# South Asian Association of Regional Cooperation (SAARC) Regional Strategy on Advocacy, Communication and Social Mobilization (ACSM) for TB and HIV/AIDS 2018-2023

**SAARC TB and HIV/AIDS Centre**
Thimi, Bhaktapur


# South Asian Association of Regional Cooperation (SAARC) Regional Strategy on Advocacy, Communication and Social Mobilization (ACSM) for TB and HIV/AIDS

## 2018-2023

**SAARC TB and HIV/AIDS Centre**
Thimi, Bhaktapur

Publications of the SAARC Tuberculosis and HIV/AIDS Centre (STAC) can be obtained from STAC Office, Thimi, Bhaktapur, GPO Box No 9517, Kathmandu, Nepal.

Email: saarctb@mos.com.np

Website: www.saarctb.org



*Printed in Nepal*

# Table of Contents

# PREFACE

Advocacy, Communication and Social Mobilization (ACSM) role is vital in TB and HIV/AIDS control strategies. ACSM is crucial in achieving a world free of TB and HIV/AIDS. Its aim 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, and empower people affected by TB and HIV/AIDS and to mobilize political commitment and resources for TB and HIV/AIDS. ACSM is an important component of the TB and HIV/AIDS control strategy to ensure long-term, sustained impact. Advocacy seeks to ensure strong commitment. Policy advocacy informs politicians and administrators about how to issue affects the country and outlines the actions to improve laws and policies. Program advocacy targets opinion leaders at the community level on the need for local action and media advocacy validates the relevance of the subject so as to raise awareness of the problem and its possible solutions. Communication aims to change knowledge, attitudes and practices whereas Social Mobilization brings together community members and stakeholders to strengthen community participant for sustainability and self-reliance.

The outcome of the first ACSM Strategy strongly emphasized on advocacy, communication and social mobilization. The SAARC Goodwill Ambassador Programme on HIV/AIDS has made a very positive change in sensitization, advocacy and social mobilization. It has helped in the prevention of HIV/AIDS and issues of stigma and discrimination related to people living with HIV/AIDS. The SAARC prize on HIV/AIDS and TB has been awarded to two distinguish persons who had done exemplary work towards the control of TB and HIV/AIDS in the SAARC Region. SAARC exposure visit to observe the best practices on TB and HIV/AIDS in the member countries has provided knowledge about the best practice used to these diseases. Commemoration of World TB Day and SAARC TB Day and World AIDS Day has become pivotal activity of advocacy, communication and social mobilization.

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. This strategy will be implemented for a period of five years (2018-2023).

I would like to express my heartfelt thanks to H.E. Secretary General, South Asian Association for Regional Cooperation (SAARC), the Governing Board Members, Programme Managers, National TB and HIV/AIDS Control Programmes, Ministries of Foreign/External Affairs, Member States of SAARC and different partners for their support, coordination & contribution for the preparation of this document. I am thankful to Dr. R.P. Bicha, Former Director and Dr. A.P. Weerakoon, Epidemiologist for their contribution while preparing this document.

Dr. R.P. Pant
Director

# ABBREVIATIONS

| | |
|---|---|
| **ACSM** | Advocacy, Communication and Social Mobilization |
| **AIDS** | Acquired Immune-Deficiency Syndrome |
| **ART** | Anti Retroviral Therapy |
| **ARV** | Antiretroviral |
| **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 |
| **DTC** | District Tuberculosis Centre |
| **FSW** | Female Sex Worker |
| **IAS** | International AIDS Society |
| **ICAAP** | International Congress on AIDS in Asia and the Pacific |
| **IEC** | Information, Education, Communication |
| **IPC** | Inter- Personal Communication |
| **IDUs** | Injectable Drug Users |
| **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 |
| **MDG** | Millennium Development Goal |
| **MSM** | Men having Sex with Men |
| **NACPs** | National AIDS Control Programme of Member Countries |
| **NCASC** | National Centre for AIDS and STD Control |
| **NGO** | Non Governmental Organization |
| **NPHL** | National Public Health Laboratory |
| **NTRL** | National TB Reference Laboratory |
| **NTP** | National TB Control Programme |
| **PMTCT** | Prevention of Mother-to-Child Transmission |
| **PLHIV** | People Living with HIV |
| **PLWHA** | People Living with HIV/AID |
| **PPM** | Public Private Mix |

| | |
|---|---|
| **RNTCP** | Revised National TB Control Programme |
| **SHG** | Self Help Groups |
| **SAARC** | South Asian Association for Regional Cooperation |
| **SDC** | Sexually Transmitted Diseases |
| **SDG** | Sustainable Development Goal |
| **STAC** | SAARC Tuberculosis and HIV/AIDS Centre |
| **UHC** | Universal Health Coverage |
| **UNAIDS** | United Nations Programme on HIV and AIDS |
| **USAID** | United States Agency for International Development |
| **WHO** | World Health organization |

# CHAPTER I

## Background of Regional TB Epidemiology & HIV/AIDS Role of STAC

This chapter briefly discusses the TB & HIV/AIDS scenario in SAARC Region and the SAARC TB & HIV/AIDS Center that was launched in 1994 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 Members States.

### 1.1 Scenario of TB in SAARC Region:

The estimated population of SAARC region in the year 2016 was 1.76 billion which is 24% of the Global Population. In 2016, there were 3.7 million estimated incidences of TB cases, which carried 36% of global burden of TB diseases. The estimated deaths due to TB in the region was 0.5 million, which is 31% of global deaths due to TB. Three out of eight Member States in the SAARC Region are high TB and MDR-TB burden countries among 30 high burden countries. India alone accounts for 31% of the world's Global TB deaths.

A total 2.6 million TB cases were notified in 2016 in the SAARC region. It shows that 77 % treatment success rate among 2.4 million total new and relapse cases. A remarkable progress has been made for DOTS since its inception in 1993 in this SAARC Region. All Member States started DOTS strategy for TB control in 1997. Its coverage within the SAARC region has steadily increased since 2000. Population coverage in 1997 was 11%. Since then it has increased and reached 99% in 2006 and from 2007 it is 100%. The treatment success rate for new smear positive cases is 77% in the SAARC Region. Regarding the treatment success rate, WHO target was achieved in 2005.

The SAARC region in 2016, had 1,06,918 total number of an estimated MDR/RR-TB cases among notified pulmonary TB cases. Laboratory confirmed cases in the same year were 43,243 MDR/RR-TB cases and 3003 XDR-TB cases. However,

37,322 MDR/RR-TB and 2576 XDR-TB patients started the treatment. In 2016, the region had 4,0255 TB patients with known HIV status and among them 39,506 (98%) were on Antiretroviral Therapy (ART). India accounts to 39,815 TB patients with known HIV status and among them 98% patients are on ART. However Afghanistan and Maldives have provided 100% ART to TB patients with known HIV status in this region. Around 29% Children (age<5) household contract of bacteriological-confirmed TB cases are on Isoniazid treatment in the SAARC region.

## 1.2 Scenario of HIV/AIDS in SAARC Region:

HIV/AIDS continues to be a major public health problem in the SAARC Region. All eight Member States of the SAARC region are designated as low prevalence countries. On the basis of latest available information this region is home for an estimated number of 2.28 million HIV infected people and 0.07 million AIDS deaths in 2016. Three countries namely India, Nepal and Pakistan account for majority of the regional burden. The first HIV infected persons were diagnosed in 1986 in India and Pakistan. By 1993, all SAARC Member States had reported the existence of HIV infection in their countries.

The overall adult HIV prevalence in SAARC region remains below 1%. However, there are important variations existing between countries. Of the estimated number of 2.28 million PLHIV in SAARC region, 2.1 million are living in India. Progressing towards 90-90-90 targets in the SAARC Region, there are 49% of people living with HIV knew their status and from them 53% of people who knew their status are on ART. 80% of people on ART achieved viral suppression in the year 2016. Country wise estimated size of populations in key populations for HIV has shown that India accounted for highest in size of populations among Sex Worker (SW), and people who inject drugs and prisoners. However, Pakistan accounted for highest in size of populations among Men who have sex with men (MSM) and Transgender.

Elimination of Mother to child transmission of HIV in the SAARC Region, there are 37,500 pregnant women needing ARV for PMTCT. About one million people are receiving ART in year 2016 and 80,200 deaths were averted due to ART in 2015. Nepal has covered 64% of ART which is the highest among the SAARC Member States.

***Scenario of HIV/AIDS in SAARC Region***

| *Country* | *Popula-tion('000)*** | *Estimated No. of PLHA* | *HIV Prevalence Rate (%)* | *Estimated New HIV infection in 2016(all ages)* | *HIV Incidence per 1000 population* | AIDS- related Deaths |
|---|---|---|---|---|---|---|
| **Afghanistan** | 35000 | 7500 | < 0.1 | < 1000 | 0.03 | <500 |
| **Bangladesh** | 163000 | 12000 | < 0.1 | 1500 | <0.01 | 1000 |
| **Bhutan** | 802 | N/A | N/A | N/A | NA | NA |
| **India** | 1324000 | 2.1 million | 0.3 | 80000 | NA | 62000 |
| **Maldives** | 379 | N/A | N/A | N/A | NA | NA |
| **Nepal** | 29000 | 32000 | 0.2 | <1000 | 0.03 | 1700 |
| **Pakistan** | 193000 | 130000 | 0.1 | 19000 | 0.1 | 5500 |
| **Sri- Lanka** | 21000 | 4000 | < 0.1 | < 1000 | 0.03 | <200 |
| **Regional** | **1.76 Billion** | **2.28 million** | | **0.1 million** | | **0.07 million** |

*Source: HIV/AIDS SAARC Region, Updates 2017*

## 1.3 Introduction of SAATC TB & HIV/AIDS Centre (STAC) :

SAARC Tuberculosis and HIV/AIDS Centre (STAC) is one of the Regional Centres of SAARC working for prevention and control of TB and HIV/AIDS in the Region by coordinating the efforts of the National TB Control Programmes (NTPs) and National AIDS Control Programmes (NACPs) of Member Countries.

The Second Meeting of the Foreign Ministers of SAARC Member Countries held at Male in July 1984 suggested for formulation of specific projects pertaining to one of the five disease control areas identified by working group of health & population activities

Accordingly, a proposal for establishment of the SAARC TB Centre in Nepal was submitted. The Technical Committee at its eighth meeting held in Colombo from 16 - 18th July 1990 considered the proposal. The Standing Committee at its thirteenth session held at Male from 16 - 17th November 1990 decided that a revised proposal on the regional centre for Tuberculosis be prepared by Nepal.

The Heads of State or Government of Member Countries of SAARC at their Fifth Summit held in Male from 22 - 23rd November 1990 decided that SAARC Tuberculosis Centre would be set up in Nepal. Accordingly the SAARC TB Centre established in 1992 and started its functioning since 1994.

Considering the efficiency and appreciating the efforts and activities related to work on TB and TB/HIV Co-infection and HIV/AIDS done by the Centre, the Meeting of Thirty-first Session of Standing Committee of SAARC held in Dhaka on 9-10th November, 2005 approved the renaming of the Centre as SAARC Tuberculosis and HIV/AIDS Centre (STAC).

**Vision:** SAARC TB and HIV/AIDS Centre (STAC) be the leading institute to support and guide SAARC Member States to make the region free of TB and HIV/AIDS.

**Mission:** To support the efforts of National TB and HIV/AIDS Control Programmes through evidence based policy guidance, coordination and technical support.

**Goal:** To minimize the mortality and morbidity due to TB and HIV/AIDS in the region and to minimize the transmission of both infections until TB and HIV/AIDS cease to be major public health problems in the SAARC Region

## 1.4 Achievements of TB/HIV/AIDS Control in SAARC Region

1. Overall SAARC region has achieved MDG in all three Tuberculosis related indicators namely incidence, prevalence and mortality in 2015.
2. All SAARC member states have achieved WHO Tuberculosis targets of 70% case detection rate and 85% treatment success rate in 2005 and maintain till date.
3. All SAARC member states have achieved 100% DOTS coverage in 2007 and maintain till date.
4. Quality assurance of sputum microscopy of National TB Reference laboratories (NTRL) in SAARC member states has been assessed by STAC every year and results show that almost all NTRLs in SAARC member states have been shown very good performance in external quality assurance for sputum smear microscopy.
5. New infections of HIV have diminished by 57% in India and treatment access has increased from a few hundreds to over 0.98 million since 2001 in the region.
6. Anti Retroviral Treatment for HIV/AIDS averted approximately 170,000 deaths from AIDS between 2000 and 2015 in SAARC Region.
7. All SAARC member states have been committed to provide care and support to people living with HIV/AIDS by establishing appropriate policies.

## 1.5 Role of STAC on 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 Region
2. To provide technical assistance/ expertise to member countries 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 and TB/HIV Co-infection.
5. To document and share best practices at the region level and provide platform for learning from experience of others to improve the quality and effectiveness of ACSM interventions in the member countries.

## 1.6 Opportunities for STAC :

1. STAC has mandate to build capacities of the member countries by providing training and extending technical support to strengthen ACSM component for monitoring and research
2. STAC has existing mechanism for sharing material (newsletter), website which can be used for sharing communication material and tools and innovations
3. STAC has existing platform for coordination and collaboration, sharing expertise, experience and good/ best practices
4. STAC has regional level parliamentarian meetings which can help to mobilize policy/law makers for advocacy activities and increase visibility in respective countries
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 TB and Cross border TB and HIV policy

# CHAPTER – II

# ACSM- Rationale and Context

## 2.1. Rationale

Advocacy, Communication and Social Mobilization (ACSM) are an integral part of TB & HIV/AIDS prevention and care activities. They highlight and bring to focus on key areas that are essential to control TB & HIV/AIDS; garner political commitment and mobilize resources required for these key areas through collaborative approaches; increased awareness about the diseases and the visibility of available services; and empower communities to be a partner, play a decision-making role and monitor the quality of services that they ultimately receive.

Member States in the Region have varied requirements and priorities, and specific national plans therefore need to be developed within the agreed framework. This 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.

Although distinct from one another, Advocacy, Communication and Social Mobilization (ACSM) are most effective when used together.

The distinct feature of ACSM strategy is as follows;

**Advocacy** seeks to ensure that there is strong political commitment towards ensuring public health safety in the South Asia Region through collective action by all member states. Through advocacy, the SAARC Tuberculosis and HIV/AIDS Center (STAC) intend to connect with the member states and the varied stakeholders to garner their support and collaboration.

- Policy advocacy intend to inform the politicians and administrators on the issues related to public health security in the region and need for collective action to end AIDS & TB in the region. Programme advocacy informs the opinion leaders at the community level on the need for local action towards prevention and control of HIV/AIDS & TB.

- Media advocacy validates the relevance of the subject, puts issues on the public agenda, and encourages the media to cover TB/HIV/AIDS -related topics regularly and in a responsible manner so as to raise awareness of problems and possible solutions.

**Communication** aims to favorably change knowledge, attitudes, behaviours, and practices among various audiences.

**Social Mobilization** brings together community members and other stakeholders to strengthen community participation for sustainability and self-reliance.

## 2.2. ACSM and TB Control:

ACSM is an important component of the TB control strategy and is necessary to ensure long term and sustained impact. To achieve universal access to TB care, it is critical to design and implement issue based region and audience specific ACSM initiatives.

The key objective of ACSM in TB control is to garner political commitment towards sustaining TB control interventions at the country level, generate demand for quality TB diagnosis and treatment and increase treatment adherence, leading to cure of all forms TB. ACSM helps to improve health communication by bringing about awareness and changes in health perceptions and health seeking behaviors.

***Table 1: Advocacy, communication and social mobilization support for the three pillars of End TB Strategy;***

| No. | Pillars of End TB Strategy | Advocacy | Communication | Social Mobilization |
|---|---|---|---|---|
| 1 | Integrated, patient centered care and prevention. | Enhanced political commitment to ensure early diagnosis, treatment and prevention of TB. | Policy advocacy for universal access to TB diagnosis and treatment. | TB control prioritization by community leaders. |

| No. | Pillars of End TB Strategy | Advocacy | Communication | Social Mobilization |
|---|---|---|---|---|
| 2 | Bold Policies and supportive system. | Adequate resource allocation for systems strengthening. | Strengthened health and social sector policies and systems to prevent and end TB. | Continued engagement of community members and CSOs in the planning and implementation of end TB interventions. |
| 3 | Intensified Research & Innovation. | Increased resource allocation for scientific research and new discoveries. | Intensification of research activities to break the trajectory of the epidemic and reach the global targets. | Attract and encourage researchers and academia to undertake more research. |

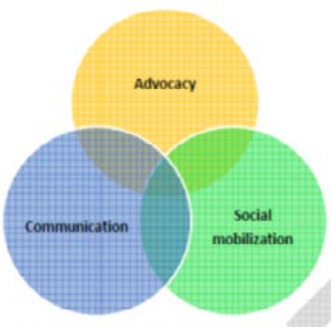
## 2.3. ACSM and HIV/AIDS Prevention:

Globally, there is consensus that the countries need to fast track its response to end AIDS epidemic by 2030 in line with Sustainable Development Goal #3. The fast track targets of 90-90-90 by 2020 and 95-95-95 by 2030 forms basis for the countries to align the national targets in the prevention and control of HIV/AIDS. Improved case detection, early enrollment on ARV treatment and retention on care to achieve viral load suppression are some of the key strategies to end AIDS epidemic. Therefore the ACSM play vital role in garnering political commitment to ensure universal access to HIV prevention and treatment services, and improve the life of the People living with HIV/AIDS through improved treatment outcome. The ACSM for HIV/AIDS prevention programme also emphasizes on community involvement in the prevention and control of HIV/AIDS in the region.

*Table 2: Advocacy, communication and social mobilization support for Fast Tracking Response to End AIDS by 2030.*

| No. | Components under Fast track response. | Advocacy | Communication | Social Mobilization |
|---|---|---|---|---|
| 1 | 90% of the People Living with HIV/AIDS should know their HIV status. | Improved political commitment and resource allocation to strengthen HIV diagnostic services. | Promotion of HIV testing through community led HIV testing services. | Community engagement to carry out outreach and inreach HIV prevention programmes. |
| 2 | 90% of the People Diagnosed with HIV/AIDS should be put on ARV treatment. | Adequate resource allocation to provide uninterrupted free ARV medication for all people living with HIV/AIDS./ | Increased awareness HIV/AIDS and advantage of ARV medication and its shortfalls. | Community involvement in providing HIV/ AIDS treatment services including, contact tracing and default retrieval. |
| 3 | 90% of PLHIV on treatment retained on treatment leading to undetectable viral load. | Political commitment to ensure accessibility to viral load testing. | Improved knowledge on ARV therapy and importance of adherence. | Community empowerment and demand generation for quality services. |

Figure 1: ACSM is interlinked




Source: PATH training curriculum on advocacy, communication, and social mobilization[10]

# CHAPTER- III

## ACSM- Concept and Strategy

### 3.1 Vision

Ensuring equitable access to quality diagnosis, treatment and care for all HIV/AIDS and TB clients.

### 3.2 Mission

improving the quality of the life of People living with HIV/AIDS and those infected by TB through improved access to prevention and care.

### 3.3 Goal

Strengthened planning, implementation and monitoring of ACSM activities in the Region, leading to adequate resource availability, enhanced awareness of all stakeholders and development of patient support structures within communities.

### 3.4 Objectives

- To contribute to the implementation of the Ending TB & HIV/AIDS as integral part of related activities and catalyse achievement of the SDG goal by 2030.
- To broadbase ACSM activities: active participation from all stakeholders including community representatives to maximize synergies.
- To strengthen ACSM capacity in the Region.

**The Objectives specific to components are:**
**Advocacy;**

- To enhance political commitment to fully implementing the Fast track response to End AIDS and End TB strategy.
- To mobilize domestic and external resources for HIV/AIDS & TB Control.

**Communication:**

- To strengthen communication for appropriate awareness generation regarding HIV/AIDS & TB prevention, care and treatment and to reduce stigma.

**Social Mobilization:**

- To empower communities to play a greater, decisive role in the prevention and control of HIV/AIDS & TB.

## 3.5 Guiding Principles:

The regional ACSM framework in developed in the spirit of supporting the high level political declarations and resolutions from the World Health Assembly, following are the guiding principles;

1. Sustainable Goal 3.3 "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases".
2. 2016 United Nations political declaration on Ending AIDS , "Fast-track to end the epidemic by 2030".
3. Global End TB Strategy endorsed by World Health Assembly, comprising of 194 member states in 2014.
4. Delhi Call for Action to End TB in the South-East Asia Region by 2030, adopted during the Ministerial Meeting held in New Delhi, 15-16 March, 2017.
5. Moscow Declaration (November, 2017); Global Ministerial Conference on Ending TB in the Sustainable Development Era.

## 3.6 ACSM Strategic Directions:

ACSM is the cross cutting subject, hence the involvement of multi-stakeholder is crucial in terms of effectively implementing the ACSM activities targeted towards prevention and control of HIV/AIDS & TB in the region. The following table 3 highlights some of the key strategic directions to guide the ACSM activities in the region.

*Table 3; ACSM Strategic directions;*

| Sl. | Components | Strategic Directions; |
|---|---|---|
| 1 | Advocacy | 1) Addressing programme policy gaps through sustained, year round advocacy activities.<br>2) Resource mapping and mobilization for TB & HIV/AIDS control to meet programme needs in various countries.<br>3) Innovative and context-specific advocacy messages.<br>4) Joint monitoring of the programme by community representatives to increase accountability to those served.<br>5) Including human rights as an item in advocacy activities, with a specific focus on unreached, marginalized and vulnerable populations.<br>6) Strengthening collaboration between various stakeholders and multiple sectors at regional and country level. |
| 2 | Communication | 1) Identifying and using opportunities for message delivery, which would include specific events accompanied by regular, synchronized mass media campaigns, community media and Regional Framework for Advocacy, Communication and Social Mobilization and IPC.<br>2) Gaining media attention for TB and HIV/AIDS control initiatives, as media has important role to play in dissemination of messages.<br>3) Using community media approaches such as citizen journalism or participatory radio programmes. While more complex, these can be very effective for facilitating participation and community empowerment.<br>4) Strengthening Interpersonal communication (IPC) by health staff—an important component of communication at the point of health care delivery and for ensuring patient adherence.<br>5) Raising awareness regarding newer challenges through various academic and social forums and groups.<br>6) Documentation and dissemination of data on available human resources and infrastructure vis-à-vis requirements. This will support communication on systems strengthening.<br>7) Identifying and involving socially influential personalities and opinion leaders for message dissemination. |

| Sl. | Components | Strategic Directions; |
|---|---|---|
| 3 | Social Mobilization | 1) Continuous dialogue between National programmes, stakeholders and community is the first step in getting the community's perspective on TB & HIV/AIDS care services and how to improve them. Continuous participation by the community will enhance its role in planning, implementation and monitoring of TB & HIV/AIDS care and control services, which will eventually build trust between the programme and recipients of services.<br>2) Involving community in policy and decision-making, service provision and monitoring of services.<br>3) Strengthening linkages with community groups involved in TB & HIV/AIDS care, and involvement of various community groups, Self Help Groups and groups of people living with Living with HIV/AIDS.<br>4) Community mobilization by increasing knowledge on HIV/AIDS, TB-HIV, MDR-TB and XDR-TB.<br>5) Strengthening community resources through trainings and capacity building.<br>6) Community monitoring systems on sale of TB drugs from pharmacies and availability of over-the-counter drugs and nonstandard regimens.<br>7) Continuous dialogue and interaction with community representatives so that members contribute to policy issues and discussions.<br>8) Community empowerment for research and community-led innovation in research. |

## 3.7 Target audience for ACSM Framework:

Based on the identified barriers and challenges before the program, identify the target audience(s) for ACSM. Table 4 presents some examples of the target audience for ACSM activities.

*Table 4; ACSM target audience;*

| Components of ACSM | Target Audience |
|---|---|
| Advocacy | • Decision-makers at national, regional, and district levels.<br>• Policy-makers<br>• Professional groups /Researchers/Academia<br>• Donors<br>• Media Agencies |
| Communication | • General public, including different vulnerable groups, health care workers.<br>• TB patients currently on treatment as well as cured TB patients<br>• Contacts of patients with active TB<br>• People at high risk of developing TB |
| Social Mobilization | • Communities<br>• Community groups<br>• National and local level leaders<br>• Local NGOs, youth organizations, CBOs |

# CHAPTER IV

# ACSM- Planning, Implementation & Monitoring

## 4.1 Planning:

### Step 1: Situation analysis

Analyze in detail the causes/reasons for a program challenge, for example, poor case detection.

There could be several possible reasons, such as:

- Lack of awareness
- Poor knowledge of TB symptoms
- Poor risk perception
- Misconceptions about costs
- Faith in non-DOTS treatment
- No nearby testing facility

### STEP 2: Audience segmentation, prioritizing, and profiling

- Segmenting divides and organizes populations into smaller groups or audiences with similar communication-related needs, preferences, and characteristics.
- Prioritizing helps to determine what audiences we should focus on.
- Profiling or describing allows us to imagine what the audience looks like and what its communication needs could be by personalizing audience members.

Identify the specific target audiences that need to be addressed to remove the causes/reasons that are hindering program objectives. Target audiences could include:

- General public
- Specific community/groups
- TB/HIV patients
- DOTS Health service providers

**STEP 3: Developing ACSM objectives**

Once situational analysis and audience segmentation has been completed, developing and defining communication objectives will provide direction and answers to the following questions:

1. What do we want our audience/target group to change?
2. Why is it not already happening (that is, what are the barriers)?
3. Which of the barriers will be addressed by communication?

**STEP 4: Defining the strategic approach**

Now is the time to decide on the approach that needs to be followed to reach the intended audience and effectively address program challenge(s). Make a decision on whether advocacy will be more appropriate or use of mass media/ mid-media channels of communication will be more cost effective or social/ community mobilization will better address program issues.

**STEP 5: Selection of channels**

Having identified the reasons and target audiences for ACSM intervention, we need to select the most appropriate and cost-effective media/channels of communication to reach the audience with the communication messages. Addressing each of the program challenges requires different audiences to be targeted with appropriate messages, using an appropriate approach and appropriate channels of communication.

**Select the appropriate media/channels to achieve your communication objectives by keeping in mind the following points:**

- Generally, mass media are more effective for creating mass awareness over a large area, say national/state level.
- Mid-media work well for local areas like district, block, or community level.
- IPC is generally more effective for education, motivation, and behavior change.

Channels of communication that could address context-based issues for specific audiences need to be carefully selected on the basis of channels' 'strengths' and 'weaknesses'.

**STEP 6: Creating and messaging**

A scientific approach should be employed in creation and design of communication messages. Ensure that communication messages are developed with initial concept testing, message designing, and pre-testing. All these processes and steps involve proper research to address the actual need of the population. All the important principles of communication should be followed while designing communication messages.

## 4.2 ACSM implementation

Quality implementation of ACSM activities requires preparedness and attention to all aspects/arrangements. Every planned activity requires preparation and arrangement before execution, be it a simple activity like organizing a meeting with the members before preparation and arrangements for World TB Day.

**Developing and Pre-Testing Concepts, Messages, Materials & Activities:**

**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.

## 4.3 Monitoring & Evaluation and Research

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 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 need 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 Implementation at the Regional, Country level clearly understand and appreciate the difference between Monitoring and Evaluation and identify indicators at the planning stage itself.

The Monitoring and Evaluation framework will be adopted by all implementing partners, i.e., ACSM Unit of NTP and 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 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 understand and collect data regularly.

## 4.4 Theoretical Framework for Monitoring and Evaluation Indicators

| | |
|---|---|
| **INPUTS**<br>Program inputs refer to the set of resources: | 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/program.<br><br>The monitoring of inputs through devising measurable indicators is the first step of M&E |
| **PROCESSES/ ACTIVITIES**<br>Program processes refer to the set of activities in which program inputs are utilized in pursuit of the results expected from the program. | Refers to the different steps in the implementation of projects/programs. It refers primarily to the fact that the activities are actually happening or not. |
| **OUTPUTS**<br>Program outputs are the results obtained at the program level through the execution of activities using program resources**.** | The immediate results of the activities conducted. Outputs are most often expressed for each activity separately.<br>Examples:<br>• the number (or proportion) of people reached through behavior change activities,<br>• the number (or proportion) of PFP trained<br>• the number of TB/ HIV patients diagnosed treated,<br>• the number of health staff trained for IPC |

| | |
|---|---|
| **OUTCOMES**<br>Progress outcomes are the set of results expected to occur at the population level due to program activities and the generation of program outputs. | The medium term results of one or several activities. Outcomes are therefore, mostly expressed for a set of activities.<br>They often require separate surveys (KAP) to be measured.<br>Examples:<br>• the proportion of target population that is right information about symptoms of TB/ HIV,<br>• the proportion of target clinical staff that has adequate tools and resources for detection of TB and HIV/ AIDS ,<br>• the proportion target population that received DOT/ ART |
| **IMPACT**<br>What and how much change occurred at the program or population level that is attributable to the program | 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.<br>Examples:<br>• decrease in the incidence or prevalence of TB/ HIV;<br>• reduced mortality rate due to TB and HIV,<br>• Increased contribution of non-government partners in HIV and TB and HIV/AIDS care and control.<br>• 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. |

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 diagnosis and treatment
- Percentage of community/ migrant have basic information on HIV and AIDS
- Improvement in referral linkages health services

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

## 4.5 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 evidenced based work plans
- Enhanced capacity/ skills for developing monitoring indicators
- Increase number of KAP studies / OR on ACSM

Each Member Country 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.

# ANNEXURE 1: Outcome and findings from the first SAARC ACSM Strategy (2013-2017)

The first SAARC Regional on Strategy Advocacy, Communication and Social Mobilization was developed in 2012 and implemented from 2013-2017. Following are the desk review findings from the implementation of 1st ACSM strategy;

1) Participation in the sixth meeting of the SAARC Ministers of Health and preceding meeting of Senior Officials in Colombo, Sri Lanka, 27-29th July 2017. Hon'ble Minister of Health, Nutrition and Indigenous Medicine of Sri Lanka pointed out that non-communicable diseases, malnutrition and tuberculosis are identified as major health issues faced by the people of South Asia. He shared Sri Lanka experience in curbing the increase in non-communicable diseases and highlighted the importance of universal access to education and the empowerment of women. STAC Director interacted with the Senior Officials regarding the progress, challenges and future plan of STAC.

2) SAARC exposure visit to observe the best practices on Tuberculosis in India from 4-8th December 2017 was participated by member countries from Bangladesh, Bhutan, India, Maldives and Sri Lanka. The participants visited different places like RNTCP, Central TB Division and Delhi TB Centre as per the exposure visit to observe the best practices on TB in India.

3) SAARC exposure visit to observe the best practices on HIV/AIDS in Nepal from 11-15th September 2017 was participated by member countries from Afghanistan, Bangladesh, Nepal and Sri Lanka. The Participants visited different places like National Centre for AIDS and STD Control (NCASC), National Public Health Laboratory (NPHL), Sparsh Nepal, Dhulikhel Community Hospital, Bhaktapur Hospital and Youth Vision Nepal. The team also made a courtesy call visit to the H.E. the Secretary General - SAARC

4) The SAARC Goodwill Ambassador for HIV/AIDS is an honorary title which has been conferred to MS. Runa Laila (Bangladesh), Shree Ajay Devgan (India) and Ms. Sharmeen Obaid-Chinoy (Pakistan) on 2nd January 2013 for two years. The objective of the Goodwill Ambassador programme was to facilitate the SAARC Regional Strategy on HIV/AIDS work plan. Ms. Runa Laila, SAARC Goodwill Ambassador made an official visit to India on 31-3 August 2013 to extend support on the prevention of HIV/AIDS and issues of stigma and discrimination related to people living with HIV/AIDS (PLHIV).

5) Shree Ajay Devgan, SAARC Goodwill Ambassador for HIV/AIDS was involved in the programme for country level sensitization, advocacy and social mobilization on HIV/AIDS and TB in India on 12 January 2015 was involved in National Youth Day Programme in Mumbai, India. Shree Ajay Devgan would contribute towards creating awareness on HIV/AIDS through public appearances and support the National Youth Day theme **'hum se hai nayi shuruwaat'**.

6) SAARC prize on HIV/AIDS 2012 was handed to Mr. Tshewang Nidup of Bhutan by Hon'ble Minister of Health Zangley Dukpa for his exemplary work towards the control and prevention of HIV/AIDS.

7) SAARC prize on Tuberculosis 2015 was handed to Ms. Shameema Hussain of Maldives by Hon'ble Minister of Health for her remarkable contribution in control of Tuberculosis.

8) Review, Coordination Meeting and Sharing of Best Practices with Authorities of Ministry of Health, National TB and HIV/AIDS Control Programmes & SAARC Regional Centre's in Member States as directed the Governing Board STAC visited Afghanistan from 26th to 29th May 2013 and Sri Lanka from 11th to 12th June 2013. The objective of the programme was to share/exchange the ideas, new updates for the control of TB and HIV/AIDS

9) SAARC Regional Training on Leadership & Strategic Management for Tuberculosis & HIV/ AIDS Control programmes, Maldives was organized by STAC with Ministry of Health, Maldives from 6-10 June 2013, Male. The objective of the programme was to strengthen the collaboration and coordination among TB and HIV/AIDS Control programmes

10) SAARC Regional Training on Management Information for Action (MIFA) for Tuberculosis & HIV/AIDS Control Programmes, Sri Lanka was organized by STAC in Colombo, Sri Lanka from 13-17 June 2013. The objectives of the training programme were to support the Member States of TB and HIV/ AIDS control programmes through improving the knowledge and skills of Data Management on TB and HIV/AIDS and to assist Member States in review of their epidemiological data.

11) SAARC Workshop on Experiences and Best Practices on Pediatric TB/TB-Diabetes, Sri Lanka was organized by STAC from 14- 16 July 2014. The objectives of the workshop were to discuss/share the information and data on Child TB and TB-diabetes in the Member States as well as to discuss on the best practices of NTPs for management of diseases & its challenges.

12) SAARC Regional Training on Leadership & Strategic Management for Tuberculosis & HIV/AIDS Control Programmes, Maldives was jointly organized by STAC, NTP and NACP of Maldives from 6-10 November 2014, Male. The Objectives of the Training were to enhance the existing understanding, knowledge & skills on Leadership & Strategic Management among National/Regional/District level Programme Managers of National TB & HIV/AIDS Control Programmes and to scale-up and strengthen the TB & HIV/AIDS prevention & control activities.

13) SAARC Regional Meeting of the Programme Managers of NTPs and NACPs of Member States, Bhutan was organized by STAC from 5-6 December 2014. The objectives of the meeting were to share the achievements, experiences and challenges and to discuss the progress on TB and HIV/ AIDS in the SAARC Member States.

14) SAARC Regional Training on MDR & XDR TB on Clinical and Programmatic Management, Bangladesh jointly organized by STAC and NTP Bangladesh from 11-15 December 2015. The Objectives of the training was to update global/regional MDR/XDR and principles of MDR TB control Programme

15) Workshop on Piloting the SAARC Regional Pediatric Tuberculosis Guidelines and Training of Trainers (ToT) Manual was organized by STAC in Dhulikhel, Kavrepalanchowk, Nepal from 5 - 6 September 2016. The objective of the workshop was piloting of the Pediatric TB Guidelines and ToT Manual as well as to build the capacity of health workers on management of Pediatric TB at their work station.

16) SAARC Expert Group Meeting to finalize the SAARC Regional Strategy on HIV/AIDS 2013-2017 was held in Thimphu, Bhutan from 5-6 March 2013 in collaboration with UNAIDS. The objective of the meeting was to finalize the SAARC Regional Strategy on HIV/AIDS (2013-2017).

17) SAARC Regional Meeting of the Programme Managers of National TB and HIV/AIDS Control Programmes was organized by STAC in Thimphu, Bhutan from 5 - 6 December 2014. The objectives of the meeting were to share the achievements, experiences and challenges and to discuss the progress the outcome of the meeting was that STAC should develop strategy, guidelines SOPs and formats etc. to address the cross border issues for prevention and control of TB and HIV/AIDS in the region.

18) SAARC Meeting of National Programme Managers on TB and HIV/AIDS along with the meeting of Heads of National TB Reference Laboratories of Member States was held in Kathmandu from 30th September to 2nd October 2015. The objectives of the meeting was to share the achievements, experience, innovations and challenges in NTPs, NACPs and National Reference Laboratories

19) SAARC Regional Meeting of Programme Managers and Cross Border Issues on TB and HIV/AIDS Control Programmes was held in Thimphu, Bhutan on 29-31 May, 2017.The objectives of the meeting was to share

the achievements, experiences and innovations on TB and HIV/AIDS by the SAARC Member States and learn from best practices.

20) SAARC Exposure Visit to Observe the Best Practices on HIV/AIDS in Nepal was jointly organized by SAARC TB and HIV/AIDS Centre (STAC), Nepal and National Centre for AIDS and STD Control (NCASC) Nepal from 11-15 September 2017. Participants from different member states were in involve on that visit.

21) SAARC Regional Training on Leadership & Strategic Management for Tuberculosis & HIV/AIDS Control Programme was organized jointly by SAARC TB and HIV/AIDS Centre, Nepal and National Tuberculosis Control Programme and National HIV/AIDS Control Programme of Government of Maldives from 6th to 10th November 2014 in Male.

22) **Participation in 20th International AIDS Conference, Melbourne, Australia:**

The International AIDS Society (IAS) hosted 20th International AIDS Conference in Melbourne; Australia Convention Centre dated 20th to 25th July 2014. A range of organizations, researcher and policy makers were participated highlighting their specific activates and priorities before, during and after the conference. The theme of stepping up the pace recognize that we are at a critical time and we need to capture the optimism that has recently and build on it to ensure that HIV remains on top of the global agenda.

23) **Participation in Regional Consultation Meeting on HIV and Universal Health Coverage (UHC):**

Director, SAARC TB and HIV/AIDS Centre, Nepal participated in a consultation meeting organized by WHO/SEARO, New Delhi from 1- 3 June 2015. Recognizing the need for a framework to address the HIV epidemic in the context of universal health coverage and post - 2015 sustainable development agenda, the World Health Organization (WHO) Regional

Office for South - East Asia convened a meeting for Member States. The key objectives of the meeting were to discuss the contribution of the HIV response to UHC and the opportunities to use the UHC framework in strengthening the HIV response that will set the course for ending the HIV epidemic in the South-East Asia region by 2030.

24) **Regional partners meeting on Adolescents, Bangladesh, 2015:**

SAARC TB and HIV/AIDS Centre assigned Research Officer to participate in the Regional partners' Meeting on HIV and AIDS among Young Key Affected Populations in South Asia held in Dhaka, Bangladesh from 11-13 May, 2015 organized by UNICEF Regional Office for South Asia. The objective of the meeting was to bring together national counterparts, key stakeholders and UN colleagues to take forward the all in agenda and catalyze efforts around ending the AIDS epidemic among adolescents in South Asia.

25) **Participation in IAS 2015, Vancouver, Canada:**

Director, STAC participated in the 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention at the Vancouver Convention Centre held from 19- 22 July 2015 in Vancouver, British Columbia, Canada with the objective to share the experiences with the international communities. Director STAC shared the experiences and challenges revealed during the implementation of the HIV and AIDS programme in the SAARC Region with the international HIV/AIDS experts attending the conference.

26) **12th International Congress on AIDS in Asia and the Pacific (ICAAP l2) 12th – 14th March, 2016, Dhaka Bangladesh:**

Director, STAC participated in the 12th International Congress on AIDS in Asia and the Pacific (ICAAP l2), Dhaka, Bangladesh on 12 – 14 March 2016. The visit was performed at the invitation of UNICEF/ROSA. The STAC has the aim to disseminate new research findings and achievements by

participating in the Regional Conferences in the Member States as well as in other countries.

27) **Participation in Sixth Meeting of the SAARC Ministers of Health and preceding Meeting of Senior Officials, Colombo, Sri Lanka:**

Participation in the Sixth Meeting of the SAARC Ministers of Health and preceding Meeting of Senior Officials organized in Colombo, Sri Lanka from 27th to 29th July 2017.

28) **Commemoration of World TB Day/SAARC TB Day:**

The World TB Day is observed on 24 March each year to create awareness about the threat posed by the disease to public health and to advocate global campaign against its spread. One cannot overemphasize the significance of the Day in the view of the fact that TB continues to remain a major public health challenge across the world, even while it is preventable and curable.

The post-2015 End TB Strategy envisions a world free of tuberculosis-zero deaths, disease and suffering due to tuberculosis, with the aim of ending the global tuberculosis epidemic by 2035. In this backdrop, observation of the World TB Day each year is a welcome opportunity to mobilize political and social commitment towards eliminating TB, which is a public health burden globally.

In this connection STAC has been organizing partnership programmes with the nursing colleges on advocacy and awareness on Tuberculosis. The objectives of the programme was to make school students aware about situation of TB & HIV/AIDS, its spread and social & economic impact on individual, family and community along with the responsibility of students for the prevention to tuberculosis. Others ACSM activities such as publication of the H.E. Secretary General, SAARC message in the newspaper on the occasion of World TB Day/SAARC TB Day, participation

in joint programme organized by NTP, Nepal and preparation of hoarding board, exhibition and awareness materials are some the important activities conducted in this occasion.

29) **Commemoration of World AIDS Day**

The World AIDS Day is commemorated on 1st December every year to raise awareness about HIV & AIDS and to demonstrate international solidarity in the face of the epidemic. The day is an opportunity for public and private partners to disseminate information about the status of the epidemic and to encourage progress in HIV & AIDS prevention, treatment, care and support around the world, particularly in high prevalence countries.

In connection to the commemoration of World AIDS Day an interaction programme was held with two National Networks; the National Federation of Women Living with HIV/AIDS (NFWLHA) and Jagriti Mahila Maha Sang (JMMS). The interaction programme is a means to facilitate and provide technical support for the regional networks and partnerships. It will facilitate capacity building and include these networks in various consultation meetings. In this context this was one of the initial interactions with these networks to introduce them into regional networking. This was one of the main themes of the programme. In addition they were briefed on the efforts of STAC towards prevention and control of HIV/AIDS in the Region within the past ten years. Similarly, the fine arts on TB and HIV/AIDS prepared by the students were displayed under the different topics and observed by the Hon'ble Minister, dignitaries, guests, officials and invitees. Message of the H.E. the Secretary General, SAARC was published on the occasion of World AIDS Day. STAC participated in the joint programme organized by National Centre for AIDS & STD Control, Nepal. Other activities such message on HI/AIDS was displayed on the hoarding board and exhibition related to progress on prevention HIV/AIDS and efforts implemented by different National and International NGOs were displayed.

# Annexure 2: Operational Plan

| ACSM Component | Strategic direction. | Activities | Lead Role | Implementing partner(s) | Time Frame 2018-2023 |
|---|---|---|---|---|---|
| **Advocacy** | 1) Addressing programme policy gaps through sustained, year round advocacy activities. | • Programme Managers meetings to address cross border issues in TB and HIV/ AIDS and develop policy guidelines<br>• Meeting with Parliamentarians<br>• Health Ministers Meeting | STAC/MS | STAC/MS | Annually |
| | 2) Resource mapping and mobilization for TB & HIV/AIDS control to meet programme needs in various countries. | • Mobilizing support of professional bodies with expertise in ACSM, stakeholders for advocacy/ traning tools kits on skill building of care providers | STAC/MS | STAC/MS | Annually |
| | 3) Innovative and context-specific advocacy messages. | • Organize trainings/ workshop for development of communication materials/ tools for use by the Member States as per their needs | STAC/MS | STAC/MS | 2021 |
| | 4) Joint monitoring of the programme by community representatives to increase accountability to those served. | • Collaborated Meeting with Community Members/ Representatives/Stake holders | STAC | STAC | As per the requirement |

| ACSM Component | Strategic direction. | Activities | Lead Role | Implementing partner(s) | Time Frame 2018-2023 |
|---|---|---|---|---|---|
| | 5) Including human rights as an item in advocacy activities, with a specific focus on unreached, marginalized and vulnerable populations. | • Regional level parlamentarian meeting to mobilize policy/law makers | STAC | STAC | |
| | 6) Strengthening collaboration between various stakeholders and multiple sectors at regional and country level. | • Formation of Advocacy Teams at the regional level with dedicated communication specialists to support activities | STAC/MS | STAC/MS | 2021 |
| **Communication** | 1) Identifying and using opportunities for message delivery, which would include specific events accompanied by regular, synchronized mass media campaigns, community media and Regional Framework for Advocacy, Communication and Social Mobilization and IPC. | • organize video conferencing for TB & HIV/AIDS personnel and stake holder | STAC | STAC | 2021 |

| ACSM Component | Strategic direction. | Activities | Lead Role | Implementing partner(s) | Time Frame 2018-2023 |
|---|---|---|---|---|---|
| | 2) Gaining media attention for TB and HIV/AIDS control initiatives, as media has important role to play in dissemination of messages. Using community media approaches such as citizen journalism or participatory radio programmes. | • Compile World TB and World AIDS Day Messages from Member Countries<br>• Press Release issued on TB & HIV related programmes<br>• Media Personnel awareness programme<br>• Publish success stories with patients of TB and HIV/AIDS | STAC | STAC | 2021 |
| | 3) Strengthening Interpersonal communication (IPC) | • Partnership programmes with students/community members/ media | STAC | STAC | As per the requirement |
| | 4) Raising awareness regarding newer challenges through various academic and social forums and groups. | • Workshop on IPC for health personnel<br>• Workshop with public private practitioners<br>• Organize Conference on TB, HIV/AIDS and Respiratory Diseases | STAC | STAC | As per the requirement |

| ACSM Component | Strategic direction. | Activities | Lead Role | Implementing partner(s) | Time Frame 2018-2023 |
|---|---|---|---|---|---|
| | 5) Documentation and dissemination of data on available human resources and infrastructure vis-à-vis requirements. | • Documentation and dissemination of best practices creating opportunities for information sharing, especially best practice models amongst NTP/NACP and other stakeholders<br>• Collect, review and share communication materials already developed by Members States through different ways.<br>• Start process for developing web-based resource centre for communication materials and tools<br>• Identify and develop new communication materials for specific target groups in light of the review of existing communication materials<br>• Operationalizing web-based resource centre for sharing of prototype communication materials and tools | STAC | STAC/MS | As per the requirement |

| ACSM Component | Strategic direction. | Activities | Lead Role | Implementing partner(s) | Time Frame 2018-2023 |
|---|---|---|---|---|---|
| | 6) Identifying and involving socially influential personalities and opinion leaders for message dissemination. | • Meeting with Parliamentarians<br>• Health Ministers Meeting | STAC | STAC/MS | Annually |
| **Social Mobilization** | 1) Continuous dialogue between National programmes, stakeholders and community. | • Collaborative meeting with stakeholder to help to develop their own ACSM<br>• Inclusion of TB and HIV/AIDS agenda in SAARC Health Ministries Meeting | STAC | STAC/MS | As per the requirement |
| | 2) Involving community in policy and decision-making, service provision and monitoring of services. | • To address the cross border issues, regular meetings with programme managers in the border districts | STAC | STAC/MS | As per the requirement |
| | 3) Strengthening linkages with community groups involved in TB & HIV/AIDS care, and involvement of various community groups, Self Help Groups and groups of people living with Living with HIV/ AIDS. | • Rallies with stakeholders on World TB and World AIDS Day<br>• Partnership programmes with the most vulnerable TB and HIV/AIDS groups<br>• Networking with various association working with TB and HIV/AIDS | STAC | STAC/MS | Annually |

| ACSM Component | Strategic direction. | Activities | Lead Role | Implementing partner(s) | Time Frame 2018-2023 |
|---|---|---|---|---|---|
| | 4) Community mobilization by increasing knowledge on HIV/ AIDS, TB-HIV, MDR-TB and XDR-TB. | • Development of guidelines<br>• Partnership programmes with community members | STAC | STAC | As per the requirement |
| | 5) Strengthening community resources through trainings and capacity building. | • Strengthen capacities of ACSM implementing agencies in documentation and impact evaluation | STAC | STAC | 2021 |
| | 6) Community monitoring systems on sale of TB drugs from pharmacies and availability of over-the-counter drugs and nonstandard regimens. | • Partnership programme with pharmacist | STAC | STAC | As per the requirement |
| | 7) Continuous dialogue and interaction with community representatives so that members contribute to policy issues and discussions. | • Public Private Mix programme | STAC | STAC | As per the requirement |
| | 8) Community empowerment for research and community-led innovation in research | • Develop ACSM related research methods and instruments for formative research and ACSM impact and outcome evaluation | STAC | STAC | As per the requirement |

## References


1. Advocacy, Communication and Social Mobilization "10-Year Framework for Action," , Stop TB Partnership: 2006
2. Advocacy, Communication and Social Mobilization (ACSM) for tuberculosis control: A Handbook for country programmes: WHO 2007
3. Advocacy, Communication and Social Mobilization for Tuberculosis Control: A Guide for developing Knowledge, Attitude and Practice Survey,: WHO 2008
4. Delhi Call for Action to End TB in SEAR Region by 2030; WHO-SEARO (2017): http://theunion.org/news-centre/news/body/Call-for-Action.pdf
5. Forging Partnerships with NGOs- (http://w3.whosea.org/tb/tb&you2.)
6. Global Health Sector Strategy for HIV/AIDS (2003-2007), WHO.
7. Global End TB Strategy Hand Book: World Health Organization, 2016: http:// who.int/tb/End_TB_brochure.pdf
8. HIV & AIDS SAARC Region Update, SAARC Tuberculosis and HIV/AIDS Centre 2017
9. Operational Handbook on Advocacy, Communication and Social Mobilization (ACSM) for RNTCP, Central TB Division, Ministry of Health and Family Welfare, Government of India, New Delhi, March 2014. http://nrhmhp.gov.in/sites/default/files/files/l%20Handbook%20on%20ACSM%20%202014_04_02.pdf
10. Moscow Declaration (November, 2017): Global Ministerial Conference on Ending TB in the Sustainable Development Era. http:// who.int/media centre/events/2017/ministerial-conference-tb/en/
11. National HIV and AIDS Communication Strategy 2005-2010; Government of the People's Republic of Bangladesh, national AIDS/STD Programme, Directorate General of Health Services, June 2006
12. Regional Framework for Advocacy, Communication and Social Mobilization; World Health Organization :2011 http://apps.searo.who.int/PDS_DOCS/B4739.pdf
13. Report of the Regional Workshop on Advocacy, Communication and social Mobilization , Colombo, Sri Lanka 14-17 September 2010
14. Report of the Consultative Meeting of Positive Women's Network in SAARC Region, Kathmandu, 17-18 ,May 2011
15. SAARC Regional Strategy on TB/ HIV co-infection 2006-2010 , SAARC Tuberculosis and HIV/AIDS Centre, 2006
16. SAARC Regional Strategy on TB/ HIV co-infection 2011-2015 , SAARC Tuberculosis and HIV/AIDS Centre, 2011

17. SAARC Regional Strategy on Advocacy, Communication and Social Mobilization (2013-2017): SAARC TB & HIV/AIDS Center, Kathmandu, Nepal. http:// STAC/ SAARC-Regional-Strategy-on-ACSM.pdf

18. SAARC Guidelines for partnership with media in prevention and Control of TB and HIV/AIDS, SAARC TB and HIV/AIDS Centre, 2006

19. SAARC Regional Strategy for TB/HIV Co-infection 2004

20. Tuberculosis Control SAARC Region, Update 20101; SAARC TB and HIV/AIDS Centre, 2010

21. TB India 2011, Revised National TB Control Programme Annual report 2011

22. 2004 Report on Global AIDS Epidemic UNAIDS

23. Vision Document- Vision on Control of TB and HIV/ AIDS in SAARC Region, SAARC TB and HIV/AIDS Centre (STAC) 2011