par with men. This has grave implications for the health of migrants, as mobility process makes women more vulnerable to communicable diseases. They are more likely to suffer gender-based harassment and violence (including sexual). Also women are also more likely to move with their young children who will also be susceptible to communicable diseases.

b) Increased cross-border trafficking and involuntary movement. Although documented evidence is difficult to come by due to clandestine nature of such movements, it is said to be on the increase, particularly of adolescent children for illegal labour and sexual exploitation. Girls are particularly vulnerable in this process.

c) Increased movement of skilled health workers out of the region, which may lead to problems in service delivery, including for communicable diseases, in the source countries.

d) Increased frequency of circular movement with mobile people tending to go back home more often. This impact on movement of communicable diseases between source, transit and destination communities and the resultant need for more coordinated control action.

e) High proportion of undocumented travel and stay in foreign countries leading to difficulties in access to health services for communicable diseases

f) Preponderance of intra-regional mobility. The majority of foreign arrivals into SADC MS are from other SADC MS, demonstrating the close ties that exist but also highlighting the need for intra-regional cross-border programming particularly for communicable diseases which do not recognize borders.

g) North- South Movements. Movement is generally from the north to the south of the region where economic opportunities are greater, so that the burden would be expected to be disproportionately greater in the south (though there are also MS in the north with burdens of displaced people such as refugees).

h) Multiple reasons for migration. The reasons for movement across borders has broadened beyond the traditional men seeking employment, to include travel on business, shopping, tourism or simply to visit relatives across the border. The widening of the scope and reasons for moving would entail targeted responses and the involvement and participation of many sectors and organizations to mitigate the effects of communicable diseases on cross-border travelers as well as to control these diseases in the region.

2.2 The Regional Response to Communicable Diseases

In recognition of the need for a regional response Articles 9 to 12 of the SADC Protocol on Health specifically address communicable disease control, with emphasis on the three priority diseases of HIV and AIDS, TB and Malaria. Some of the key themes

identified for the response are: a) harmonization of policies, programmes and activities b) standardization of systems and c) coordination and sharing of information across the region. Regional plans for dealing with these three important communicable diseases have been drawn up. Each MS also has policies and programmes to control communicable diseases within its borders.

2.3 Current Gaps

While all Member States have clear policies and programs to deal with communicable diseases for their populations, they do not deliberately extend to people who cross borders in most cases. Current plans and strategies to control communicable diseases in the region, both at MS and regional level, have not factored in the increasing cross-border movement of people and its impact both on control efforts and on the health of those who move. Some of the gaps that need to be addressed include:

i. I**nadequate harmonization and coordination** in the areas of:

- **a)** **Disease Specific Management Guidelines** – though this has started for some diseases such as malaria and TB, it is not yet complete and has yet to be initiated for others such as HIV and AIDS and cholera.
- **b)** **Port Health Services** – Lists of communicable diseases monitored at the borders are variable, even on both sides of one border, and the action taken is also variable leading to confusion and inconvenience to travelers who might cross one side only to be detained or turned back at the other side. Implementation and enforcement of the International Health Regulations is also variable.
- **c)** **Cross-border referral –** Cross-border patient referral services are not optimal. Patients do get lost to health systems when they cross borders and may be re-started on treatment as new patients thus increasing the chances of drug resistance and sub-optimal outcomes.
- d) **Disease control across borderlines** – Along border areas, where cross-border movement of people is a daily occurrence, effective communicable disease control requires harmonization of strategies on both sides and coordination of action. Experience from other regions shows the need to formalize disease control activities through agreements of cooperation, for long term continuity and effectiveness.

ii. **Difficulty in accessing health services** for communicable diseases when people cross borders. African Heads of States have pledged universal access to health care for all citizens. How this can be assured for nationals who cross borders has yet to be clearly articulated. For **curative services**, barriers include:

- substantially higher fees for non-nationals,
- no information as to where services are provided;
- reluctance among health care providers to re-supply drugs for diseases requiring long treatment such as TB or AIDS to visitors,
- reluctance among health care providers to start treatment for communicable diseases requiring long treatment such as TB or AIDS diagnosed in a foreign country and
- Differing treatment protocols in the different countries leading to confusion in some cases;

- immigration status issues for undocumented mobile people and trafficked people (e.g. no passport, visa or work permit etc) leading to reluctance to access services.
- weak health systems both in the source and destination countries, such as shortages of drugs, personnel and equipment.

For **preventive services** the issues include

- inadequate attention to prevention of communicable diseases,
- poor living and working conditions for cross-border mobile people,
- low priority to services to mobile populations,
- ignorance and non-use of preventive services and
- inadequate attention to the gender dimensions of cross-border mobility.
- affordable means to protect themselves are not always available, such as ITNs at rented accommodation for travelers. malaria prophylaxis for travelers from non-malaria areas; and condoms for HIV prevention. Even vaccination services to needy mobile adults, women and children may not always be easily accessible.

iii. I**nadequate disease surveillance and epidemic preparedness.**

- Regional harmonization of case definitions and notification systems, and sharing of information on outbreaks and epidemics of communicable diseases has started for the three articulated in the Protocol on Health (Malaria, TB and HIV and AIDS), though it is not yet operational.
- Regional harmonization of case definitions and notification systems has yet to be initiated for those diseases not articulated in the Protocol but deemed to be of regional significance such as cholera and other highly communicable diseases.
- Plans to deal with regional health emergency situations and epidemics, as called for under Article 25 of the SADC Protocol on Health, have yet to be formulated.
- The lead agency and mechanisms to deal with regional health emergencies and epidemics has not been clearly defined though the Military health sector has responded on the occasions it has been called on to do so.

iv. **Inadequate Information, Education and Participation of Mobile People**.

- Though mobile people could be allies in the control of communicable diseases, they are seldom involved.
- In the majority of cases, community knowledge of communicable diseases is not sufficient for them to take pro-active steps to protect themselves and others.
- Not enough information targeted at mobile people is produced, since they have needs that are different from the general community.
- Of the information that is produced, messages are in “official” languages which are not necessarily the languages spoken by the majority, both in the destination communities and among communities of mobile people.

- Destination communities are not engaged and sensitized to the needs of mobile communities and resultant misconception may increase the difficulties mobile people encounter.

v. **Inadequate operations research and sharing of information**.

- There is, in general, inadequate research conducted on the dynamics between population mobility and communicable diseases in the region.

- According to the 2007 SADC regional HIV and AIDS Epidemic Report, of the strategies being used to control HIV and AIDS (prevention, treatment, care and support and mitigation), prevention is lagging behind the rest. Perhaps some of the reasons are inadequate sharing of information on best practices among MS in the region and limited design and testing of innovative interventions. The report states that, for example, condom promotion and distribution has produced positive results in some MS, while in others, condom use has remained low. However, the reasons behind some MS success has yet to be examined, documented and shared.
- There is also need for more research into which mobile populations are most at risk, how they get the risk and the best ways to prevent and control communicable diseases among them.

vi. **Legal, and administrative barriers.**

- Difficulties in getting travel documents (passports, visas), and administrative procedures (e.g. health workers reporting undocumented people to the police) lead to hurdles to mobile people in accessing health services since health workers in some MS insist on those documents;
- Foreign workers are more likely to be on contract employment (or even employed illegally) with no health benefits – lessening their means to protect themselves against communicable diseases; and
- Administrative delays at border crossing points, coupled with inadequate facilities (e.g. accommodation) at border crossing points, increase the vulnerability of mobile populations to communicable diseases such as malaria and HIV and AIDS.
- Limited or absence of multi-sectoral structures to deal with mobile populations in the MS and at regional level.

3. Purpose and Scope of the Framework

The SADC Protocol on Health lays emphasis on the control of communicable diseases. At the same time other protocols emphasize free movement of people and goods in the region. The main purpose of this framework is to provide guidance on how both objectives can be met without compromising each other. This Framework therefore provides guidance on:

a) the protection of the health of cross-border mobile people in the face of communicable diseases, including source, transit and destination communities
b) the control of communicable diseases in the face of movement of people across borders in the region.

The Framework:

- is aimed at policy makers and programme managers and other stakeholders dealing with mobile people and communicable diseases;
- should be generally applicable to all communicable diseases;
- complements the ongoing work on general policy harmonization within the region;
- augments existing policies and strategies on specific diseases in MS and in region and;
- complements policies for specific groups of mobile people which take into account their special circumstance such as policies to deal with communicable disease control under emergency or humanitarian situations for malaria and TB among refugees and displaced persons developed by WHO; and
- covers cross-border movement of people (external mobility) - voluntary or involuntary, legal or undocumented regardless of duration of stay at their destination. For example, this includes refugees and asylum seekers, tourists, cross-border traders, trafficked people in particular women and children, undocumented mobile people, (long-stay) foreign residents in other countries and border communities. MS already take care of their citizens who are mobile people within their borders, and these are not considered in this Framework.

4. Foundation

The principles guiding this framework are premised on:

- the founding Charter of SADC which under article 6 stresses non-discrimination;
- the SADC Protocol on Health which under articles 9 to 12 prioritizes communicable disease control and;
- human rights principles as enshrined in the Universal Declaration of Human Rights and reaffirmed in the African Charter on Human and Peoples' Rights both of which stress the right to health as well as the principles of:
  - participation and inclusion;
  - non-discrimination and equality;
  - universality and inalienability

  of rights to which mobile people are entitled without regard to location or immigration status;
- the SADC Protocol on Gender and Development whose objective, among others, is to ensure gender equality and equity in all development endeavours within the SADC region; and
- Resolution WHA61.17 of the sixty-first World Health Assembly of May 2008 which calls on Member States to among others, promote migrant-sensitive health policies; promote equitable access to health promotion, disease prevention and care for migrants; to establish health information systems in order to assess and analyse trends in migrants' health; gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination; and promote bilateral and

multilateral cooperation on migrants' health among countries involved in the whole migratory process.

5. Policy Guidelines for Programming for Population Mobility and Communicable Diseases

The following guidelines address the issues that affect mobile populations and communicable disease control as identified in the Situation Assessment, such as the need for more harmonized regional guidelines, difficulties in accessing health services and lack of information on communicable diseases by mobile populations. They should inform programming on population mobility and communicable diseases at MS level and the region.

The main policy areas identified and elaborated on below are:

a. Regional harmonisation and coordination of communicable disease control
b. Equitable Access to Health Services by Cross-border Mobile Populations
c. Coordinated regional public health surveillance and epidemic preparedness
d. Information, Education and Health Promotion in Mobile Populations
e. Operational research and strategic information.
f. Legal, Regulatory and Administrative Reforms

5.1 Regional harmonisation and coordination

i. Harmonized communicable diseases treatment regimens and management guidelines across MS in the region.
ii. Coordinated cross-border referral services and mechanisms for continuity of care for patients with communicable diseases, particularly diseases requiring prolonged treatment such as TB (especially drug resistant TB) and HIV .
iii. Joint programming for communicable disease control along common borders, with harmonized strategies and activities on either side.
iv. Harmonised Port Health Services in line with International Health Regulations, with harmonized lists of diseases targeted for surveillance at the borders and procedures used to deal with them.
vi. Coordinated multi-sectoral responses involving all stakeholders at all levels

5.2 Equitable Access to Health Services by Cross-border Mobile Populations

i. Access to the regionally agreed minimum standards of services for communicable diseases and re-supply of drugs for the treatment and management of chronic communicable diseases such as TB and HIV and AIDS, in the public sector without discrimination.
ii. Targeting the responses to the diverse nature of mobile populations to reach all groups particularly the vulnerable and disadvantaged
iii. Recognition of the special needs of women, children and adolescents in prevention, treatment, care and support
iv. Recognition the need for a holistic approach to prevention, treatment and care.

iv. Formalized use of health facilities along common borders by populations on either side for the treatment and management of communicable diseases.
v. Strengthening public-private collaboration for service delivery
vi. Addressing the environmental and structural vulnerability factors leading to vulnerability to communicable diseases, such as poor living and working conditions; unsupportive laws and regulations; gender dimensions; livelihood skills
vii Harmonization of the fee structures in service delivery for both residents and none residents
viii. Agreed on referral mechanisms for populations in transit or that are mobile

5.3 Coordinated Regional Public Health Surveillance and Epidemic Preparedness

i. Harmonized communicable diseases case definitions, notification and referrals systems across MS.
ii. Clearly defined regional mechanisms and institutional frameworks for monitoring, managing and reporting health emergencies and communicable disease threats and epidemics.
iii. Regularly updated regional health emergency and epidemic preparedness and response plan.
iv. Harmonised collection, analysis and use of disaggregated data (including by age and sex) on population mobility and communicable disease control
v. Strengthened data collection and sharing of information on population mobility and communicable diseases, for example on numbers of mobile people entering MS, numbers contracting communicable diseases and numbers accessing treatment and other services to allow better planning for service delivery
vi. Regional forum for data management and sharing.

5.4 Information, Education and Health Promotion for Mobile Populations

i. Participation and involvement of mobile people in programmes aimed to control communicable diseases among them.
ii. Information and education on mobile peoples' rights, the services available to them and the means to prevent communicable diseases (incl. sexual violence laws and PEP).
iii. Information, education and involvement of source, transit and destination communities in programmes aimed to control communicable diseases among mobile people and those with whom they interact to dispel myths and misconception and reduce discrimination and xenophobia.
iv. Use of languages appropriate to the target groups in information and education for mobile people.
v. Sensitization and involvement of the mass media on the information needs of mobile people

5.5 Operational Research and Strategic Information

i. Operational research on the vulnerabilities (including age and gender-based) of mobile population groups to various communicable diseases to guide targeted responses
ii. Strengthened data collection and sharing of information on population mobility and communicable diseases, for example on numbers of mobile people entering MS, numbers contracting communicable diseases and numbers accessing treatment and other services to allow better planning for service delivery.
iii. Documentation and sharing of best practices among MS
v. Regional for and mechanisms for information sharing.

5.6 Legal, Regulatory and Administrative Reforms

i. Alignment of MS laws, regulations and policies on communicable diseases to international norms and standards, including this Framework, e.g. to protect mobile people from mandatory testing for communicable diseases such as HIV.
ii. Protection of women, girls and other children who are disproportionately adversely affected by the mobility process with consequent increased vulnerability to communicable diseases
iii. Protection of foreign workers in high risk work environments such as mining and agriculture by minimizing unfair labour practices (e.g. contract employment without health benefits) and enacting regulations to improve work and living conditions
iv. Minimization of hurdles to access to travel and other documents (e.g. passports, visas, work permits) to minimize undocumented travel, stay and work in foreign countries.
v. Inclusion of population mobility in programmes and strategies to control communicable diseases
vi. Appropriate fee structures to allow equal access to curative and preventive services
vii. Agree on follow-up actions with MS if increments of particular communicable diseases are noted which are caused by inactivity by the concerned MS.
viii. Agree to establish multi-sectoral mechanisms at national and regional levels to effectively respond to issues of mobile populations.

6. Institutional Framework

This Framework will require the input and collaboration of various stakeholders to address the needs of mobile populations which vary by category. For example the needs of tourists are different from those of refugees and might require different organizations to assist in addressing them. Addressing the needs of undocumented mobile people requires collaboration beyond “authority” channels to be effective. Implementation of the Framework will thus require collaboration among all the

stakeholders outlined below for its success. It will be implemented within the established institutional framework of SADC outlined in the Implementation Plan of the SADC Protocol on Health, as outlined below:

6.1 SADC Ministers of Health

The SADC Health Ministers will oversee and monitor the implementation of this Framework.

6.2 SADC Secretariat

The Health Desk within the Directorate of Social and Human Development and Special Programmes (DSHD&SP) will coordinate overall implementation **and monitoring** on behalf of the Ministers of Health, as well as coordinate resource mobilization. In addition, it will ensure:

- Harmonized treatment and management protocols are produced
- Harmonized follow-up and referral system for chronic communicable diseases is in place
- Standardized case detection and reporting and timely and complete reporting
- Continuous monitoring of disease patterns in MS and keep all informed
- A regional health emergency and epidemic response plan is in place
- Trans-border coordination of disease control
- Non-discriminatory access to services in place
- The Framework is adapted to specific diseases of importance to the region
- The establishment of a regional multi-sectoral mechanism to oversee the implementation of the framework

6.3 Member States' (MS)

MS will lead implementation of the policies at a national level, through multi-sectoral collaboration led by their Ministries responsible for Health. They will also support the process through assigning resources, including human resources when appropriate. In addition, MS will:

- Agree on harmonized and coordinated mechanisms in:
    - disease treatment and management guidelines;
    - cross-border referral and continuity of care for chronic diseases;
    - Port Health Services.
    - Case definitions and disease surveillance for communicable diseases
- Provide minimum standard services to all regardless of nationality.
- Agree on a workable financing system to ensure mobile people are not disadvantaged
- Formalise trans-border disease control
- Establish early case detection and notification
- Attend to, and minimise, gender differences
- Provide appropriate information and education and ensure the participation of mobile populations and source, transit and destination communities for implementation.

- Public-private sector collaboration to complement each other depending on comparative advantages in delivering services to mobile populations
- Establish national multi-sectoral teams for effective implementation.

6.4 Other Stakeholders

Other stakeholders include UN Agencies, Local and International NGOs, CSOs and communities (including of mobile people, and source, transit and destination communities) themselves, bilateral donors and development partners, the private sector and research and teaching institutions. All are essential for the successful implementation of the Framework

6.4.1 UN Agencies and other Development Partners

. Their roles will vary but will include:

- assisting with inputs in harmonizing the diseases management protocols and the surveillance and notification systems, and in designing of the epidemic preparedness plan and fine-tuning the M&E framework to monitor implementation of this Framework,
- assisting with fine-tuning and aligning the provisions of the Framework to specific target mobile populations such as refugees, asylum seekers, undocumented mobile people and trafficked persons.
- augmenting resources to ensure implementation of the Framework

6.4.2 Local and international NGOs and CSOs

These will:

- work with mobile people at the grassroots level in individual MS, to ensure that the benefits reach the intended beneficiaries
- Assist in implementation of agreed on frameworks;
- Maintain advocacy dialogues for the needs of mobile populations;
- Augment resources to ensure implementation of the framework
- Provide feedback on experiences to policy makers

7. Financing Mechanisms

Among other items, funds for the implementation of the Framework will be required for: ensuring that access to services by cross-border mobile people is assured; for regional cross-border control of communicable diseases; for the development and implementation of the regional health emergency and epidemic response plan and; for the Secretariat to harmonise and coordinate the activities.

Movement of people is not even throughout the region so that he burden of catering for cross-border mobile people will be disproportionate among MS. For this reason, a regional mechanism to finance the control of communicable diseases and to cater for cross-border mobile people will be necessary. The current SADC HIV Trust Fund could be expanded to cater for all communicable diseases control efforts. Other mechanisms to ensure access by cross-border mobile people to health services for communicable

diseases will also be explored, such as a re-imbursable system for MS to pay for the treatment of their citizens wherever they seek services in the region. Development partners will also be part of the resource mobilization.

8 Monitoring and Evaluation

Annual reports will be produced to monitor implementation of this Framework, coordinated by the Health Desk of the Directorate Social and Human Development and Special Programmes (DSHD&SP) in the SADC Secretariat. Some of the items to be reported on will include:

- progress on
    - harmonization of treatment and management protocols for communicable diseases across MS
    - harmonization of patient follow-up and referral mechanisms for chronic communicable diseases across borders in the region
    - harmonisation of Port Health Services and use of IHR
    - standardization of case detection and reporting systems across MS and timeliness and completeness of reporting.
    - the development and implementation of a regional health emergency and epidemic response plan
    - trans-border coordination of communicable disease control and harmonization of control strategies across borders
    - minimization of gender differences in access to services for communicable diseases in mobile populations.
    - adaptation and inclusion of the provisions of this Framework into domestic legislation, regulations, policies and programmes
    - dissemination to mobile populations of information on their rights and the services to control communicable diseases among them
    - translation of these principles into practice at different levels and by various stakeholders
- MS adherence to agreed minimum standards for communicable diseases
- Communicable disease patterns and epidemic situations in MS, including among mobile population groups
- Accessibility of health services for communicable diseases by cross-border mobile people.

All MS will report on progress to adapt this Framework to its situation as well as on activities to control communicable diseases among mobile populations and the communities which they interact.

Monitoring tools will be developed for data collection from MS supplemented by operations research and periodic surveys.

Annex 1 : Additional Guidelines for Specific Diseases

While the Framework provides general guidance on all communicable diseases of public health importance for the region, it is recognized that there are issues specific to a particular communicable disease which cannot be covered by a general framework. The SADC Protocol on Health has already identified malaria, tuberculosis (TB) and HIV and AIDS as being of public health importance for the region. In addition, emerging illnesses or epidemics such as cholera, which is currently a topical needs a special attention.

The following policies for these specific diseases are in addition to the general policies outlined above. They should always be read/used together with the general policies.

A1.1 Additional Guidelines for Malaria and Population Mobility

i. Harmonized and coordinated cross-border malaria control activities with formal agreements of cooperation along borders of MS at the pre-elimination and later phases
ii. Free malaria prophylaxis to their nationals for MS at pre-elimination and later phases traveling to malaria endemic areas
iii. ITNs and other personal protection methods in all rented accommodation in malaria endemic areas, with information on how to use them properly.
iv Spraying of all vehicles (air, road, sea), carrying passengers from endemic to non endemic malaria areas within the SADC region
v. Spraying of border posts and airport buildings every 6 months with insecticides
vi. Malaria IEC package for travelers provided by Ministries of Tourism, Immigration and Health with clear indication on where to seek immediate treatment upon recognition of signs and symptoms of malaria
vii. Malaria confirmatory tests and appropriate and effective treatment at health facilities along the borders
viii. Regional malaria data base, including among mobile populations, and information sharing forum
ix. Strengthened malaria Epidemic Preparedness and Response and early warning systems, with information sharing with neighbours about malaria outbreaks along borders.
xi. Active case detection, immediate treatment and follow up (particularly member states at the pre-elimination stage) as part of Port Health Services

A1.2 Additional Guidelines for TB and Population Mobility

i. Coordination and service delivery linkages between TB and HIV and AIDS programmes in MS and between MS in the context of collaborative TB/HIV activities.
ii. Periodic intensive TB case finding with full supervised treatment in high risk-mobile groups such as refugees, mineworkers and farm workers.
iii. Community-based adherence support strategies among mobile communities such as refugees, mineworkers and farm workers etc.

iv. Regional harmonization of treatment policies and clinical management guidelines of patients with TB, including MDR /XDR and TB and HIV co-infection

v. Region-wide adoption and implementation of the three Is (Intensive case finding, IPT and Infection control) initiative for People Living with HIV and AIDS

vi. Unfettered access to affordable TB diagnostic and treatment services for TB high risk populations working in the private sector through appropriate public-private partnerships between National TB Control Programmes and private and corporate sectors such as the mining industry.

vii. Provision of adequate working and living conditions for employees that minimize the risk of TB transmission.

viii. Recruitment agencies to (by regulation) provide information on TB risks (e.g. association with silicosis in mining sector) to prospective clients for employment in foreign countries.

ix. Implementation of work place programmes that include entry and periodic screening for active TB and work place TB DOTS services for patients on treatment

x. Establishment of SADC regulated cross border notification and referral systems for drug resistant TB cases; and regional TB surveillance system

xi. Establishment of regional TB Reference Laboratory facilities of excellence capable of supporting MS with limited local capacity to diagnose MDR and XDR-TB, and to coordinate regional Quality Assurance and Control of TB microscopy and microbiological services

A1.3 Additional Guidelines for HIV and AIDS and Population Mobility

i. Universal implementation of the three Is (Intensive TB case finding, IPT and Infection control) initiative for People Living with HIV and AIDS as part of broader collaborative TB /HIV activities

ii. Strengthening and capacity building of networks of PLWHA for cross-border collaboration

iii. Information and education on gender-based violence and harmonised response measures such as PEP.

iv Resource mobilisation for IEC material production and ensuring dissemination to targeted populations.

v, Involvement of all key partners at Borders in programming including people living with HIV and AIDS.

vi. Mechanism for effective logistic management for health supplies. E.g. drugs

vii. Review of regulations and laws that discriminate against PLHIV on entry.

A1.4 Additional Guidelines for Emerging Illnesses/epidemics and Population Mobility

i. Harmonised and strengthened regional surveillance system
ii. Regional Epidemic preparedness and response plans specific to emerging epidemics such as cholera (including who should coordinate them)
iii. Cross-border exchange of information
iv. Standardised case definition
v. Harmonized case management
vi. Regional rapid notification system
vii. Technical and material assistance among MS