



SAARC Regional Strategy on Advocacy, Communication & Social Mobilization for TB and HIV/AIDS

SAARC Tuberculosis and HIV/AIDS Centre (STAC)





**SAARC Regional Strategy on Advocacy,
Communication and Social Mobilization for
TB and HIV/AIDS**

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PREFACE

The role of ACSM is crucial in achieving a world free of TB and HIV/AIDS. The aim of Advocacy, Communication and Social Mobilization (ACSM) is to support National TB and HIV/AIDS Control Programmes of the SAARC Region to combat stigma and discrimination, improve case detection and treatment adherence, empower people affected by TB and HIV/AIDS and to mobilize political commitment and resources for TB and HIV/AIDS. ACSM strategy incorporates various types of communication programming, including mass media, interpersonal communication, community mobilization and advocacy.

Advocacy is an organized effort to influence decision making. It denotes activities designed to place TB control high on the political and development agenda, foster political will, increase financial and other resources on a sustainable basis, and hold authorities accountable to ensure that pledges are fulfilled and results achieved. Policy advocacy includes data and approaches to advocate to senior politicians and administrators about the impact of the issue at the National level, and the need for action. Advocacy is used at the local, community level to convince opinion leaders about the need for local action. Related forms of advocacy include media advocacy to generate support from governments and donors, validate the relevance of a subject, put issues onto the public agenda, and encourage the media to cover TB-related issues regularly and in a responsible manner. Communication is concerned with informing, and enhancing knowledge among, the general public and people with TB and HIV/AIDS. Communication also works to create an environment through which communities, particularly affected communities, can discuss debate, organize, and communicate their own perspectives on TB. It is aimed at changing behaviors (such as persuading people with symptoms to seek treatment) but can also be used to catalyze social change such as supporting community. Social mobilization is the process of bringing together all possible and practical inter-sectoral partners to increase people's knowledge of and demand for good-quality health care in general and specifically for TB and HIV/AIDS care and treatment and strengthens community participation for sustainability. Assessing the HIV/AIDS prevention, care and support needs of potential target populations is essential. This information, as well as more practical information on the available human, financial and material resources and capacities, will guide decisions about: the objectives of the communication strategy, the communication approach, the content of the communication and the stakeholders. Whether they are primary target populations or secondary populations, all of these people have a stake in the outcome of our programmes and thus constitute the stakeholders. Behavior Change Communication's (BCC) role in HIV/AIDS programmes is to help change, or support, decisions and behaviour related to prevention and care. The principles and tools of BCC are useful to advocacy and communication in a number of ways. BCC approaches are useful, to enhance awareness of HIV/AIDS as a regional and national issue among policy makers and the communities, to contribute to a favorable political and social climate for HIV/AIDS prevention and care, to mobilize the community and civil

society organizations for prevention and care, to popularize technical information about prevention and care, to deal with specific community problems through proper messages and media directed at identified target audiences.

I am very much hopeful that this ACSM strategy can and will bring a positive change in the region and will certainly help in bringing down the menace of TB and HIV/AIDS in the SAARC Region.



Dr. Kashi Kant Jha
Director

ABBREVIATIONS

ACSM	Advocacy, Communication and Social Mobilization
AIDS	Acquired Immune-Deficiency Syndrome
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
BRAC	Bangladesh Rural Advancement Committee
CBO	Community-Based Organization
CSOs	Civil Society Organizations
CSW	Commercial Sex Workers
DOT	Directly Observed Treatment
DOTS	Directly Observed Therapy-Short Course
FSW	Female Sex Worker
IEC	Information, Education, Communication
IPC	Inter- Personal Communication
IDUs	Injectable Drug Users
ISTC	International Standards for TB Care
IUATLD	The International Union Against Tuberculosis and Lung Disease
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MSM	Men having Sex with Men
NACP	National AIDS Control Programme
NTP	National Tuberculosis Control Programme
PLHA	People Living with HIV/AIDS
PPM	Public Private Mix
SHG	Self Help Groups
SAARC	South Asian Association for Regional Cooperation
STAC	SAARC Tuberculosis and HIV/AIDS Centre
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

SECTION I

1. Overview of the TB and HIV/AIDS Situation in the SAARC Region

1.1. Background

South Asian Association for Regional Cooperation (SAARC) is an association of eight Member States, namely- Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

The Fifth Summit of the Heads of State or Government decided to set-up SAARC Tuberculosis Centre (STC) in Nepal. In 1994 it started functioning and in 2005, it was renamed as SAARC Tuberculosis and HIV/AIDS Centre (STAC) with the objective *to work for prevention and control of TB and HIV/AIDS in the Region by coordinating the efforts of the National TB Control Programmes and National HIV/AIDS Control Programmes of the SAARC Member States.*

The SAARC Regional Strategy for TB and HIV Co-infection recognizes that TB and HIV/AIDS are two major public health problems in the SAARC Region. Out of the eight countries, four countries- namely Afghanistan, Bangladesh, India and Pakistan are among 22 high TB burden countries, globally.

TB is the most common opportunistic infection and the cause of death for those infected with HIV/AIDS. TB adds to the burden of illness of people infected with HIV while HIV accelerates the progress of TB infection to active TB disease, and has implications for the public health.

In this region, the HIV/AIDS prevalence in general population is still low but its prevalence among high risk groups has increased during the last decade which is a cause of concern.

1.2. TB and HIV/AIDS burden within SAARC Region & associated factors

1.2.1 Burden of TB

SAARC region with 22% of the world population bears 32% of the global TB burden. About 2.85 million of all forms of TB cases occur in 2010, out of which about 1.2 million are sputum smear positive (with the potential of spreading TB to others, if untreated - or delayed treatment).

About 75% of cases are within the economically most productive age group (15-49 years). Isolated studies have revealed that on an average, 3-4 months of work time are lost if an adult is ill with TB. The economic losses to the family and community are staggering. It is estimated that a loss of 20-30% of annual household income and an average of 15 years of income loss if the person dies of the disease. TB imposes significant indirect social and economic costs, with an estimated annual economic toll equivalent to USD \$12 billion from the income of poor, developing nations. Recent estimates suggest that the losses sustained within SAARC region due to TB annually are around USD \$4.0 billion. For example, within India, more than 300,000 children leave school because of their parents' illness due to TB, with approximately 100,000 women being abandoned by their families because of TB illness.

1.2.2. Burden of HIV/AIDS

HIV infection increases susceptibility to TB and is the most potent factor in moving latent or recently acquired TB infection to active clinical disease. A person with HIV is up to 30 times more likely to develop active clinical TB than a person with a healthy immune system. Someone with active pulmonary TB, if left untreated, will pass it along to an average of 15 other people in one year. It is estimated that 40-50 % of the adult population within South Asia is infected with the TB bacillus and, therefore, at increased risk of developing active TB if infected with HIV. TB is the biggest killer of people with AIDS, shortening their lives by six to 24 months. As the HIV/AIDS epidemic spreads within SAARC countries, the incidence of TB will also rise.

Country	HIV Prevalence Rate (%)	Estimated number of people living with HIV
Afghanistan	<0.1	2,000
Bangladesh	<0.1	7,500
Bhutan	<0.1	<500
India	0.31	2.39 million
Maldives	<0.1	<100
Nepal	0.33	63,528
Pakistan	0.1	96,000
Sri- Lanka	<0.1	3, 000
Regional		2.56 million

Source: HIV/AIDS SAARC Region, Update 2011

1.2.3. TB and HIV/AIDS among the Vulnerable Population

Out of the eight countries in the region four countries (Afghanistan, Bangladesh, India and Pakistan) are among the 22 high TB burden countries in the world.

SAARC Region possesses the large population numbers and ingredients necessary for exponential increase in TB, HIV/AIDS and TB/HIV co-infection. For example, high-risk groups such as CSWs, IDUs (who share needles), men who have sex with men, sexual activity involving multiple partners, migrant workers, etc., all exist to put this region at a particular risk for morbidity and mortality from HIV and the encroaching TB/HIV co-infection.

Lack of awareness about TB and HIV/AIDS; lack of knowledge about blood safety; poverty; illiteracy; trafficking of women and young girls within the sex trade are high risk factors within the SAARC countries.

Poverty also results in lack of access to information and care. For example there is a lack of information among masses about sexually transmitted diseases, a known risk factor for susceptibility to HIV infection; about simple preventive measures (e.g. condoms) and basic information on HIV/AIDS. As poverty increases, the number of migrants from rural to urban areas across national borders also increases. Persons are dislocated from their communities and are most vulnerable to high-risk sexual behaviour or drug use and least able to access support and care.

The prevalence of HIV/AIDS in general population is still low in the SAARC Region but its prevalence has increased among high-risk groups in the region and it can spread to the general population in the due course of time.

The HIV infection varies between countries and within countries. The challenge comes in light of the fact that the trend is an increasing one within SAARC Region.

1.2.4. TB, HIV/AIDS and Women

TB in women creates orphans, impoverishes families and impedes the economic development of countries. Among the world's region, South-Asia has the most pronounced gender differentials in health status and the use of health services. In high prevalence countries with poor health services, such as in most of South Asia, more women die of TB than of any other maternal causes.

Women in this region are at disadvantaged position due to social and cultural factors and face discrimination which makes them highly vulnerable to TB and HIV/AIDS. Traditional values and norms also make women and youth vulnerable to HIV/AIDS.

Women are especially vulnerable to HIV infection during their reproductive years. In South Asia, heterosexual transmission is the most common route of HIV infection and as the epidemic becomes generalized the proportion of women among those infected will also increase.

Women, especially from poor and rural areas have little/limited knowledge about their bodies or about reproductive health and their lower social status within the family and society does not allow them to demand services or have any say about use of contraceptive. Young men may leave their homes for employment (for long periods of time) and expose themselves to unprotected sex, and on their return expose women (wife) to HIV infection. In addition, young girls are trafficked across South Asian borders to work in brothels and those who contract HIV are sent home, only to be ostracized by their families and, out of economic necessity, return to commercial sex work. In remote areas, cultural beliefs and traditions pertaining to sex and sexuality mean that STDs remain hidden and untreated, especially among women.

1.2.5. TB, HIV/AIDS and Migration

Migration within South Asia occurs within countries, across national borders, within the region and from the region to countries where there are more employment opportunities. Migration in all the three instances may be voluntary or forced, legal or illegal. Migration poses special challenges for national TB and HIV prevention programmes. Mobile populations are difficult to treat. A migrant with TB may face barriers in accessing health care services for treatment (e.g., lack of legal status; financial, cultural and linguistic constraints). A migrant crossing a border while under treatment for TB may face problems due to different drug regimens in adjacent countries. All of these factors contribute to lower cure rates, ongoing transmission of infection and increasing prevalence of drug resistant TB.

Migration is also compounding the HIV epidemic. Migrant women and girls are at risk of being lured or forced into sex work or they may have been specifically trafficked for this purpose. Many migrants are young men, often travelling alone or in small groups dislocated from the normal support and social control of their home environments. This situation lends itself to high-risk behaviour, such as casual sex and/or injection drug use, which contribute to the spread of HIV. HIV positive migrants bring the infection at their home and may infect their sexual partners, usually their wives.

Though the prevalence rate of HIV among general population in SAARC Member States is low (less than 1%) which may drive complacency in the prevention and control programme. Low prevalence does not mean that there is low risk of infection. There is risk of spread of infection to general population. The dual challenge is prevention and control efforts not only with the general public but also with the high-risk groups.

1.3. SAARC Regional Strategy for HIV/AIDS and TB/HIV Co-infection

Consequences of TB/HIV co-infection on national TB control programmes within the SAARC region include increased caseloads, low TB cure rates, and high case fatality rates during treatment, under diagnosis of TB, the potential of high default rates and the accelerated emergence of drug resistant TB. Hence, early TB and HIV diagnosis, treatment and management, are vital in the management of the dual epidemics within SAARC Region.

The countries of the region have already developed comprehensive strategic plans to address TB and HIV/AIDS and are implementing them. All countries of the region have adopted DOTS strategy and have achieved significant progress in prevention and control of TB. However, the achievements may face the challenges due to HIV/AIDS in the region. There is urgent need for action by the SAARC Member States to address the double burden of TB and HIV/AIDS for improving the public health situation in the region.

1.3.1. SAARC Regional Strategy on HIV/AIDS (2006-2010)

The strategy was developed with the vision to halt and reverse the spread of and impact of HIV/AIDS; to commit leaders to lead the fight against HIV/AIDS and to provide PLWHA with access to affordable treatment and care with dignity.

The key components of SAARC Regional Strategy on HIV/AIDS are:

1. Policy and Advocacy for:
 - a. Resource mobilization within the countries and from international regional resources
 - b. Counteracting stigma and discrimination
 - c. Scaling up response for vulnerable groups
 - d. Raising public awareness about dangers of human trafficking
2. Preventive strategies
 - a. Promoting use of contraceptives (condom promotion), and management of STIs by sharing best practices from within and outside SAARC
 - b. Prevention of mother to child transmission – sharing guidelines on primary prevention among prospective parents, prevention of unwanted pregnancies among HIV positive women
 - c. Provision of safe blood

3. Treatment strategies
 - a. Reviewing best existing procedures and guidelines; share with Member States best practices in TB and HIV; and facilitate updating of national guidelines and their implementation
 - b. Establish functional coordination between national TB and HIV and AIDS programmes and cross referral for PLWHA and TB patients for treatment
 - c. Facilitate increased access to affordable drugs and facilities
4. Gender sensitive programmes
 - a. Use established structure on gender for HIV and AIDS work
 - b. Advocate for integrating HIV and AIDS in schools and colleges
5. Collaboration, coordination and networking for
 - a. Strengthening epidemiological surveillance and networking
 - b. Collaboration and coordination between regional level organizations to share experiences and technical expertise
6. Capacity building, training and research
 - a. At regional and national level
 - b. Training on programme related areas
7. Monitoring, Evaluation and Review

1.3.2. SAARC Regional Strategy on TB/HIV Co-infection (2011-2015)

The strategy consists of the following components:

1. Political & administrative commitment
2. Support HIV surveillance among Tuberculosis patients and Tuberculosis surveillance among PLHA at National/ Sub-National level
3. Decrease the burden of HIV in TB patients and TB in PLHA (including four "I"s)
4. Support Regional and National capacity building including training and research
5. Monitoring and evaluation of collaborative activities

Component 1: Political & Administrative Commitment

To establish/strengthen National TB/HIV Co-ordination committee

For many years, those involved primarily with tackling tuberculosis and those involved primarily with tackling HIV, have largely pursued separate courses. Collaboration between TB and HIV/AIDS control programmes brings benefits to both programmes, not only in accelerating universal access to comprehensive TB and HIV prevention, treatment and care services, but also in building political commitment, advocating for resources and strengthening health systems. TB/HIV coordinating bodies are needed to ensure more effective collaboration between existing HIV/AIDS and Tuberculosis control programme efforts at all levels (National/State/Provincial and District). Evidence from operational research and expert opinion has shown that having TB/HIV coordinating bodies operating at all levels, so that all stakeholders from the HIV/AIDS and TB control programmes can participate, is feasible and ensures commitment and ownership.

The Coordinating Committee for TB/HIV collaboration may comprise of key officials from National TB and HIV/AIDS Control Programmes, representatives from WHO, UNAIDS, funding agencies, people living with TB and HIV/AIDS, NGOs working with TB and HIV/AIDS control programmes, private sector and other important stakeholders. Important areas of responsibility for the Coordination Committee are to ensure:

- Governance and mobilization of resources for TB/HIV activities
- Capacity building including training
- Ensuring coherence of communication about TB/HIV
- Ensuring the participation of the community in joint TB/HIV activities
- Overseeing the preparation of the evidence base
- Monitoring of policy and plan implementation
- Ensuring policy and plan implementation
- Intensified TB case finding among PLHA
- Introduce HIV prevention methods
- Joint Training of staff (in-service and pre-service)

To develop, strengthen and implement National joint collaborative TB/HIV strategic plan

Joint strategic planning between both programmes is needed to enable systematic and successful collaboration. The roles and responsibilities of each programme in implementing specific TB/HIV activities at national and local levels must be clearly defined.

Crucial elements for joint planning include resource mobilization for TB/HIV, capacity building and training, TB/HIV communication (advocacy, programme communication and social mobilization), service delivery for reducing the burden of TB in HIV infected & HIV in TB Patients & TB/HIV co-infection, preventive services, enhanced community involvement, infection control and operational research. For preparation/updating of strategic plans, STAC TB/HIV Co-infection Strategy may be used as a guide.

Advocacy, Communication and Social Mobilization (ACSM)

Advocacy on TB/HIV is very important for ensuring political commitment and influencing policy development, programme implementation and resource mobilization. Similarly, health professionals need to be informed to enable them to provide appropriate health services. Raising public awareness about issues related to TB/HIV is important for achieving the social mobilization necessary to secure public and political support for collaborative activities.

Advocacy targeted at influencing policy, programme implementation and resource mobilization is very important to accelerate the implementation of collaborative TB/HIV activities. Social mobilization that generates public will and secures broad consensus and social commitment among all stakeholders is critical for stigma mitigation and prevention of TB and HIV, as well as encouraging participation in collaborative TB/HIV activities.

Currently most of the SAARC Member States have their ACSM strategy. As part of the revised TB/HIV co-infection strategy, Member States are encouraged to include elements of TB/HIV co-infection responses in their ACSM strategy.

All appropriate and effective methods of information dissemination, awareness creation and sensitization should be utilized. Information, education and prevention materials related to both diseases and co-infection with TB/HIV to be developed and implemented by Member States. The IEC materials of National TB Control Programme (NTP) should also include HIV information; similarly National HIV/AIDS Control Programme (NACP) materials and messages should also include TB information.

Component 2: Support National HIV surveillance among tuberculosis patients and tuberculosis surveillance among PLHA.

Periodic or sentinel surveys on HIV infection among TB patients & TB among HIV infected patients

Surveillance is essential for programme planning and implementation. In many countries, HIV prevalence in TB patients is a sensitive indicator of the spread of HIV into the general population. Information on HIV infection in TB patients is essential to respond

to the increasing requirement to provide comprehensive HIV/AIDS care and support, including ART therapy to HIV positive TB patients and also to provide optimal TB care. Evidence from descriptive studies has shown HIV surveillance among TB patients to be a critical activity in understanding the trends of the epidemic and in the development of sound strategies to address the dual TB/HIV epidemic.

Member States will develop/strengthen a surveillance system at selected centers for collection of epidemiological information on the TB/HIV co-infection. Surveillance may be conducted through periodic surveys, sentinel methods or collection of data through routine care. The methods chosen will depend on the state of HIV & TB epidemics and the availability of resources and expertise. If requested by the Member States, STAC shall provide technical support in developing standardized protocols for conducting periodic surveys or for developing protocol for Sentinel Surveillance.

Drug Resistance surveillance for first and second line Anti TB Drugs among HIV infected TB patients

The growing HIV infection epidemic presents challenges to TB control programmes and could lead to loss of gains made for TB control. If TB is complicated with HIV infection and drug resistance (especially XDR-TB) then controlling such type of TB will be a major hurdle for the TB control programmes. In the SAARC region apart from the individual studies, limited periodic National level Drug Resistance Surveillance (DRS) is carried out routinely in TB/HIV co-infected patients. Hence, it is recommended to initiate Drug Resistance Surveillance for first and second line Anti-TB drugs among HIV infected TB patients in Member States where prevalence of TB/HIV co-infection is relatively high.

The methodology operates on three main principles:

- (1) The survey must be based on a sample of TB/HIV co-infected patients representative of all cases in the geographical setting under evaluation
- (2) Drug resistance must be clearly distinguished according to the treatment history of the patients (i.e. never treated or previously treated) in order to allow correct interpretation of the data; and
- (3) Optimal laboratory performance of each participating laboratory must be attained through engaging in a quality assurance programme.

If requested by the Member States, STAC shall provide technical support for carrying out Drug Resistance Surveillance among HIV infected TB patients.

Component 3: Decrease the burden of HIV in TB patients and TB in PLHA including four "I"s Intensified Case Finding – First 'I'

Intensified tuberculosis case finding comprises screening for symptoms and signs of tuberculosis in settings where HIV infected people are concentrated. It also includes diagnosis of HIV infection among TB patients. Early identification of signs and symptoms of tuberculosis, followed by diagnosis and prompt treatment in PLHA, their household contacts, groups at high risk for HIV and those in congregate settings, increases the chance of survival, improves quality of life and reduces transmission of tuberculosis in the community. In areas with concentrated and low HIV epidemic, selective referrals for high risk groups identified through routine screening shall be practiced. In areas where HIV prevalence is high, all TB patients will be offered HIV counseling and testing. Evidence has shown that intensified case finding and treatment of TB among HIV infected persons interrupt disease transmission by infectious cases, prevent mortality, decrease risk of nosocomial TB transmission and offer the opportunity to provide TB preventive therapy to HIV positive patients. It has been established that intensified tuberculosis case finding is feasible, and can be done at limited additional cost in existing health services. One of the studies conducted in Haiti revealed that previously undiagnosed TB was detected in up to 11% of PLHA identified through HIV testing and counseling.

The strategy for intensified case finding will include:

Establishment of Cross-Referral between TB and HIV/AIDS programme delivery sites

In areas with concentrated or low HIV epidemic, at present, some Member States have a policy of "selective referral for HIV counseling and testing" in relation to TB patients. Patients with TB disease registered under National TB Control Programme who give a history of high risk behavior for HIV, and /or who have a history of present or past STI , and /or signs and symptoms suggestive of other HIV related opportunistic infections are referred for counseling and testing for HIV. Countries where currently system of cross referral is not functioning, referral linkages will be established between HIV Counseling, Testing and Treatment services and Tuberculosis Diagnostic and Treatment Services.

National HIV/AIDS and TB programmes of SAARC Member States will jointly develop mechanism for the documentation and reporting on performance of cross referrals between above sites.

HIV counseling and testing offered to all TB patients in areas with generalized HIV epidemic

World Health Organization recommends for HIV Counseling and Testing for all TB patients in countries or parts of countries, where HIV prevalence is above 1% in general population. Though, all SAARC Member States have HIV prevalence below 1% in general population, some parts (States/Provinces/Districts) in some Member States have HIV prevalence above 1%. In high HIV prevalence settings universal offer of HIV counseling/testing for all TB patients is carried out.

Establishment of Linkages between TB & HIV/AIDS Control Programmes service delivery sites:

For the purpose of establishment of diagnosis of TB Disease and HIV infection and to provide optimal care to TB/HIV co-infected patients, optimal linkages will be developed between the following sites:

- VCT Centres and Microscopy Centres
- ART Centres and Microscopy Centres
- Drop-in-Centres and Microscopy Centres
- DOTS Centres and VCT Centres
- DOTS Centres and ART Centres
- DOTS Centres and Drop-in-Centres/similar entities

INH Prophylactic Treatment (IPT) for PLHA with latent TB-Second 'I'

In 1998, based on several randomized placebo controlled trials the World Health Organization (WHO) and the joint United Nations Programme on HIV and AIDS (UNAIDS) issued a policy statement that recognized the effectiveness of TB preventive therapy in persons living with HIV (PLHIV), and recommended the use of targeted Isoniazid preventive therapy (IPT) as part of the package of care for PLHA. In 2004, the WHO produced an interim policy on TB-HIV collaborative activities to reduce the joint burden of TB and HIV (WHO 2004). One of the important policy recommendations is that National HIV/AIDS Programmes (NAPs) should provide IPT for PLHA on the condition that active TB has been safely excluded. This recommendation has also been included in the new 10-year Global Plan to Stop TB (2006– 2015) and the Stop TB Strategy and is regarded as an important component of several collaborative TB-HIV activities.

Isoniazid (INH) is given to individuals with latent infection with *M. tuberculosis* in order to prevent progression to active disease. INH has been documented to be effective for prevention of development of active TB disease in individuals with latent TB infection, with or without HIV infection. Exclusion of active tuberculosis is critically important

before the therapy is started in order to prevent drug resistance. Use of antiretroviral drugs does not preclude its use.

HIV/AIDS Control Programmes of Member States will provide IPT to people with HIV/AIDS, once the active TB is safely excluded (at Tertiary Care Institutes). Linkages will be developed between both the programmes for institution of IPT in individuals with TB/HIV co-infection. Information will be disseminated about benefits of IPT to people with HIV/AIDS.

Introduce Anti Retroviral Therapy (ART) for eligible TB patients diagnosed as HIV Positive

Tuberculosis will be an entry point for a significant proportion of patients eligible for ART. There is evidence that potent ART can reduce the incidence of tuberculosis in HIV positive persons by more than 80%. However, for ART to prevent a significant fraction of tuberculosis cases, initiation of the treatment early in course of HIV infection and a high rate of compliance are required. Antiretroviral therapy is recommended for all patients with TB with a CD4 count <200 cells/mm³ and should be considered for patients with CD4 <350 cells/mm³. ART significantly improves the quality of life, reduce morbidity and enhances the survival of people living with advanced HIV infection or AIDS. Additionally, it reduces HIV transmission and TB incidence. HIV positive TB patients are one of the largest groups already in contact with the health service who are likely to benefit from ART, and efforts should be made to identify and treat those who are eligible. Studies have proposed that directly observed treatment (DOT) programmes of TB can be used as a model for ART delivery in some situations.

Tuberculosis and HIV/AIDS programme of SAARC Member States should create/strengthen a mechanism to provide ART to eligible HIV-positive TB patients.

World Health Organization has recommended following recommendations on ART for TB/HIV co-infection (WHO 2010):

1. Start ART in all HIV-infected individuals with active TB irrespective of CD4 cell count
2. Start TB treatment first, followed by ART as soon as possible after starting TB treatment
3. Use Efavirenz (EFV) as the preferred non-nucleoside reverse transcriptase inhibitors (NNRTI) in patients starting ART while on TB treatment

Integrated Case Management including Anti Retro-viral Therapy (ART) and DOTS- Third 'I'

People living with HIV/AIDS (PLHA), including those infected with tuberculosis, to be provided with treatment, care and support services. This includes DOTS and ART. Antiretroviral therapy improves the quality of life and greatly improves survival for PLHA. There is evidence that potent anti retroviral therapy can reduce the incidence of tuberculosis in HIV-positive patients by more than 80%.

However, for ART to prevent a significant fraction of tuberculosis cases, initiation of the therapy early in the course of HIV infection and a high rate of compliance are required. The availability of anti retroviral therapy can serve as an incentive for people to be tested for HIV.

ART should be provided to HIV infected tuberculosis patients, depending on the eligibility criteria for the therapy in tuberculosis patients in each Member States and any possible drug interaction (with Rifampicin). DOTS can be used as a model for scaling up access to ART.

Optimal case management is required for TB Patients with HIV infection (on ART or not on ART or who are eligible for ART) and HIV infected TB Patients (who are on ART or are eligible for initiation of ART). The TB patients with HIV infection who are not on ART and are also not eligible for start of ART, also require HIV care and support in terms of prevention of other opportunistic infections and care and support. Special attention is required for TB and Anti Retroviral Treatment due to Anti TB and ART Drug interaction. The National TB & HIV/AIDS Control Programmes will jointly develop guidelines for management of such patients in all kinds of possible situations.

Implementation of feasible and effective infection control measures in health care settings, Fourth 'I'

Evidence has shown there to be an increased risk of TB among health workers, medical and nursing students with patient contact, prisoners, forces in military barracks, which is exacerbated by the HIV epidemic. HIV promotes progression to active TB in people with recently acquired infection or with latent *M. tuberculosis* infection. Infection control measures can reduce the risk of *M. tuberculosis* transmission even in settings with limited resources. TB infection control is based on a 3-level hierarchy of controls, including administrative or work practice, environmental control and respiratory protection.

Work practice and administrative control measures are the first line of defense against *M. tuberculosis* transmission within facilities caring for people with HIV infection. Their goals are to prevent exposure of staff and patients to TB and to reduce the spread of

infection by ensuring rapid and appropriate diagnostic investigation and treatment for patients and staff suspected or known to have TB. Components to good work practice and administrative controls include the following

- An infection control plan
- Administrative support for procedures in the plan including quality assurance
- Training of staff
- Education of patients and increasing community awareness
- Coordination and communication between the HIV/AIDS and TB programme

General guidelines for infection control will be prepared/strengthened and their implementation should be ensured based on the resources available within each Member State.

Co-trimoxazole Prophylactic Treatment (CPT) to reduce the morbidity and mortality of PLHA and HIV positive TB patients

Randomized clinical trials, studies using historical controls and observational cohort studies have demonstrated the effectiveness of co-trimoxazole prophylaxis in reducing mortality and morbidity of PLHA and HIV positive TB patients.

Consistent evidence from all studies that include CD4 cell count supports the effectiveness of Co-trimoxazole prophylaxis among people with CD4 counts <200 cells per mm³.

Similarly, studies show that individuals with WHO clinical stages 3 or 4 for HIV disease (including tuberculosis) clearly benefit from Co-trimoxazole prophylaxis.

More recently, evidence supports the use of Co-trimoxazole prophylaxis among people with higher CD4 counts and those with less advanced HIV disease (WHO clinical stages 1 and 2). Co-trimoxazole is used for the prevention of secondary bacterial and parasitic infections in eligible PLHA, including tuberculosis patients. Evidence from randomized controlled trials of CPT has shown reduced mortality among HIV positive smear-positive tuberculosis patients and reduced hospitalization and morbidity among PLHA.

HIV/AIDS National Control Programmes in SAARC Member States will provide CPT to eligible PLHA who have active tuberculosis. In addition, information about the benefits of CPT shall be provided to PLHA.

Both these strategies, i.e. Regional HIV/AIDS strategy and TB/HIV co-infection strategy identifies the scope, direction and mechanism to achieve overall the objective of prevention and control of TB and HIV/AIDS in the Region by coordinating the efforts

of the National TB Programmes and National HIV/AIDS Control Programmes of the SAARC Member States.

1.4. Key issues and challenges in implementing strategies on HIV/AIDS and TB/HIV co-infection

1. Influencing Social Issues

- The control of tuberculosis and HIV/AIDS in the Region is affected by variations in social and economic factors such as marital discord, social ostracisation, poverty, urbanization, access to health services and equity.
- High risk groups such as Commercial Sex Workers (CSWs), IDUs (who share needles), men who have sex with men (MSMs), sexual activities involving multiple partners, migrant workers, etc., all exist in the region and put this region at particular risk for morbidity and mortality from HIV and the encroaching TB/HIV co-infection.
- Lack of awareness, lack of knowledge about blood safety; poverty; illiteracy; trafficking of women and young girls within the sex trade; and the low and unequal status of women.
- Stigma and discrimination associated with TB and HIV/AIDS
- Gender issues in TB and HIV/AIDS care and support services

2. Programmatic challenges in implementing HIV and TB/HIV collaborative activities:

- Early diagnosis and treatment of TB and HIV by the existing health services – universal access to quality TB and HIV/AIDS care and support services
- The administrative barriers to collaboration between two often very different health programmes, and to mobilize the necessary political will and resources at all levels.
- Resources to build an effective network of diagnostic services within National HIV/AIDS programmes, and to link these to the existing and expanding network of diagnostic and treatment facilities and providers working with TB programmes.
- Early treatment to patients diagnosed with both HIV and active TB. The patients need to be provided optimal care for TB and promptly linked to the care and support services of National HIV/AIDS Control Programmes, including for Co-trimoxazole prophylaxis and anti-retroviral treatment.

- Ensuring a patient-centric approach at a unified point of care.
- Lastly, programmes must find rationale ways to monitor and evaluate these activities.

These challenges need to be addressed to reduce mortality and morbidity due to TB and HIV/AIDS in the region. Effective Advocacy, Communication and Social Mobilization can support, foster and complement the efforts of TB and HIV/AIDS Control Programmes to provide universal access to services to all TB and HIV/AIDS patients with dignity.

SECTION II

2. ACSM Strategic Framework for TB and HIV/AIDS for the SAARC Region

2.1. Rationale

Rationale for ACSM Strategy for TB and HIV/AIDS for the SAARC Region

The goal of SAARC TB and HIV/ AIDS Centre (STAC) is to minimize the mortality and morbidity due to TB and HIV/AIDS in the region and to minimize transmission of both infections until TB and HIV/AIDS cease to be major public health problems in the SAARC Region¹. ACSM is one of the major components of the strategies under the Vision document, to achieve this goal.

Advocacy, Communication and Social Mobilization (ACSM) are an integral part of TB and HIV/AIDS care and control activities. ACSM activities can highlight and bring to focus key areas that are essential to control TB and HIV/AIDS; mobilize resources required for these key areas through collaborative approaches; increase awareness about TB and HIV/AIDS and the visibility of available services; and empower communities to be a partner, in decision-making process and in monitoring the quality of services and generate demand for quality treatment and care.

The Member States in the SAARC Region have already prepared and are implementing strategies for TB and HIV/AIDS control. ACSM activities are closely linked to all components of these strategies. ACSM can catalyze the interventions linked to each and every component of the TB and HIV/AIDS strategy.

Member States in the Region may have varied requirements and priorities, and specific National plans. This ACSM strategy document aims to provide a general framework to Member States for drawing up their own ACSM strategic plans to complement and support implementation of the National strategic plans for TB and HIV/AIDS control.

This document is intended to be a guide for countries to identify and analyze gaps that can be addressed through a comprehensive set of ACSM activities, while STAC will have ACSM strategic framework and work plan to achieve the overall objectives to work for prevention and control of TB and HIV/AIDS in the region by coordinating the efforts of the National TB and HIV/AIDS Control Programmes of the SAARC Member States.

¹ Vision document 2011

2.2. Objectives of ACSM Strategy for the SAARC Region

General objectives:

1. To contribute in the implementation of the global and regional TB, HIV/AIDS and TB/HIV Co-infection Strategy for achieving TB and HIV/AIDS related MDGs
2. To strengthen ACSM capacity in the region
3. To broaden the base of activities with the participation from all stakeholders to maximize synergies and collaboration.

Specific Objectives:

Advocacy

- To mobilize political and administrative commitments for TB, HIV/AIDS and TB/HIV co-infection activities in the region and in the Member States
- To support Member States to mobilize resources for TB, HIV/AIDS and TB/HIV co-infection control

Communication

- To enhance communication for awareness generation, regarding TB, HIV/AIDS and TB/HIV co-infection care and control in the region

Social Mobilization

- To support activities for empowering communities in the Member States for care and control of TB and HIV/AIDS

2.3. Role of STAC in ACSM

STAC as an apex institution at the regional level is mandated to address following objectives for ACSM:

1. To strengthen ACSM capacity in the SAARC Region
2. To provide technical assistance/expertise to the Member States to develop/ modify country specific ACSM plans to address all components of TB and HIV/ AIDS and TB/HIV co-infection strategies
3. To provide technical support for monitoring/reviewing ACSM activities

4. To foster partnerships for implementing the Regional Strategy for TB, HIV/AIDS and TB/HIV co-infection.
5. To document and share best practices at the regional level and provide platform for learning from experience of others to improve the quality and effectiveness of ACSM interventions in the Member States.

STAC will be performing all the above functions to address three components of ACSM- Advocacy, Communication and Social Mobilization

1. Advocacy for administrative support for policy and resources for implementing TB, HIV and TB/HIV co-infection strategies at the regional level and in the Member States
2. Communication with stakeholders, care providers and beneficiaries for ensuring universal access to good quality TB and HIV diagnosis and treatment for all patients
3. Social mobilization for empowering civil society organization, professional groups, positive people's network, TB supports group and communities to demand quality care.

2.4. Regional ACSM Framework for TB, HIV/AIDS and TB/HIV Co-infection

Regional ACSM Strategy framework presents ACSM activities individually. It must be remembered that they are cross-cutting for all elements of TB and HIV/AIDS care and that in practice these activities overlap and complement each other.

1. ACSM activities are integral, cross cutting, set agenda for discussion and mobilization, improve awareness, understanding and knowledge; shape public attitudes toward risk behaviour.
2. These are aimed at enhancing equitable access to quality diagnosis, treatment and care with dignity for all TB and HIV/AIDS patients.
3. Effective ACSM will lead to adequate resource availability, enhanced awareness of all stakeholders and development of patient support structures for communities.
4. ACSM activities are evidence driven, contextual and ever evolving.

The ACSM strategy framework will support and complement each component of the TB, HIV/AIDS and TB/HIV co-infection strategy which will ensure:

1. Early diagnosis and treatment - Universal access to TB and HIV/AIDS quality services with dignity for all TB and HIV patients Resource Mobilization for care of HIV infected TB patients. This includes early diagnosis and treatment of both TB and HIV; prevention of TB among PLHA by adopting (i) Intensified case finding; (ii) Isoniazid preventive therapy; (iii) Infection control; and (iv) Integrated case management.
2. Strengthening and scaling up programme coordination and collaboration
3. Prevention of TB and HIV among populations

The Member States have ACSM plans to address, TB and HIV/AIDS collaboration activities. This strategy document is intended to support and complement those efforts. At the regional level, it will identify each component of ACSM that can be planned to support country level efforts.

While ACSM activities cannot fully resolve all the challenges, they can certainly support/ complement efforts simply by drawing the attention of appropriate agencies or directly mobilizing resources and support through community action.

2.4.1. Regional ACSM Strategy Framework

Advocacy:

- To mobilize domestic and external resources for TB, HIV/AIDS and TB/ HIV co-infection care and support
- To enhance political commitment for TB and HIV/AIDS strategies

Communication

- To strengthen communication for correct information regarding TB, HIV/AIDS and TB/HIV co-infection
- To reduce stigma and discrimination

Social Mobilization

- To empower communities, support groups to play active part in TB and HIV/AIDS care and control activities

Opportunities for STAC

1. STAC has mandate to build capacities of the Member States by providing training and extending technical support to strengthen ACSM component for monitoring and research.
2. STAC has existing mechanism for sharing information, materials (newsletter, journal etc.), website which can be used for sharing communication materials, tools and innovations.
3. STAC has existing platform for coordination and collaboration, sharing expertise, experience and good/best practices.
4. STAC has Goodwill Ambassador Programme which can help support advocacy activities and increase visibility in the respective Member States.
5. STAC has scope to build partnerships formal or informal that would lead to improved collaboration.
6. Plan for inter country referral for better care and services, and plan for cross border issue on TB and HIV/AIDS control policy.

2.4.2. Suggested framework to address different components of TB and HIV/AIDS

Issues	Advocacy	Communication	Social Mobilization
Universal access of TB and HIV/AIDS quality care and support services with dignity	<ul style="list-style-type: none"> • Advocate with government and other stakeholders for commitment and prioritization of TB and HIV/AIDS care and control • Using Goodwill Ambassador to make a point • Media advocacy 	<ul style="list-style-type: none"> • Increased awareness about TB and HIV/AIDS and use of available services • Demand generation for quality services • Improved patient/community interaction with health workers • Awareness about available services to promote use of services 	<ul style="list-style-type: none"> • Community empowerment and demand generation for quality services • Community involvement in providing TB and HIV/AIDS care and support services

Issues	Advocacy	Communication	Social Mobilization
Resource Mobilization for care of HIV infected TB patients. This includes early diagnosis and treatment of both TB and HIV; prevention of TB among PLWHA	<ul style="list-style-type: none"> Resource allocation for making available quality services to the masses, introduction of newer services, technologies, etc. Policy focus on marginalized, vulnerable and at risk groups Discussions in conferences and seminars Using goodwill ambassadors and other influencers 	Media focus on marginalized, vulnerable and at risk groups	<ul style="list-style-type: none"> Community support groups for marginalized, vulnerable and at-risk groups Demand generation for quality services-use of patient support groups and positive people networks
Strengthening and Scaling up programme of coordination and collaboration	<ul style="list-style-type: none"> Bring together various sectors for formulation of appropriate policies and their implementation Using professional bodies and spokespersons to advocate with health care providers for quality care as per international standards and guidelines 	Strengthened coordination and collaboration across programmes through dialogue	<ul style="list-style-type: none"> Stakeholders meetings at regional and country level Publications/newsletters for professional bodies Joint monitoring of ACSM activities

Issues	Advocacy	Communication	Social Mobilization
Prevention of TB and HIV/AIDS among populations	Prioritization of TB and HIV/AIDS amongst local leaders	<ul style="list-style-type: none"> • Outreach to community groups and local leaders • Community participation in message development • Community forums for message dissemination • Linkage of various community groups • Media activities for informing communities, care providers and stakeholders 	<ul style="list-style-type: none"> • Supporting organization of community events at the country and sub country level • Meetings of local media on preventive aspects and mobilize support at the country and sub country level • Providing platform for sharing of experiences of community support groups • Community events for awareness generation and mobilizing community support

2.4.3. Regional level activities

At the regional level STAC has four distinct functions

1. ACSM capacity building through trainings and skill building of country level Programme Managers/experts and designated ACSM personnel at country level.
2. Technical support for developing ACSM plans and development of communication materials/tools for use by the Member States.
3. Fostering partnerships for engaging civil society, care providers etc.
4. Documentation and dissemination of best practices.

ACSM Capacity Building

ACSM capacity building will address following components:

- i. Planning** – An effective ACSM plan and how to develop realistic and practical plan with available resources.
- ii. Implementation** – For implementing the ACSM plan it should be clear ‘who’ does ‘what’, ‘when’ and ‘where’. This is common to implementing any project but is especially relevant to ACSM activities because it is difficult to attribute outcomes to specific activities. Hence, clarity on implementation brings clarity in assessing the outcomes.
- iii. Monitoring and evaluation** – It is important to monitor process, outputs and outcomes. Process monitoring helps to evaluate the progress and strategies and any unforeseen outcomes of activities. It helps in mid-course corrections to the implementation plan. The outputs help to monitor achievement of targets, and initial outputs may also help forecast cost efficiency. Outcomes monitoring helps in assessment of implementation efficiency and effectiveness.
- iv. Operations Research (OR)** - to assess efficacy of ACSM and community models. This will also help in documentation of results.
- v. Documentation and Dissemination**- The capacity building exercise will include the need for documentation and dissemination of best practices, and lessons learnt. This will help in assessing the results of different models - what works and what does not.

Technical support for developing communication materials for use by the Member States

STAC in consultation with the Member States may also engage in development of communication tools for specific target groups and also pilot effectiveness of these communication tools. Though most of the countries have developed and are using communication materials.

Communication materials/tools may be developed to address cross border issues, for imparting correct information on HIV/AIDS & STIs. Material such as fact sheets, short DVDs on issues relating to external migration addressing target groups - political associations dealing with migration issue such as Ministry for Expatriates, Welfare, Overseas Employment, Labour Ministries, etc. These communication tools can be developed at the regional level and shared with the Member States for use by the concerned departments.

Communication materials/tools for male motivation and self efficacy around use of condom use during pre-departure, post arrival and re-entry (buying, use and disposal of condoms). Communication materials to increase condom negotiation skills among women, for increasing health seeking behaviour for any kind of infection can also be developed at the regional level.

Communication tools to strengthen skills of peer educators, outreach workers, volunteers working with external migrants may also be developed by the STAC for use by the Member States. These materials may include small videos, print material, and counseling guidelines.

Most of the countries have communication materials for use at country level, however, the regional level communication materials/tools can address issues which are of common concern- for migrant groups. This material will also focus on TB and HIV/ AIDS and promote early diagnosis and treatment of TB among HIV persons and vice versa.

These materials can be developed in consultation with the Member States, pre-tested, piloted and made available for wider use, and also posted on the website. Prototype communication materials may be posted on the website. Web-based resource centre may be developed by STAC which can host communication tools for different target groups. These can be adapted, modified, translated in local languages by the Member States for use at sub National level. The web based resource centre may be managed by the STAC. The Member States can also share new communication materials with the STAC which can be reviewed and posted on the web site for wider use.

Fostering Partnership

Partnerships can be viewed as a means of maximizing benefits. Partnerships are mechanism to tap resources - technical, financial, human and physical infrastructure - to fill gaps in the programme implementation. The incentives for working in a partnership are not limited to monetary benefits; they include specific skills derived from the learning experience, greater collective capacity to respond to the problem, and increased quality of solutions. Various resources available through partnerships include:

- Technical resources through technical agencies, academic institutions, professional bodies located within countries
- Public and private human resources, including NGOs and other civil society organizations, health care providers, community volunteers
- Financial resources, which can be harnessed through development partners, corporations and business houses

- Public and private physical infrastructure, including for-profit and not-for-profit organizations, health facilities, community-based organizations

In resource-constrained settings, partnerships are a mechanism to induce synergies and avoid duplication.

STAC will identify partners especially technical, human and physical infrastructure and discuss mechanisms for collaboration in the Member States. STAC will also have pool of resources to foster partnerships.

The partnership will also include scope for operational research especially on ACSM. The resource pool will also have experts to support STAC in extending technical support for monitoring activities including development of indicators, documentation of best practices.

Documentation and Dissemination of Best Practices

A best practice is a technique or methodology that, through experience and research, has proven to reliably lead to a desired result. A commitment to using the best practices in any field is a commitment to using all the knowledge and technology at one's disposal to ensure success. The term is used frequently in the field of health care.

STAC will take the lead in providing platform for sharing of best practices that will help the Member States to:

- raise the overall quality of services
- learn from other's experiences to improve poorly performing operations
- avoid duplication of effort or "reinventing the wheel"
- minimize the need to redo work; and
- save money through increased productivity and efficiency

This can be done through annual meetings, workshops, interactive website, newsletter or other publications.

Developing generic guidelines & development of ACSM plans

Most of the Member States have strategies and plans to address TB and HIV/AIDS challenge in their respective countries. However, it is desired to have a framework for reference which the countries can adopt to make evidence driven ACSM Plans which clearly identify programme challenges, prioritize challenges and identify components that can be fostered with ACSM intervention.

This strategic framework is intended to act as a guide to relook at the plans to ascertain that all steps have been followed and each component of the TB and HIV/AIDS strategy is addressed. It will also help the Member States ascertain that Annual ACSM Plans have clearly defined objectives, target audiences, timeline, and output and outcome indicators. The steps in planning and implementation of ACSM activities are elaborated below.

2.5. Steps in Planning and Implementation of ACSM

Steps in Planning and Implementation of ACSM

- 1) Identification of challenges – Based on desk review/surveys:
 - Using programme data - This may be case detection rates, treatment outcomes, default rates, or programme management reports on TB and HIV/AIDS collaborative activities, cross referral, review meetings etc.
 - Using gap analysis tool - Identify the indicators where the programme is underperforming. Identify barriers that might be contributing to underperformance. Barriers might exist at individual, community or system levels.
- 2) Prioritization of challenges – What needs to be addressed first? Most countries work in resource-constrained settings and their resources may not always be available to address all the challenges. Programme Managers will know what challenges can be most easily and quickly overcome, addressing a wider group of people/situations.
- 3) Identify elements of TB and HIV/AIDS that need to be strengthened.
- 4) Identifying appropriate activities to meet those challenges and strengthen Stop -TB Strategy components.
- 5) Resource Mapping – Available financial and technical resources must be mapped. This includes NGOs and CBOs, who may be best, suited for implementing certain activities, especially at grass root level.
 - Action plan – An action plan will include listing activities and setting a time frame for their completion. The time of launch/organization of certain activities can be synchronized with important events and other opportunities. An action plan also needs to identify cost centres involved in each activity and match the activity with the available budget.

- Deciding on indicators – Technical and corresponding financial indicators that will help monitor the performance and, if required, make mid-course corrections to activities.

2.6. Key Issues and Challenges that can be addressed through ACSM

The key issues and challenges that can be addressed through ACSM interventions

1. Universal access to TB and HIV quality care and services through
 - a. Informing and sharing information about right diagnosis, treatment, care and support services
 - b. Creating awareness among those who don't know about TB and HIV/AIDS
 - c. Reaching out to all section through partnership with private care providers, CBOs, CSOs
 - d. Providing care and support services in the community for TB and HIV/AIDS
 - e. Reaching out to those who are 'attitudinally' resistant – towards the system, disease, treatment or care
 - f. Provision of services at convenient time and place
2. Resource Mobilization for HIV care and support infrastructure to match with HIV burden in the Member States. Commitment of both the programmes for collaboration and coordination
 - a. Adequate testing and treatment centres for HIV; and provision of DOTS in the peripheral health facilities – ART facilities
 - b. Scaling up HIV infrastructure to match TB
 - i. Diagnosing TB in HIV patients and vice versa
3. Empowering Communities and PLHA
 - a. Awareness and sensitivity for early diagnosis, treatment and care of TB among HIV (creating demand for quality services through + people's networks)
 - b. Informing and counseling TB patient about the need for HIV testing
 - i. Enhancing communication skills of care providers for communicating and counseling TB patients for testing and revealing results, especially in low HIV prevalence areas and scattered patients in large areas
 - ii. Demand for quality services by the patients and community

4. Prevention of TB and HIV infection
 - a. Informing communities, care providers and Influencers
 - b. Creating demand for services in the communities
 - c. Mobilizing patient support groups
 - d. Sensitizing political leadership
 - e. Forming partnership with other care providers

2.7. ACSM Planning Cycle

ACSM Planning Cycle

The ACSM Activities Planning Cycle consists of four key stages:

1. Planning
2. Development
3. Implementation
4. Monitoring & Evaluation

Planning

ACSM Needs Assessment through Research

- 1) The first essential step in ACSM planning is to conduct situation/needs assessment. The useful information about general health seeking behaviour. Knowledge, Attitude and Practice (KAP) can be used for identifying the areas which need to be addressed through ACSM activities.
- 2) Financial and human resources are necessary to plan and implement ACSM interventions. These need to be included in the annual budget proposals. Financial and human resources will also need to be included for designing and implement research (population-based survey research) including resources to plan, develop, implement and monitor ACSM activities for the next five years.

Research may be conducted by impartial, professionally trained research organizations, with expertise in data collection and quality. Data shall be analysed and findings should be used for developing interventions. It is critical to link KAP survey findings to the ACSM planning. Possibilities of engaging educational institutions, research organizations and development partners, should be explored for base line and subsequent research (mid line and end line). The subsequent research will have questions related to the cultural and language competence of local and health care staff; improved understanding of the emerging private sector in health care provision, and the improved or change in understanding of community responses to TB and HIV/AIDS treatment and care services including level of satisfaction among care receivers.

Frame work of ACSM Plan development objectives

Audience Based Objectives	<ul style="list-style-type: none"> • <i>Increase awareness</i> – ever having heard of TB and HIV/AIDS; correct knowledge about signs and symptoms of TB and AIDS; modes of transmission; duration of treatment. • <i>Change attitudes and perceptions</i> – attitudes toward TB and AIDS patients; personal risk perceptions; self-efficacy perceptions toward early health seeking behavior; treatment adherence and efficacy. • <i>Increase behavioral intentions</i> - toward early detection, early help seeking behaviour, treatment adherence and patient support. • <i>Increase behavior change and maintenance</i> - successfully treated patients advocating for DOTS.
Service Delivery Objectives	<ul style="list-style-type: none"> • Increase ACSM capacity of care providers to provide TB and HIV/AIDS care and support services to meet clients' expectations, advocate for early health seeking treatment, appropriate early referrals, cross-referral complete treatment and adherence.
Community Based Objectives	<ul style="list-style-type: none"> • Enable key influencers – community leaders, health workers, traditional healers and positive people's networks to understand and answer frequently asked questions on TB and HIV/AIDS in the communities. • Develop user-friendly communication aids (material) to support the training of community influencers. • Create opportunities for dialogue on TB and HIV/AIDS prevention, treatment and care through resource support and advocacy initiatives between health care providers and communities, between NGOs and communities in planning and implementation of TB and HIV/AIDS prevention, treatment and care programmes.
TB and HIV/AIDS Strategy Objectives (Overall Objectives)	<ul style="list-style-type: none"> • Sustain the global targets of achieving case detection and treatment success among TB cases under DOTS in all Districts. • Reach toward achieving the Millennium Development Goals set by 2015. • Eliminate TB and HIV/AIDS as a public health problem.

Development

The development of ACSM interventions and activities will aim at achieving audience based objectives, service delivery objectives and community based objectives, with overall objectives of TB and HIV/AIDS strategy.

However, this needs to be understood that these objectives are for the purpose of

developing ACSM interventions. This categorization simplifies implementation of ACSM interventions with clear objectives and also helps in developing M&E plan for ACSM interventions. Implementation is easy and effective when it is clearly identified if particular ACSM activities are aimed at achieving audience based objectives, service delivery objectives or community based objectives. The overall TB and HIV/AIDS strategy objectives are central to all these interventions.

Planning, development and implementation are not distinct or liner stages, but are overlapping stages. Planning will lead to development of ACSM interventions in the light of clear objectives. Development and Implementation will overlap.

Implementation

1. Creating structures for implementation of ACSM activities at National, Provincial/State and district levels or depending upon the health service structure in the respective Member States

There needs to designate a person for ACSM coordinating for ACSM activities for TB and HIV/AIDS, for developing plans along with programme managers, for training, guiding and assisting health education/promotion department for the development of training material on IPC and communication material.

2. Development of messages and materials

Messages must be based on audience research and reflect the cultural, spiritual, and socio-economic determinants impacting on behaviour change. The principal challenge is to identify a single key message point that will motivate the audience to think or act differently and to follow through on the *call to action*. Messages for each campaign will be single-minded, uniformly applied, delivered in an engaging way, and sustained over time in order to achieve the desired results.

Monitoring and Evaluation:

A good monitoring and evaluation system is the only way of establishing what is being done and if the interventions being undertaken are making a difference. It is important to identify core indicators and additional indicators that cover program inputs, activities/processes, outputs, outcomes and impact.

SECTION III

3. Work Plan for Five Years for Implementing SAARC Regional ACSM Strategy (2011-2015)

The previous section identifies four distinct functions at the regional level for STAC, apart from developing generic guidelines for improving the quality of country specific ACSM planning and implementation.

1. ACSM capacity building through trainings and skill building of country level Programme Managers/experts and designate ACSM focal person.
2. Technical support for developing ACSM plans and development of communication materials/tools for use by the Member States.
3. Fostering Partnership for engaging civil society, care providers etc.
4. Documentation and dissemination of best practices.

To implement Regional strategy STAC needs to create structure/human resource at the regional level to support implementation of SAARC Regional ACSM Strategy for TB and HIV/AIDS.

3.1. Creating structure to implement SAARC Regional ACSM Strategy

At present STAC have technical experts to take care of the clinical, biomedical, administrative aspect of the strategies at the regional level. SAARC Regional TB and HIV/AIDS co-infection strategy identifies social cultural aspects that need systematic planning, implementation, to address social determinant of health. ACSM is one of the fields which require expertise of social scientist who has good understanding of social issues, behaviour sciences and developmental issue.

It necessitates that there should be a nodal person at STAC who will support STAC in planning and implementing interventions which are inclusive of social, cultural, behaviour aspects. This person may be full time person at STAC, who will plan, coordinate and support implementation of Regional ACSM Strategy. This nodal person will develop annual work plan in consultation with the Member States, and organize events, capacity building trainings, provide platform for interaction and sharing of experiences and also work closely with the SAARC Goodwill Ambassador.

3.2. Identifying areas for collaboration and coordination for ACSM at the Regional level

1. ACSM capacity building training and skill building of programme managers/ experts and designated ACSM nodal persons for TB and HIV/AIDS programmes in the Member States.
2. Assist the Member States in development of an annual ACSM work plan with identified priorities, target groups and expected outputs/outcomes, technical support to the Member States for developing/modifying/fine tuning evidence based ACSM Plans.
3. Technical needs assessment of the Member States based on ACSM strategic plan and other ACSM felt needs in the Region.
4. Support the Member States in development of ACSM training plans. Assist Member States in adopting and piloting appropriate ACSM methodologies and approaches through tools development, trainings, technical advice and information exchange.
5. Supporting the Member States in monitoring of ACSM interventions and research relating in the field of ACSM through technical expertise, strengthen capacities of ACSM implementing agencies in documentation and impact evaluation. Develop research methods and instruments for formative research and ACSM impact and outcome evaluation.
6. In consultation with the Member States organize trainings/workshops for development of communication materials/tools and undertake exercise to develop communication materials/tools for use by the Member States.
7. Advocacy with other countries/concerned ministries/international organizations for developing policy to address cross border issues relating to TB & HIV/AIDS and develop policy guidelines.
8. Engage Goodwill Ambassador for advocacy and also for the Member States specific concerns.
9. Mobilizing support of professional bodies with expertise in ACSM, stakeholders for advocacy/training tool kits on specific skill building of care providers.
10. Energize scope for documentation and dissemination of best practices. Creating opportunities for information sharing, especially best practice models amongst NTP/NACP and other stakeholders.

3.3. Work Plan for Five years

First year

1. Share Regional ACSM Strategy document with the Member States and get their feedback.
2. Have an ACSM Expert at the STAC level for planning, guiding, coordinating, and implementing SAARC Regional ACSM Strategy.
3. To strengthen ACSM capacity and implementation in the region.
 - o At least one ACSM training workshop to help the Member States to develop realistic work plan.
4. Provide technical support to the Member States for planning and organization of country specific ACSM activities. Share the SAARC Regional ACSM strategy document and request for feedback and ask Member States to identify areas where they need support from the STAC. Upon the request of the Member States ACSM expert from STAC may monitor the ACSM activities in the Member States.
5. Collect, review and share communication materials already developed by the Member States through different ways. Start process for developing Web-based Resource Centre for communication materials and tools.

Second year

1. ACSM capacity building training in the light of feedback and lessons learnt from the previous workshop.
2. One workshop on adopting and piloting appropriate ACSM methodologies and approaches through tools development, training, technical advice and information exchange.
3. Regional level advocacy meeting to address cross border issues in TB and HIV/AIDS - participation of the Ministers of Health/professional association, other concerned ministries, stakeholders and Goodwill Ambassador. STAC as an institution can do advocacy for cross border policy for prevention of spread of infections and address the issue of migration associated with TB and HIV/AIDS – to address stigma and discrimination on the basis of HIV status.
4. Formation of Advocacy Teams at the regional level with dedicated communication specialists to support activities.

5. Identify and develop new communication materials for specific target groups in light of the review of existing communication materials.
6. Operationalizing Web-based Resource Centre for sharing of prototype communication materials and tools

Third year

1. ACSM capacity building with feedback and lessons learnt from the previous workshop/training.
2. Follow up of Regional level advocacy meeting to address cross border issues in TB and HIV/AIDS

Workshop for development of communication materials and tools plans for subsequent years will be drawn on the basis of progress feedback from the Member States.

SECTION IV

4. Monitoring and Evaluation of ACSM Activities

4.1. Monitoring and Evaluation (M&E)

Like all other components of TB and HIV/AIDS strategy, ACSM strategy also needs to have good monitoring and evaluation system. A good monitoring and evaluation system is the only way of establishing what is being done and if the interventions being undertaken are really making a difference. It is important to identify core indicators and additional indicators that cover program inputs, activities/processes, outputs, outcomes and impact.

It is said that “What doesn’t get measured, doesn’t get done!” - is the essence of monitoring and evaluation.

A SMART indicator is highly recommended for efficient and effective M&E. An indicator is SMART if it is Specific, Measurable, Attainable, Relevant and Time bound.

ACSM plan also needs to have good M&E indicators.

While monitoring and evaluation are complementary, they are two distinct processes. Monitoring follows a management model with a focus on improving day to day operations evaluation uses a research model to assess the extent to which project objectives have been met or surpassed. However, monitoring and evaluation are most effective as interwoven activities. The clear difference between monitoring and evaluation, are given below for the benefit of Programme Managers and implementing partners.

It is important that people engaged in ACSM planning and implementations at the Regional/country level clearly understands and appreciates the difference between monitoring and evaluation and identify indicators at the planning stage itself.

The monitoring and evaluation framework will be adopted by all the implementing partners, i.e., ACSM Unit of NTP/NACP and partner organizations to monitor the overall progress of all the programme activities. The information generated by the M&E system would be the essential part of making realistic and practical decisions. The maintenance of the M&E system will be an ongoing process to improve the overall system. Eventually, the M&E system will enhance job performance throughout the ACSM programme.

The TB team (Community Volunteers, TB responsible, DTCs, and National level staff) will have clear understanding of M&E indicators for ACSM so that they comprehend and collect data regularly.

4.2. Theoretical Framework for Monitoring and Evaluation Indicators

<p>INPUTS Program inputs refer to the set of resources:</p>	<p>The financial, human, material, information resources provided by stakeholders (i.e. donors, programme implementers and beneficiaries) that are necessary to produce the intended output of a project/programme. The monitoring of inputs through devising measurable indicators is the first step of M&E.</p>
<p>PROCESSES/ ACTIVITIES Programme processes refer to the set of activities in which programme inputs are utilized in pursuit of the results expected from the programme.</p>	<p>Refers to the different steps in the implementation of projects/programmes. It refers primarily to the fact that the activities are actually happening or not.</p>
<p>OUTPUTS Programme outputs are the results obtained at the programme level through the execution of activities using programme resources.</p>	<p>The immediate results of the activities conducted. Outputs are most often expressed for each activity separately. Examples:</p> <ul style="list-style-type: none"> • the number (or proportion) of people reached through behavior change activities, • the number (or proportion) of PFP trained • the number of TB and HIV/AIDS patients diagnosed treated • the number of health staff trained for IPC
<p>OUTCOMES Progress outcomes are the set of results expected to occur at the population level due to programme activities and the generation of programme outputs.</p>	<p>The medium term results of one or several activities. Outcomes are therefore, mostly expressed for a set of activities. They often require separate surveys (KAP) to be measured. Examples:</p> <ul style="list-style-type: none"> • the proportion of target population that is right information about symptoms of TB and HIV/AIDS, • the proportion of target clinical staff that has adequate tools and resources for detection of TB and HIV/AIDS , • the proportion target population that received DOTS and ART

<p>IMPACT What and how much change occurred at the programme or population level that is attributable to the programme.</p>	<p>Refers to the highest level of results, to the long-term results expected of the project/programme. Impact therefore, generally refers to the overall goal or goals of the project/programme. Examples:</p> <ul style="list-style-type: none"> • Decrease in the incidence or prevalence of TB and HIV/AIDS • Reduced mortality rate due to TB and HIV/AIDS • Increased contribution of non-government partners in TB and HIV/AIDS care and control. • This is difficult to assess since so many factors and other interventions may affect such outcomes. It may be necessary to differentiate between short and long term outcomes. For example, if your advocacy objective is to secure political commitment to renovate 5 laboratories; the short term outcome may be approval of funding for the 5 laboratories, while the long term outcome is that the labs are actually renovated.
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Tracking the results at the output level, will demonstrate (such as monitoring) whether ACSM programme has been able to:

- Create the desired environment where the community promptly reach for TB and HIV/AIDS diagnosis and treatment
- Percentage of community/migrant have basic information on TB and HIV/AIDS
- Improvement in referral linkage health services

ACSM programme M&E will improve the ultimate impact through better information and increased understanding even when activities are in progress.

4.3. Some suggested outcome indicators for ACSM activities

Outcomes are mostly expressed for a set of activities. They often require separate surveys (KAP) to be measured (As indicated in the above log frame).

- Enhanced capacity of Programme Managers to develop and implement evidence based work plans
- Enhanced capacity/skills for developing monitoring indicators
- Increase number of KAP studies/OR on ACSM

Each SAARC Member States will have M&E indicators for ACSM action plans at country level. Regional level M&E will also be developed as per the work plan. These will be monitored and evaluated as indicated in the work plan and subsequent work plans will be developed in the light of progress for these indicators. This will provide for reflection and analysis if these were and are realistic and achievable indicators.

Appendix

What is Advocacy, Communication and Social Mobilization (ACSM)

Advocacy:

Advocacy is a process, an action or influence leading to a positive change. At the country level, advocacy seeks to ensure that government, administrators and leaders at national and sub-national level, remain strongly committed to implementing TB and HIV/AIDS control policies and provide necessary resources for TB control and HIV/AIDS prevention, treatment and care & support services.

Advocacy requires broad set of coordinated interventions designed to place TB and HIV/AIDS on high political agenda, foster political will and enhance financial resource allocation, including human resources.

Good knowledge and understanding of technical issues and effective communication, persuasive and negotiation skills are essential skills for effective advocacy.

Advocacy focuses on influencing policy-makers, funding agencies and international decision-making bodies through a variety of channels – conferences, meetings between various levels of government and civil society organizations, celebrity spokespeople, news coverage, political events, partnership meetings, patients' organizations, press conferences, radio and television talk shows, service providers.

There are different types of advocacy: Policy advocacy, Programme advocacy, Media advocacy – all involve taking action to influence the target to make a positive change.

- **Policy Advocacy** is targeted towards the policy makers, to ensure that national and local governments remain strongly committed to implementing disease control policies and activities through sustain financial and other resources.
- **Programme Advocacy** is generally taken as advocacy for programme activities with community and opinion leaders.
- **Media Advocacy** is with the media to take up relevant issues for drawing community's attention, directing decision-makers to a solution, or speaking up on issues relating to disease control activities.

Communication:

Communication is a two-way process between the care providers and people with TB, and HIV/AIDS as well as healthy communities/people to improve knowledge of TB and HIV/AIDS control policies, programmes and services.

The term “communication” is used to mean the process people use to exchange information about TB and HIV/AIDS. Communication is used to generate appropriate awareness regarding TB and HIV/AIDS control services, to remove misconceptions and to promote use of available quality of services.

Communication is used for programme information, advocacy, and social mobilization.

All communication activities make use of some form of media or channel of communication (e.g. mass media, community media, and interpersonal communication).

Communication helps in creating awareness about TB, HIV/AIDS and TB/HIV co-infection, inform people what services exist and where, and empower patients by providing right information and mobilizing them to demand quality services for diagnosis and treatment.

All communication needs to be clear, simple and in a language that is understood by the target audience.

Social mobilization:

Social mobilization brings together community members and other stakeholders to strengthen community participation for sustainability and self reliance. Social mobilization works on the philosophy that a community’s problems are best understood by the community itself and that it has the potential to resolve them.

Social mobilization generates dialogue, negotiation and consensus among a range of stakeholders that includes decision-makers, the media, NGOs, opinion leaders, policy-makers, the private sector, professional associations, TB-patient networks, positive people’s networks, community leaders and religious groups.

At the heart of social mobilization is the need to involve people who are either living with active TB or HIV/AIDS or have suffered from it at some time in the past. Social Mobilization also empowers communities in general to participate in decisions regarding service provision. Communities become a partner to the process and ownership of communities is enhanced for TB and HIV/AIDS prevention, treatment, care and support services.

Social mobilization efforts lead to prioritization of TB and HIV/AIDS control by community leaders and other representatives that will enhance community participation and ownership of the programme through community empowerment.

Empowering TB and HIV/AIDS patients and the affected communities helps to achieve timely diagnosis and treatment completion, especially among families of TB patients.

It is important for countries planning social mobilization activities to ensure that plans are converted into action at ground level. The key to success of the social mobilization approach is to allow ideas for mobilization to germinate within communities itself. Communities are best positioned to find solutions for barriers to access TB control services, though they may require some external support for implementation of those solutions.

The difference between social mobilization and community mobilization - community mobilization is a grass-roots process within the broader context of social mobilization.

Advocacy, communication and social mobilization, although distinct, but overlap in many ways. Communication is central in all three activities. For example, communities could be mobilized to do advocacy. Communication with the patients/communities will lead to better understanding of disease and services etc. ACSM is most effective when used together. ACSM activities therefore need to be planned and implemented to enhance, foster programme objectives. ACSM activities are not stand alone activities. ACSM activities should not be seen as parallel to other programme implementation but as complementing the programme efforts.

Information, Education and Communication (IEC)

The term “IEC” has been used for many years by the national programmes to refer to interventions for informing, and educating patients, families and communities about the disease and services. Most of these interventions were targeted towards the beneficiaries with the understanding that, by informing people, people will be motivated to seek treatment.

IEC mostly focuses on dissemination of information and promoting normative or ideal behaviour. Most communication efforts remain confined to the knowledge area. However, knowledge per se is insufficient to bring about behaviour change. This has been empirically established the world over, and particularly so when we are talking about extremely personal behaviors such as sexual behaviors.

It has been established the world over in theory and in practice, that telling people what is ‘good for them’ does not necessarily make them do it.

It requires research to understand the reasons that motivate/trigger action. It is important to understand how new product/service/behaviour fit into the individual, social, cultural and emotional context of the target group. For any behaviour change, in situations such as sexual behaviour, we are dealing with behaviours which are much more complex and deeply ingrained. They are also a result of many economic, social and cultural factors, not all of which can even be addressed, but which nevertheless need to be understood and taken into account.

Hence, the approach known as “Behaviour Change Communication” is being used for not only informing people, but also understanding the social, economic and cultural factors that influence the attitudes and perceptions of people and influence their decisions.

Behaviour Change Communication (BCC)

Communication as such is overarching, however in the context of ACSM, it refers to Behaviour Change Communication (BCC).

- Behavior Change Communication (BCC) aims to change knowledge, attitudes and practices among various groups of people.
- It aims at informing the people about the services that exist for diagnosis and treatment and disseminate messages about the disease – such as “TB is curable”, “Visit health facility if you have a cough for more than two weeks”; or “TB is curable among HIV infected too”.
- Most of the BCC efforts are aimed at symptomatic individuals and/or patients, but providers and other stakeholders can also be targeted with communication efforts and often need specialized messages.
- Effective Behavior Change Communication and messages aim to convey more than just the medical facts, as these facts do not necessarily motivate people to visit a TB or HIV testing centre or complete their treatment. The messages explore the reasons why people do or do not take action on the information they receive, then focus on changing the actual behaviour by addressing the causes identified – social norms or personal attitudes.
- Behavior Change Communication creates an environment through which affected individuals and communities can discuss debate, organize and communicate their own perspectives on TB or HIV/AIDS.
- It is important to remember that individual behavior change does not result from improved knowledge alone, and cannot be promoted in isolation from the broader social context in which it occurs.

- A behaviour change approach explores the full range of factors that must be addressed at multiple levels to change behaviour effectively. It aims to change behaviour, such as persuading people with symptoms to seek treatment and to foster social change, supporting processes in the community to spark debate that may shift social mores and/or eliminate barriers to new behaviour. Social and Behavior Change Communication is a standardized, step-by-step process which is used to assess current behaviour and factors that are barriers or incentives to people practicing them.

Many countries use the terms ACSM, IEC and BCC interchangeably, as these refer to the communication initiatives within the programmes. The Stop-TB Partnership's Advocacy, Communication and Social Mobilization Country-Level Sub Group in its "10-Year Framework for Action," declared that a significant scale up of Advocacy, Communication and Social Mobilization (ACSM) is needed to achieve the global targets for tuberculosis control as detailed in the Global Plan to Stop-TB 2006–2015. Since then the term "ACSM" became popular and is being used by the countries engaged in TB care and control. Although distinct from one another, Advocacy, Communication and Social Mobilization (ACSM) are most effective when used together. The term "ACSM" distinctly highlight three major components and target audience and to emphasis importance each of these. This distinction is useful for planning, implementing and monitoring activities, and its outcomes.

BCC is widely used by the organizations, and programmes dealing with HIV/AIDS care and support services, dealing with "Most at Risk" groups, aiming at change in certain behaviour that will prevent spread of infection and also improve quality of life.

ACSM and BCC are being promoted over IEC by national programmes as well as by funding and donor agencies as these terms are all encompassing, scientific, allow for planning and implementation with the scope for monitoring and measuring outcomes. It allows for the same level of understanding among stakeholders.

Annexure

Annexure I

Audience Segmentation

ACSM messages will only be effective if they speak directly to the needs of particular audience segment with similar attributes and concerns. Audience segmentation for Advocacy, Communication, and Social Mobilization will be clearly identified. Audiences for advocacy will range from policy makers, influencers, media and communities, depending upon the issues to be addressed and support expected for TB services. Social mobilization activities are mainly targeted towards communities and groups. Communication activities are best achieved by looking more closely at those factors which mitigate TB and HIV/AIDS risk behaviour patterns, resistance to healthcare seeking behavior and treatment adherence.

The main audience segments identified for this strategy are as follows:

Primary Audience Segments

- TB and HIV/AIDS patients, their families and communities,
- Vulnerable populations such as people living with HIV, MARPs etc.
- Females and males in lower-socio-economic categories, people living in far flung areas, migratory & mobile populations,
- Health care providers for improved IPC skills (capacity building).

Secondary Audience Segments

- General Population - females and males in urban, rural and hilly remote areas.

Influencing Groups

- Traditional healers
- Health care promoters
- Health professionals, NGOs/ Private care providers
- Head Teachers, School Health and other Academic staff at secondary schools
- Successfully treated former TB patients and their families

For Example:

To advocate for the incorporation of TB and HIV collaborative mass media campaigns.

Primary target population

- Ministry of Health officials,
- Programme Managers for TB and HIV/AIDS
- External development partners

To increase the knowledge and attitude on the relationship between TB and HIV/AIDS and preventive care and treatment measures.

Primary Audiences will be

- Health care workers
- TB patients
- PLHA
- TB/HIV co-infected patients

To advocate for the provision of psychosocial support for patients co-infected with TB and HIV

Primary target population

- Health workers
- Counselors
- Caregivers/Palliative caregivers
- Community volunteers
- PLHA networks
- Leaders of NGOs/CBOs

Secondary target audiences

- Patients and their families
- Peer groups
- Co-workers at work place

It must be understood that advocacy activities are mainly targeted towards all those who are in position of authority and their commitment will result in improved resources - financial, human, and physical. Communication is directed towards beneficiaries, care providers and for influencers. Social mobilization is targeted towards communities, patient groups who can demand quality services.

Audience segmentation/identification of target groups help in developing targeted messages and motivating them for desired action.

Annexure II

Development of Messages and Materials

Development of messages must be based on audience research and reflect the cultural, spiritual, and socio-economic determinants impacting on behaviour change. The principal challenge is to identify a single key message point that will motivate the audience to think or act differently and to follow through on the *call to action*. Messages for each campaign will be single-minded, uniformly applied, delivered in an engaging way, and sustained over time in order to achieve the desired result.

A continuous process of formative research and message pre-testing via qualitative and quantitative techniques will be institutionalized to adequately inform the message development process. This will be supported by conducting population-based, quantitative KAP surveys exploring TB/HIV -related awareness, knowledge, attitudes, practices and behaviour prior to and following campaign phases.

A baseline for the ACSM strategy and combined Monitoring and Evaluation (M&E) approaches will ensure high quality, pre-tested messages and materials will be developed, which are responsive to audience needs.

Potential Message Themes for TB

To promote early help seeking behaviour among communities and affected groups, potential messages focus on informing the communities and building confidence to seek screening and treatment as soon as possible from the health facility. Some potential message themes to be considered for the ACSM campaigns are as follow:

Messages to encourage early Help Seeking Behaviour and Treatment Adherence

- *Promoting the benefits of early help seeking behaviour* – encouraging seeking diagnosis and treatment for cough more than 2-3 weeks. Motivating and ensuing treatment completion.
- *Promoting the Expanded Service Delivery Network* - through traditional service providers, and Community DOTS providers (Community Volunteers).
- *Providing Complementary Messaging* – linking early detection, screening and treatment for reduction in debilitation of patient, infection of other family and community members.

Specific TB Messages

- TB is fully curable, if you seek help early.
- If you have a cough for more than 2 weeks go to your local health centre.

- Sputum test is the best way to diagnose pulmonary TB.
- TB patient will need to take treatment for a 6 month period.
- Drugs need to be taken under the direct supervision of a DOTS provider to help you in completion of regular treatment.
- Irregular or discontinuing treatment, can lead to complications that is difficult to be cured.
- Early detection, screening and treatment can cure TB and prevent spread of infection to others.

Potential Messages on HIV/AIDS and TB/HIV Co-Infection

- TB is curable among HIV infected persons too
- Early diagnosis and complete treatment is a sure cure for TB
- Screening of TB patients for HIV
- ART for HIV infected

Messages risk factors

- Unprotected sex with multiple partners is a risk factor for HIV/AIDS
- Safe sex - Use condom
- Awareness about risk factors relating to injectable drug users – avoid needle and syringe sharing; avoid cocktail injections
- Awareness about risk factors associated with blood transfusion & blood products
- Awareness and sensitivity for stigma and discrimination against IDUs by police/other authorities
- Condom access, use and disposal
- Basic hygiene information
- Safe sex practices
- Awareness about stigma, discrimination and sexual abuse against MSW/Transgender through advocacy with law enforcement, religious leaders

Types of material, language, methods of communication, use of media

- In view of the low level literacy of the population, the focus should be on interactive activities, community engagement through community volunteers, and use of patient support groups. To facilitate them, communication material should be pictorial for the communities and in local language for health care providers.
- Television viewership is high in most of the countries. People like to watch message in the story form and like messages that are engaging. Health education department will place information material on prime time (before news).

- Radio listening is high among rural populations. FM is popular among youth at prime time. Radio should be used for informing communities about symptoms, diagnosis and treatment of TB and HIV/AIDS.
- Good quality, attractive, durable, glossy and colorful materials should be developed for attention of health care providers and materials will be such that each health care provider and community volunteer will like to keep and hold on to it for further use.
- Module on improved personal communication with role plays based on actual situation.

Pre-testing

Each material should be developed on the basis of formative research, following process of concept development, and pre-testing among target audiences to ensure:

- **Accuracy:** The content is valid and without errors of fact, interpretation, or judgment.
- **Availability:** Whether targeted message or other information is delivered or placed where the audience can access it. Placement varies according to the audience, message complexity, and purpose, ranging from interpersonal and social networks to billboards and mass transit signs to prime-time TV or radio, to public kiosks (print or electronic), to the Internet.
- **Balance:** Where appropriate, the content presents the benefits and risks of potential actions or recognizes different and valid perspectives on the issue.
- **Consistency:** The content remains internally consistent over time and also is consistent with information from other sources.
- **Cultural Competence:** The design, implementation, and evaluation process that accounts for special issues for select population groups (for example, ethnic, racial, and linguistic) and also educational levels and disability.
- **Evidence-based:** Relevant scientific evidence that has undergone comprehensive review and rigorous analysis to formulate practice guidelines, performance measures, review criteria, and technology assessments for tele-health applications.
- **Reach:** The content gets to or is available to the largest possible number of people in the target population.
- **Reliability:** The source of the content is credible, and the content itself is kept up to date.

Repetition: The delivery of/access to the content is continued or repeated over time, both to reinforce the impact with a given audience and to reach new generation.

Annexure III

The Patients' Charter for Tuberculosis Care (PCTC)

The Patients' Charter outlines the Rights and Responsibilities of People with Tuberculosis. It empowers people with the disease and their communities through this knowledge. Initiated and developed by patients from around the world, the Charter makes the relationship with health care providers a mutually beneficial one.

The Charter sets out the ways in which patients, the community, health providers, both private and public, and governments can work as partners in a positive and open relationship with a view to improving tuberculosis care and enhancing the effectiveness of the health care process. It allows for all parties to be held more accountable to each other, fostering mutual interaction and a 'positive partnership'.

Developed in tandem with the International Standards for Tuberculosis Care to promote a 'patient-centered' approach, the Charter bears in mind the principles on health and human rights of the United Nations, UNESCO, WHO, Council of Europe, as well as other local and National charters and conventions.

The Patients' Charter for Tuberculosis Care practices the principle of Greater Involvement of People with TB. This affirms that the empowerment of people with the disease is the catalyst for effective collaboration with health providers and authorities, and is essential to victory in the fight to stop TB. The Patients' Charter, the first global 'patient-powered' standard for care, is a cooperative tool, forged from common cause, for the entire TB Community.

PATIENTS' RIGHTS

1. Care

- a. The right to free and equitable access to tuberculosis care, from diagnosis through treatment completion, regardless of resources, race, gender, age, language, legal status, religious beliefs, sexual orientation, culture or having another illness.
- b. The right to receive medical advice and treatment which fully meets the new International Standards for Tuberculosis Care, centering on patient needs, including those with MDR-TB or TB/HIV co-infections, and preventative treatment for young children and others considered to be at high risk.
- c. The right to benefit from proactive health sector community outreach, education and prevention campaigns as part of comprehensive care programs.

2. *Dignity*

- a. The right to be treated with respect and dignity, including the delivery of services without stigma, prejudice or discrimination by health providers and authorities.
- b. The right to quality health care in a dignified environment, with moral support from family, friends and the community.

3. *Information*

- a. The rights to information about what health care services are available for tuberculosis, and what responsibilities, engagements and direct or indirect costs are involved.
- b. The right to receive a timely, concise and clear description of the medical condition, with diagnosis, prognosis (an opinion as to the likely future course of the illness), and treatment proposed, with communication of common risks and appropriate alternatives.
- c. The right to know the names and dosages of any medication or intervention to be prescribed, its normal actions and potential side-effects, and its possible impact on other conditions or treatments.
- d. The right of access to medical information which relates to the patient's condition and treatment, and a copy of the medical record if requested by the patient or a person authorized by the patient.
- e. The right to meet, share experiences with peers and other patients, and to voluntary counseling at any time from diagnosis through treatment completion.

4. *Choice*

- a. The right to a second medical opinion, with access to previous medical records.
- b. The right to accept or refuse surgical interventions if chemotherapy is possible, and to be informed of the likely medical and statutory consequences within the context of a communicable disease.
- c. The right to choose whether or not to take part in research programs without compromising care.

5. *Confidence*

- a. The right to have personal privacy, dignity, religious beliefs and culture respected.
- b. The right to have information relating to the medical condition kept confidential, and released to other authorities contingent upon the patient's consent.

6. *Justice*

- a. The right to make a complaint through channels provided for this purpose by the health authority, and to have any complaint dealt with promptly and fairly.
- b. The right to appeal to a higher authority if the above is not respected, and to be informed in writing of the outcome.

7. *Organization*

- a. The right to join, or to establish, organizations of people with or affected by tuberculosis, and to seek support for the development of these clubs and community based associations through the health providers, authorities and civil society.
- b. The right to participate as 'stakeholders' in the development, implementation, monitoring and evaluation of TB policies and programs with local, national and international health authorities.

8. *Security*

- a. The right to job security after diagnosis or appropriate rehabilitation upon completion of treatment.
- b. The right to nutritional security or food supplements if needed to meet treatment requirements.

2 PATIENTS' RESPONSIBILITIES

1. *Share Information*

- a. The responsibility to provide the health care giver as much information as possible about present health, past illnesses, any allergies and any other relevant details.
- b. The responsibility to provide information to the health provider about contacts with immediate family, friends and others who may be vulnerable to tuberculosis or may have been infected by contact.

2. *Follow Treatment*

- a. The responsibility to follow the prescribed and agreed treatment plan, and to conscientiously comply with the instructions given to protect the patient's health, and that of others.
- b. The responsibility to inform the health provider of any difficulties or problems with following treatment, or if any part of the treatment is not clearly understood.

3. *Contribute to Community Health*

- a. The responsibility to contribute to community well being by encouraging others to seek medical advice if they exhibit the symptoms of tuberculosis.
- b. The responsibility to show consideration for the rights of other patients and health care providers, understanding that this is the dignified basis and respectful foundation of the TB Community.

4. *Solidarity*

- a. The moral responsibility of showing solidarity with other patients, marching together towards cure.
- b. The moral responsibility to share information and knowledge gained during treatment, and to pass this expertise to others in the community, making empowerment contagious.

The moral responsibility to join in efforts to make the community TB Free.

HIV/AIDS and Human Rights

The following, International Guidelines on HIV and Human Rights are organized jointly by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, and are firmly anchored within a framework of existing international human rights norms and are based on many years of experience in identifying those strategies that have proven successful in addressing HIV and AIDS. The normative principles together with practical strategies provide the evidence and ideas for the states to reorient and redesign their policies and programmes to ensure respect for HIV-related rights and to be most effective in addressing the epidemic. States should provide adequate political leadership and financial resources to enable implementation of these strategies.

GUIDELINE 1: States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities across all branches of government.

GUIDELINE 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

GUIDELINE 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

GUIDELINE 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

GUIDELINE 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

GUIDELINE 6 (as revised in 2002): States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

GUIDELINE 7: States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

GUIDELINE 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

GUIDELINE 9: States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

GUIDELINE 10: States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

GUIDELINE 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

GUIDELINE 12: States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV at international level.

The key human rights principles which are essential to effective State responses to HIV are to be found in existing international instruments, such as the Universal Declaration of Human Rights, the International Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of the Child. Regional instruments, namely the American Convention on Human Rights, the European Convention for the Protection of Human Rights and Fundamental Freedoms and the African Charter on Human and Peoples' Rights also enshrine State obligations applicable to HIV. In addition, a number of conventions and recommendations of the International Labour Organization are particularly relevant to the problem of HIV, such as ILO instruments concerning discrimination in employment and occupation, termination of employment, protection of workers' privacy, and safety and health at work. Among the human rights principles relevant to HIV/AIDS are, inter alia:

- The right to non-discrimination, equal protection and equality before the law;
- The right to life;
- The right to the highest attainable standard of physical and mental health;
- The right to liberty and security of person;
- The right to freedom of movement;
- The right to seek and enjoy asylum;
- The right to privacy;
- The right to freedom of opinion and expression and the right to freely receive and impart information;
- The right to freedom of association;
- The right to work;
- The right to marry and to found a family;
- The right to equal access to education;
- The right to an adequate standard of living;
- The right to social security, assistance and welfare;
- The right to share in scientific advancement and its benefits;
- The right to participate in public and cultural life;
- The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

Annexure V

Some Illustrations of ACSM Success Stories

Afghanistan

Advocacy through Religious Leaders

Religious leaders in Afghanistan are particularly revered as a source of guidance and information for many rural communities and are inextricably linked to the political system. For this reason they may be considered of particular importance in advocacy efforts. However, religious leaders are currently under utilized in the provision of accurate health information and referrals for TB, as well as a range of other health priorities.

This may call for the development of more tailored programs which will need to emanate from discussions on the needs of the religious leaders themselves. In this way religious leaders will be able to have more ownership of the final advocacy program to be developed. This will create more opportunities for dialogue between these key influencers and the communities in which they operate.

Of particular importance is the role that religious leaders can play in reducing community stigma of TB by providing simple messages to raise awareness, build knowledge and allay fears and anxieties of community members. The acknowledgement by religious leaders of successfully treated patients can also provide powerful testimonials and build the esteem of former patients to allow them to more easily reintegrate into the community. (Afghanistan National TB Control Programme, Integrated Advocacy Communication and Social Mobilization Strategy 2009 -2013, WHO)

Bangladesh

BRAC community-based TB care model

At the core of TB control and other essential primary health care services are female community health volunteers called *shastho shebikas*. They are chosen from village organizations – BRAC female micro-credit schemes containing 40-50 members per village. Each *shastho shebika* is responsible for about 330 households – they visit each household every month to provide primary health care services, including TB control. *Shastho shebikas* are allowed to sell medicines at an agreed price and are motivated by performance-based incentives. They receive 3-4 days of training and monthly refresher courses to serve as directly observed treatment providers.

They usually spend about two hours daily working as health volunteers. When a *shastho*

shebika encounters a person suspected of having TB, she provides a sputum container, which is then taken to one of BRAC's smearing centres a few kilometres away. BRAC staff members visit the smearing centres once a week, fixing slides and taking them to a laboratory for sputum smear examination.

If the examination is positive, BRAC contacts the *shastho shebika* and provides a weekly dose of medicines for the intensive phase of treatment and several months' supply for the continuation phase. People with TB go daily to the *shastho shebika*'s home to receive directly observed treatment. If a person with TB does not turn up, the *shastho shebika* is obliged to go to his or her home. If a person with TB still has problems in adhering to treatment, *shastho shebikas* have to report this to the village authority, which will contact the person with TB to encourage them to continue treatment. (Regional Framework for Advocacy, Communication, Social Mobilization, WHO April 2011)

Educating Youth about HIV/AIDS

USAID and BCCP educate young people on HIV/AIDS. They use a multi-pronged strategy focusing on mass media, publications, and community-based programs. A major part of their approach is "Know Yourself", a series of videos, booklets and facilitator guides for teaching adolescents about their own reproductive health. The series focuses on family planning, life skills, delaying sex and marriage and substance abuse. Adolescents played an active role in developing each piece.

Bhutan

Involving Village Health Workers in TB Care

Involving Village Health Workers: Bhutan's strong Village Health Worker (VHW) programme was introduced by the government in 1978 and formally established in 1998 under the Department of Public Health. It has since been integrated into the health system, emerging as a successful outreach initiative. As of today, there are 1250 VHWs spread out in all 20 districts of the country's three regions. Most of these districts are situated in remote and hard-to-reach areas. What binds the health workers together is their singular objective of helping people access services in as efficient and economical manner as possible.

Serving as health counselors, VHWs provide a link between the community and the health system. All VHWs are volunteers, and they are either nominated by the community or sign up of their own accord. They receive training on basic health care, and how to assist with deliveries, identify health problems and make referrals, besides helping with advocacy.

In the case of TB, VHWs play a critical role by monitoring treatment status of the TB patient. Based on the list of names given by the village headman, they visit the concerned households and remind the person about going to the health centre. They also keep

checking the status of other family members to see if they need screening. (Regional Framework for Advocacy, Communication, Social Mobilization, WHO, April 2011)

Research on prevalence of HIV

Available evidence indicates that the prevalence of HIV in Bhutan remains low. However, there are indications of vulnerability. A recent general population survey found that the prevalence of conventional STIs is high. Moreover, there are aspects of the sexual structure in Bhutan that could lead to expansion of the HIV epidemic, including pockets of commercial sex, international migration and cross-border networks (with India), and in some locals, at least anecdotal reports of relatively common practice of multi-partner concurrent sexual networks. At this relatively early stage the impact of the HIV epidemic can likely be kept at a low level if the appropriate prevention strategies are chosen, targeted appropriately, and implemented at scale with sufficient quality. Therefore, the National AIDS Control Programme (NACP) of the Government of Bhutan plans to select and target prevention strategies appropriately, and to build the capacity of key personnel involved in HIV/AIDS programming to conduct rapid appraisals to support prevention program planning.

India

The "Partnership for Tuberculosis Care and Control in India"

The "Partnership for Tuberculosis Care and Control in India" (the Partnership) brings together civil society across the country on a common platform to support and strengthen India's national TB control efforts. It seeks to harness the strengths and expertise of partners in various technical and implementation areas, and to empower affected communities, in TB care and control. It consists of technical agencies, NGOs, CBOs, affected communities, the corporate sector, professional bodies and academia. Currently the Partnership includes 24 partners.

The Partnership's vision is to support India's Revised National Tuberculosis Control Programme and achieve the TB-related targets of the MDGs and the Stop TB Partnership in India through a unified response from civil society and all other stakeholders, based on shared values of mutual trust, respect and a willingness to contribute to this common vision. It seeks to synergize civil society to contribute to TB care and control in India in line with common national and international goals.

The Partnership's objectives include: advocating with national, state and district authorities and with all existing and potential stakeholders on TB control; developing a dynamic and comprehensive strategic plan for civil society participation; mobilizing resources and interfacing with donors to support partner activities; coordinating partner activities and providing tools, information and platforms to share successes, lessons, constraints and innovations; facilitating need-based technical support for partners; promoting the ISTC and PCTC as internationally accepted standardized tools; increasing the visibility of

India's national TB programme and promoting community ownership; and expanding the Partnership to harness all available resources for a self-sustaining TB control movement in India.

In a short time, the Partnership has become a hub for disseminating information, creating visibility for India's national TB programme, responding to TB related challenges and providing support to various stakeholders. (Regional Framework for Advocacy, Communication, Social Mobilization, WHO, April 2011).

Supporting Positive Living (FHI- Chennai)

Advocacy efforts helped Indian Network for People Living with HIV/AIDS (INP+) members identify where they could refer people living with HIV/AIDS for services such as temporary shelter, legal assistance and treatment for sexually transmitted and opportunistic infections.

The most sought-after service is medical care. So far INP+ has identified physicians in different states who are willing to treat HIV-positive people.

Maldives

Partnership for capacity building

The Raajje Foundation is conducting a Maldivian NGO Strengthening Pilot Project. The primary objectives of the project are to strengthen the capacity of NGOs to operate effectively and sustainably to the highest possible standards of practice and to contribute to improving the enabling environment for NGOs. The first activity of the project, which commenced in late 2007, was to conduct a capacity and needs assessment of all Male-based NGOs known to be active, using a UNDP assessment methodology. Twenty-four out of 25 known NGOs responded to invitations to participate in the assessment. The NGOs included the Society for Health Education (SHE), Journey, and the Society for Women against Drugs (SWAD). The other NGOs included in the assessment are doing work in areas other than HIV and AIDS, but may have access to target groups included in the NSP such as youth, women and detainees.

Subsequent activities of the Raajje Foundation Pilot Project include:

- Structured training programs: regular training workshops to increase knowledge and skills in the essentials of NGO project planning and management. Topics will include NGO and project management; project design and implementation; accountable and transparent systems for NGO finances and operations; resource mobilization; strategic planning and coordination; written and oral communications; advocacy, networking and partnerships; training of trainers; community asset mapping; awareness raising; media skills; staff and volunteer recruitment and retention; teamwork, and problem-solving skills; and monitoring and evaluation.

- Hands on training and guidance: to consolidate and reinforce the knowledge and skills learned during the training workshops through practical application.

Other activities include the development of manuals, toolkits and NGO resources; the establishment of knowledge and skill sharing mechanisms, and the facilitation of NGO networking and output-driven relationship building with other NGOs the South Asia region.

Nepal

Community mobilization and networks for better programming and policy development

There are nine formal and informal networks operational in the country, they are National Association of Positive People in Nepal (NAP+N), Federation of Women Living with HIV in Nepal, Recovering Nepal (network of IDUs), Federation of Third Gender and Sexual Minority in Nepal (MSM network), two Sex workers' Network, National Association of NGO Group working against AIDS in Nepal (NANGAN), National Harm Reduction Council (NHRC), National Alliance against HIV and AIDS (NEHA) and NESFADA (Networks of sports organization).

It is encouraging to note that all these networks are actively advocating on behalf of their own issues related to HIV/AIDS and human rights, gender, stigma and discrimination and working as pressure groups for gaining access to preventive, curative and supportive services and also communicating and reaching out their peers at the grass-roots to prevent and control HIV/AIDS. In preparing this report the representative from almost all these networks are actively involved as the task force members in various issues (National HIV/AIDS strategy development core group, National HIV/AIDS policy development task force, SIT-WG, UNGASS national report preparation task force, project steering committee for workplace programme, development of operational manuals and guidelines team are few to name.

Pakistan

Educating the power: HIV/AIDS and parliamentarians of Pakistan

Increasing rates of HIV have been recorded amongst the Injection Drug User community from all parts of Pakistan. This has mobilized the health authorities into definitive action before there is a general spread of the epidemic into the Pakistani populace. International collaborating agencies, including the United Nations, are aiding in the formulation of a national policy to tackle HIV/AIDS. The series of seminars help to appraise the Parliamentarians of the ground situation as pertains to HIV/AIDS in their constituencies, aiming to ultimately generate federal and provincial governmental policies, and a solid strategy to combat the spread of HIV/AIDS in Pakistan.

Sri Lanka

Involving the Community in Responding to TB/HIV: Outcomes of Community-Led Monitoring and Advocacy

Public Health Watch, a project of the Public Health Program of the Open Society Institute, aims to strengthen meaningful and sustained engagement by infected and affected communities in the development, implementation, and monitoring of TB and HIV policies, programs, and practices. Public Health Watch supports and advocates to identify, document, and articulate priority human rights issues, and to press for accountability at the national, regional, and global levels. Public Health Watch believes engaged, well-informed individuals and community groups are needed to ensure that government policies really live up to the commitments made at the international level; to scrutinize whether and how policies and guidance are implemented; and to point out where the numbers may not reflect the full reality on the ground.

Annexure VI

Linkages with the organizations working on ACSM

1. Communication Consultant/s working in the National TB and HIV/AIDS Control Programme in the Members States with the Government and with the technical agencies such as WHO, World Bank, USAID etc.
 2. Communication Experts from Global Fund, WHO, UN Agencies etc.
- Global/Regional Organizations working in ACSM, BCC.

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