Advocacy, Communications and Social Mobilization for TB Control

Report of the Regional Workshop
Colombo, Sri Lanka, 14 – 17 September, 2010

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Contents

1. Introduction

TB control programmes continue to be hampered by inadequate long-term resources, inadequate awareness of TB and of services available, and civil society participation in ensuring access and use of services. The Stop TB strategy adopted by WHO for TB control in 2006 therefore addresses advocacy, communication and social mobilization (ACSM) as essential components for effective TB control, particularly in the context of achieving equitable access to quality services for all population groups, among them the poor and marginalized who are most affected by TB. The countries of the South-East Asia Region vary widely in social, economic and demographic profiles which pose different challenges and needs in terms of the approaches to be adopted for advocacy, communications and social mobilization. A regional workshop was organized to review current experiences in countries in applying ACSM approaches, and determine ways to strengthen capacity of TB control programmes and various stakeholders in planning, implementation and monitoring ACSM activities through a more structured approach, in order to ensure adequate resources, enhance awareness and develop support structures for TB control within communities.

The workshop was organized in collaboration with the Program for Appropriate Technology in Health (PATH), and KNCV, the Royal Netherlands Foundation for TB Control, from September 14 to 17, 2010, in Colombo, Sri Lanka.

The workshop was opened by His Excellency Mr. Maithreepala Sirisena, Health Minister, Ministry of Health, Sri Lanka, who mentioned that while much progress had been achieved by the national tuberculosis control programme, tuberculosis continued to be a major public health concern in Sri Lanka. He highlighted the threats that urbanization, overcrowding and poor environmental conditions, and lack of awareness and stigma posed for TB control in the country, and said that these could only be overcome through concerted efforts by all concerned. Additional Secretary, Ministry of Health, Dr P G Maheepala, and Deputy Director General Public Health Services, Ministry of Health, Dr Sunil Settinayake, also attended the opening session of the workshop.

The message of the Regional Director, WHO South-East Asia, Dr Samlee Plianbangchang, was read out by Dr Nani Nair, the WHO Regional Adviser for TB. In his message, the Regional Director noted that while good progress has been made in Member States in TB control, further improvements and expansion of the scope of TB services were required to reach those who had not benefited from efforts so far. It had become increasingly evident that achieving the targets for TB control required going beyond ensuring diagnostic and treatment services to address the social and cultural determinants and co-morbidities that facilitated transmission of TB and hampered those affected by TB from benefiting from available services. TB control services needed to be integrated into primary health care approaches, and link with other programmes such as HIV and maternal and child health programmes; innovative approaches needed to be developed based on the realities in countries, to define effective approaches and interventions. An important component was mobilizing communities to improve the quality and scope of care to reach all TB patients including the poor and marginalized.

The regional workshop was attended by 21 participants representing both national TB control programmes and nongovernmental organizations from ten countries, namely, Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. Resource persons from PATH facilitated the sessions relating to advocacy, communication and social mobilization (ACSM), and KNCV who facilitated the introduction to new tools that could be used by national programmes and partners to effectively implement ACSM for TB control in countries.

The focus of the workshop was to share regional and country TB programme updates; review ACSM concepts; develop and apply practical skills using ACSM techniques and tools; and develop country-specific ACSM action and follow-up plans. Participants were also asked to identify their needs for technical assistance from Stop TB. The participants' evaluation of the workshop was positive.

The specific objectives of the workshop were to:

(1) Share experiences, progress and challenges in implementing ACSM activities in countries of the Region;

(2) Outline the approaches and main interventions to be pursued for ACSM within national TB control plans; and

(3) Identify areas requiring technical and financial support.

Over the four days participants increased their understanding of ACSM approaches and resources from sharing experiences with counterparts from other countries, but also from working closely with the facilitators. They were introduced to framing specific ACSM goals and objectives and linking these to the overall programme objectives. A very practical approach was applied through the "Cough-to-Cure Pathway" tool, to analyse gaps in the process, from the time a person recognizes that they should seek care for a chronic cough and fever or other symptoms that could be due to TB, to the stage of being cured of the disease. They were encouraged to identify and focus on the barriers to achieving the objectives of national TB programmes towards developing appropriate advocacy, communication and social mobilization approaches to address these.

By the end of the workshop, participants had a much clearer understanding of how ACSM, if designed and implemented appropriately, could help improve the outcomes of their national TB programmes, and were also able to apply their new skills to suggest modifications to currently planned ACSM interventions within their national plans.

2. The role of ACSM in TB control

The issues that could be addressed through ACSM are the level of prioritization of TB control within health services, allocation of resources, accountability and responsiveness of service providers, participation by sectors outside TB control, community awareness (misconceptions, stigma and discrimination against those with TB) and community utilization of TB services. Community ownership and participation in diagnosing and treating TB are crucial to address the social, economic and behavioural determinants that affect heath-seeking behaviour particularly among the poorest, most vulnerable and marginalized populations.

With these need in mind, a regional framework for ACSM was developed during 2009-2010 with input from several partners and experts. The overall aims of the framework are to outline key elements of an

effective ACSM strategy to support each component of the Stop TB strategy, towards helping countries to develop ACSM plans in support of national strategic plans for TB control; to identify areas of need and the means to build capacity for ACSM in order to achieve an equitable access to quality diagnosis, treatment and care, with dignity for all TB patients.

The objectives specific to each component are articulated below:

Advocacy

- To mobilize commitment and resources for sustained quality TB care and control, in collaboration with all sectors and stakeholders.

Communication

- To strengthen advocacy, generate awareness on TB and TB control services for better use of services, and to mobilize all stakeholders to support and promote services for TB control.

Social Mobilization

- To mobilize civil society and generate support for all those in need of TB services, through sustainable community ownership and participation.

The outcomes expected from each of these three components are as shown in Table 1 below:

Table 1: *ACSM expected outcomes*

Stop TB Strategy	Advocacy	Communication	Social mobilization
Pursuing high-quality DOTS expansion and enhancement	Enhanced political commitment; Increased resource allocation	Media advocacy and attention to TB control	Community prioritization for TB control; community participation in delivery of services

Stop TB Strategy	Advocacy	Communication	Social mobilization
Addressing TB/HIV, MDR-TB and other challenges	Increased political focus on M/XDR-TB and HIV- TB links with other sectors and health programmes	Increased awareness and utilization of services; understanding and use of prevention and treatment	Linkage with other community groups like HIV positive people, for community-based services
Contributing to health system strengthening	Improved health systems capacity	Joint platform to address health systems gaps	Social capital mobilized for TB control
Engaging all care providers	Endorsement of and advocacy for International Standard for Tuberculosis Care(ISTC) by professional bodies; quality TB services	Place TB on the agenda of professional conferences and seminars	Community demand for quality services through all sectors
Empowering people with TB and communities	Prioritization of TB amongst local leaders	Communities participate in message development and dissemination	Community members contribute to policy, plans and implementation
Enabling Research	TB OR in academic institutes	Dissemination of research results	Use of research for Community-based services

3. Country presentations

Each country made a poster presentation of their ACSM programmes/ activities. Most of the participants reported that they are doing "good" ACSM programmes/activities, but are finding monitoring and evaluating difficult and do not know whether their activities are having any impact on

the county's TB indicators. Some countries reported that despite the ongoing ACSM efforts their programme indicators remain the same.

The National TB programmes (NTPs), some together with their partners, have developed and are incorporating activities to address ACSM within their national plans. After the peer review of the country posters, it was uniformly recognized that there were gaps in these plans. These gaps relate to four areas; the structure of the plans, articulation of the expected outcomes, indicators to be used and specific components included.

The specific components highlighted as requiring greater focus were the development of inclusive partnerships; effective social mobilization; and communication, especially interpersonal communication addressing the needs of patients and families, including social factors that concerned them. Attention to addressing social determinants was considered to be very important. Another area that was felt to weak was monitoring and evaluation. Several excellent initiatives have been established by the people who were detected and treated successfully as TB. However, the documentation and dissemination of these practices has remained limited within countries. The uptake and replication of innovative models (such as utilizing social forums and networks and new communication means such as the Internet and mobile telephony) to communicate with communities and patients was slow.

The gaps identified might reflect a lower prioritization of some components; lack of capacity within programmes to conceptualize, provide clear direction, train, and monitor the various sub-components of ACSM; and unclear mandates or mechanisms to engage freely with civil society based organizations given the placement of NTPs within ministries of health. The understanding and full utilization of all opportunities for implementing ACSM through equal partnerships was therefore possibly suboptimal, with links with the communities and media remaining weak and limited to "traditional" approaches that tend to remain top down and unidirectional.

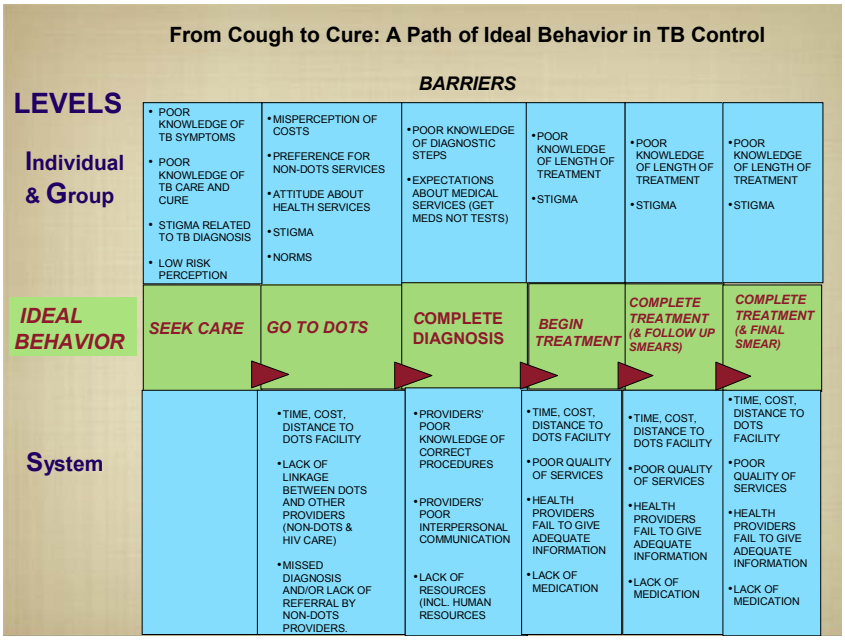
4. The "Cough-to-Cure Pathway": Analysing barriers

The "Cough-to-Cure Pathway" is an analytical tool used to identify programmatic barriers and gaps that impact individuals, families and

communities from following an expected path from the onset of symptoms of TB to achieving a successful cure, and then prioritizes and targets ACSM activities to address these barriers. Participants were introduced to this tool to determine their programme gaps and then prioritize and modify their ACSM activities based on their own analyses. This was for the participants a totally new and different approach to looking at their programme gaps and getting to the root causes for these. Participants reported that in the past when looking for gaps they only focused on one level, which was very often the patient level.

Following the introduction of the tool, participants worked in their country groups to develop activities that would help address each of the challenges identified though the use of the tool. They identified which steps patients were not completing; examined the reasons for noncompletion of each step of the pathway at the individual, family, community and systems levels; and decided which barriers to address in their country contexts after weighing the relative importance of each of the factors. They then chose an intervention or a set of interventions, based on contributing factors, likely effectiveness, and impact.

Figure 1: ***The Cough-to-Cure Pathway***



5. Understanding advocacy, communication and social mobilization

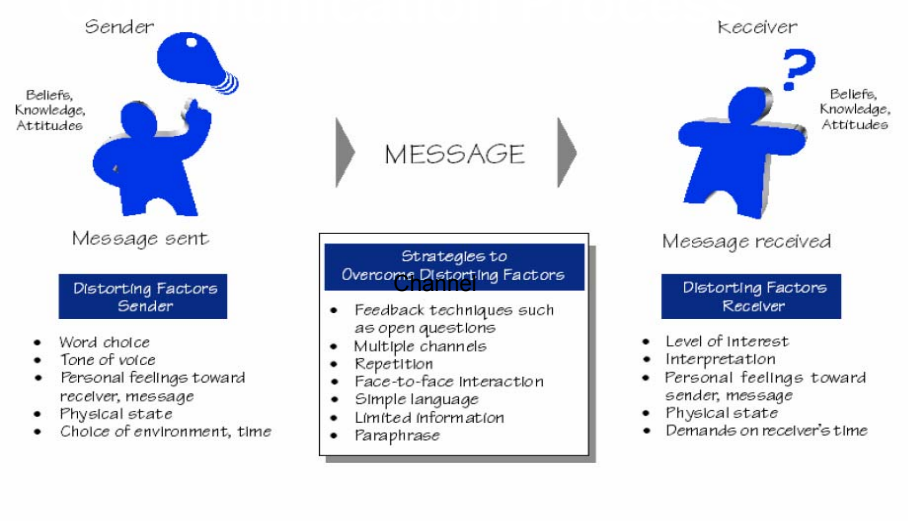
The objectives of this session were to share examples of advocacy, communication and social mobilization in the countries of the Region: identify challenges that could be addressed through specific interventions in these three areas; and introduce the skills required to undertake these interventions. Participants were given a brief introduction to each area followed by discussions on experiences in each country and group work that addressed (i) the definitions of each of the three areas (advocacy, communication and social mobilization), (ii) what tools and techniques were required; and (iii) what skills needed to be developed among staff of the NTP and implementing partners to effectively undertake activities.

Advocacy requires a broad set of coordinated interventions designed to place TB high on the political agenda, foster political will and increase financial and resource allocations. There are essentially three components: policy advocacy to engage politicians and policy-makers; programme advocacy to target opinion leaders at national level; and media advocacy that puts TB issues on the public agenda. The indicators that could be used to measure success are changes in policies, laws and practices, and a higher allocation of resources to TB services. A number of tools and techniques are available: partnership meetings, parliamentary debates, political events, bilateral negotiations, petitions, letter-writing campaigns and mass media audiovisual and written communications. The skills required are a deep knowledge and understanding of the topic and effective communication, negotiation and persuasion skills.

Communication is a two-way process of exchanging information to change the level of knowledge, understanding, attitudes and behaviour. Effective communication requires a clear understanding of the issues, availability of accurate data and the analysis of the effects of that communication on the target audience. It is well recognized that poor communication is one of the key factors for continuing stigma against TB and low utilization of TB services. Communications must therefore help create awareness about TB, inform people what services exist and where, and empower patients to seek diagnosis and treatment. Interpersonal communication between providers and patients is important to improve

treatment adherence; health providers must provide accurate and consistent information without prejudice.

Figure 2: ***The Communication Model***



Source: WHO, Networking for Policy Change an Advocacy Training Manual, 2007.

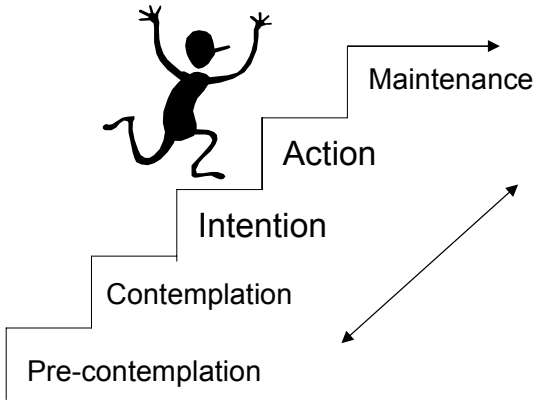
It was emphasized that all communications should be clear, simple and in the language understood by the target audience; that should be delivered on the basis of an equal dialogue, and skills to be developed in order to achieve this. In this context, health workers need to have a range of communication skills, from interpersonal communication and counselling for a patient-centred approach to media skills in order to interact effectively with the media.

Key message

- Advocacy, communication and social mobilization should support the overall TB control strategy.
- Activities should be tailored to specific challenges and achievable results.
- Planning is critical to success.

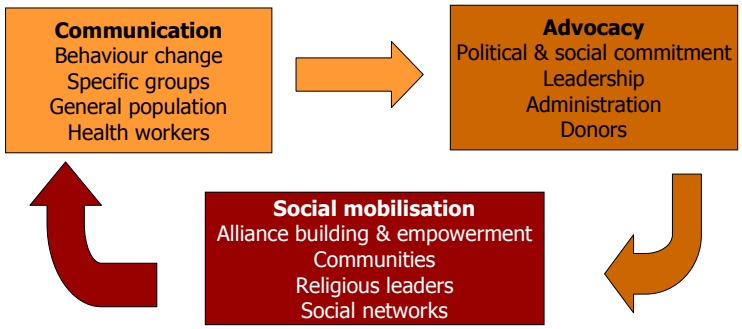
Participants were also introduced to behavioural change communication and the process from pre-awareness (no intentional changing) to awareness (recognizing the problem and thinking about changing), making a decision, taking action (trying the new behaviour) and finally maintaining the new behaviour.

Figure 3: ***Stages of behavioural change***



Social mobilization is the process of generating public will by securing broad consensus and social commitment among several stakeholders in society, ranging from policy-makers to professional and religious groups, the media, the private sector and communities. In the context of TB control, the long-term goal is to create community will and commitment to bring together all feasible and practical intersectoral activities for TB prevention and control. It emphasizes strengthening community participation for sustainability and self-reliance. Social mobilization supports communication. There is a difference between social and community mobilization—community mobilization is a grass-roots process within the broader context of social mobilization.

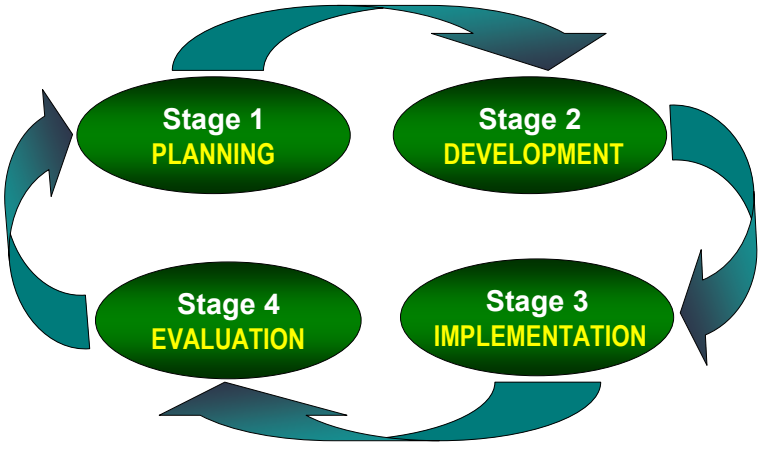
Figure 4 ACSM: ***Three interconnected communication strands***



Following the introduction of concepts and approaches in each of these areas, participants worked on case studies that illustrated the various aspects of advocacy, communication and social mobilization.

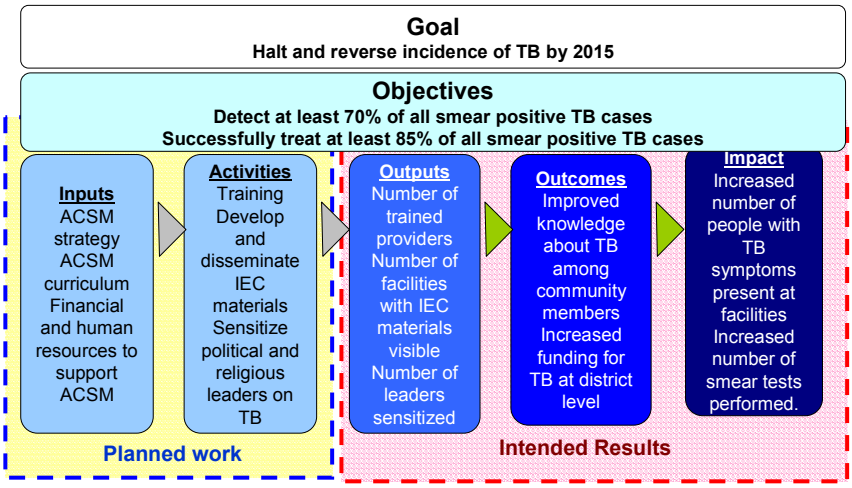
It was also emphasized that planning properly from the initiation stag was critical; participants reviewed the difference between strategic and operational planning, the components of a strategic directions versus an operational plan, and the planning cycle.

Figure 5: ***The ACSM planning cycle***



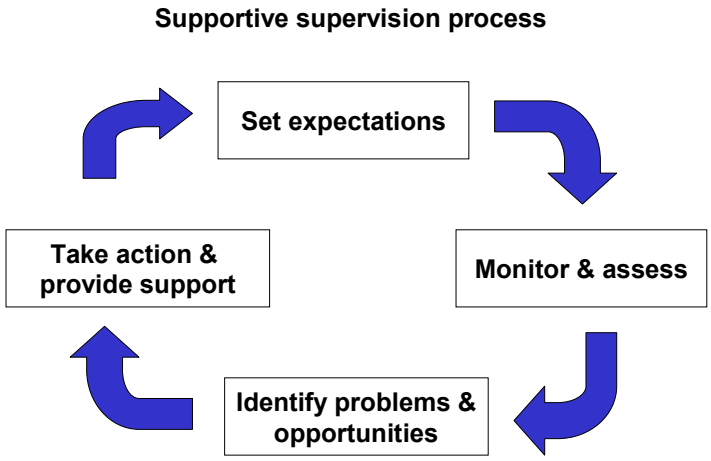
Participants also reviewed data sources, the process, and indicators for monitoring and evaluating ACSM plans and the means to overcome the challenges to effective monitoring and evaluation.

Figure 5: ***The framework for monitoring and evaluation***



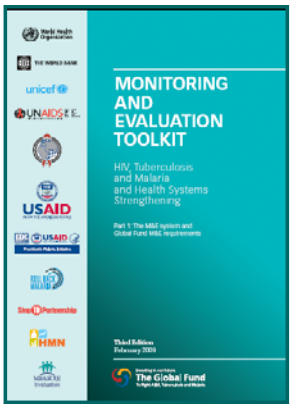
One of the important topics discussed during this session was supportive supervision. It was emphasized that it was essential to encourage open two-way communication in order to build a team approach to effectively monitor programmes, facilitate problem-solving and ensure a follow-up on measures required to improve programme performance. Supportive supervision is a process of setting expectations in line with programme objectives; monitoring and assessing progress; identifying opportunities and problems; and working together to take action through an enabling process rather than a punitive process. Setting up a system for supervision calls for proper planning, training of a course set of supervisors, developing relevant checklists, and ensuring that appropriate resources are available. Common challenges, such as distance, transportation, time and human resource capacity, need to be addressed for effective supervision.

Figure 6: ***The process of supportive supervision***



The various monitoring and evaluating tools developed jointly by several partners were also briefly introduced.

Figure 7: ***Monitoring and evaluation tools***

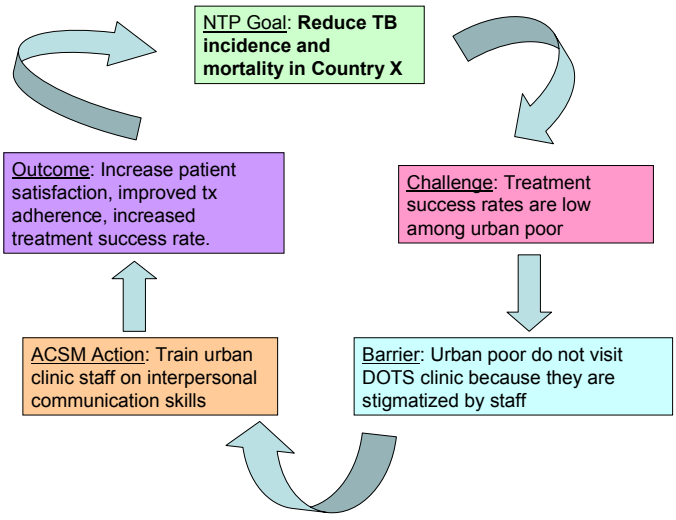


6. Overcoming challenges and barriers for effective TB control through ACSM

Working in country-wise groups, participants examined the challenges and barriers to achieving the objectives of their national TB control programmes through advocacy, communication and social mobilization interventions. Some of the common topic areas addressed were stigma, increasing drug resistance, poor health-seeking behaviour, lack of interest of health staff to provide care for TB patients, and poor resource planning and allocation.

An example of a specific challenge that was chosen for discussion and the interventions required towards achieving an expected outcome is shown below.

Figure 7: ***Linking the challenge to an intervention: Achieving higher treatment success rate among the urban poor***



Participants also discussed the importance of evidence-based programming of ACSM activities through research. The importance of having data in order to define the challenge as well as data to show the outcome of the intervention was emphasized. An overview of the research methods that are commonly used was presented.

Table 2 : *Overview of research methods*

Quantitative	**Qualitative**
Routine surveillance	Focus group discussions
Population based surveys	Key informant interviews
Secondary analysis of existing data (ex. Census, Department for Health Services, Centre for Disease Control data)	Exit interviews
Experimental design	Exit interviews
Time location surveys	Direct observation
Respondent-driven survey	Media scans
	Case studies

Quantitative data is concerned with numerical information, for example, what percentage of population stigmatizes TB can be obtained from population-based surveys that are done at the national scale. Qualitative data helps to answer the "how" and "why" and uses a variety of data sources that are not solely numerical. These provide a high level of detail on a smaller number of people but can inform quantitative research questions. Both quantitative and qualitative research need to be used to assess ACSM needs and interventions. The consequences of not doing so are often apparent — messages are not tailored to key target audiences and resources are poorly used, resulting in the objectives not being met and a loss of credibility for the programme.

7. Introduction to new tools

Participants were introduced to several tools that could be effectively used to define the problems and barriers to achieving the programme objectives and to develop interventions to appropriately overcome these barriers through either advocacy, communications, or social mobilization, or a mix of the three approaches.

The International Standards for TB Care (ISTC): ISTC describes a patient-centred approach as the focus for providing TB treatment (Standard 9). The ISTC is being implemented in several countries of the Region, with

Indonesia showing the most progress and impact to date. Although ISTC is globally understood as an essential tool for TB control efforts, there remains a need for further scale-up.

The Patient's Charter for Tuberculosis Control and Care: Based on international human and health rights, this charter outlines the rights and responsibilities of TB patients aims at increasing participation. The charter was developed in tandem with the ISTC and is now undergoing revisions, which will result in an updated version accompanied by a handbook on how to best use the charter. Focused meetings are planned in countries to advocate for scaled-up implementation—involving patient communities, the NTP and other local NGOs supporting TB activities.

The QUOTE tool: This tool assesses the quality of TB services provided by health facilities as perceived by patients and aims to improve services. QUOTE was developed and piloted in three countries – Kenya, Malawi and Uganda. While its purpose was found to be very important, the methodologies for application and analysis require social science research experience and are not very practical for easy implementation by NTPs. QUOTE was therefore simplified to a "lighter" version, and this version was introduced at this workshop for use at the country level.

The Patient Costing tool: This tool estimates cost of treating each TB patient before and during diagnosis and treatment. The results provide evidence for potential interventions to improve equity in access to care. The costing tool has been piloted and the results proved to be valuable, producing some practical recommendations on how NTPs can reduce costs for improved and equitable access to services.

The TB/HIV Literacy tool: This tool consists of different aides (video, pictures etc) to increase awareness of TB, and counseling/treatment for HIV among patients. This innovative tool was also demonstrated as a good example of actively involving patients with TB control and care activities.

8. Country plans for ACSM in support of TB control: follow-up and technical assistance needed

During the last part of the workshop participants and facilitators worked in groups to identify gaps in their current national ACSM plans and make

recommendations or plan improvements to achieve planned objectives. They used the Cough-to-Cure Pathway to identify barriers and gaps, and then prioritize and target ACSM activities based on their analyses.

Worksheets were provided to develop specific plans in three areas—advocacy, communication and social mobilization, and to help participants link the objectives of their national TB programmes with specific ACSM objectives and interventions that support the overall objectives, and then to prioritize and modifying activities to achieve these specific objectives.

On the closing day, countries presented proposed revisions to their plans, which were peer reviewed. While all countries developed and incorporated activities to address ACSM, gaps remained in these plans at the end of the workshop - these related to overall structure, some specific components, and articulation of the expected outcomes and indicators to be used. All participants mentioned that they would follow-up with each other and with relevant colleagues on return to their countries. The workshop provided, for the first time in many case, the opportunity for country programme staff and civil society partners to get together, learn what each other were doing, and create relationships and networks.

9. Follow-up and technical assistance

Most countries developed concrete follow-through plans to appropriately modify and update their national ASCM plans following the workshop. Maldives, Nepal and Thailand requested financial and technical assistance from STOP TB and WHO-SEARO to conduct similar workshops in their countries to build ACSM capacity for national teams and create ACSM master trainers in order to disseminate ACSM training to all levels. Sri Lanka requested financial and technical assistance from SEARO to support the national team to develop the national ACSM plan.

10. Key conclusions

All countries have adopted and are implementing the Stop TB strategy and recognize and understand the role of ACSM in supporting each component of the strategy.

Behavioural change communication requires a thorough understanding of health-seeking and treatment adherence behaviours—TB programmes would therefore benefit from behavioural surveillance similar to what is being done by HIV/AIDS programmes.

The concept of the patient-centred approach appears to be variably understood. Existing community-based initiatives to inform and empower patients and communities need to be further expanded to ensure that the full spectrum of this approach, in terms of an equal partnership and true engagement of patients and their families in decision-making, planning and implementation, is achieved.

Monitoring and evaluation of the outcomes and impact of ACSM is perceived as difficult; the understanding of objectives and measures for assessments need to improve. Plans, activities and expected outcomes and the means of evaluating progress need to be included and agreed upon in advance by all stakeholders.

Based on these considerations, the following recommendations were proposed.

11. Major recommendations

For National TB programmes:

Finalize national plans for ACSM, incorporating necessary additional elements based on the analyses of barriers and gaps identified through the "Cough-To-Cure Pathway", focusing especially on applying the patient-centred approach and addressing social determinants.

Organize national-level workshops to plan and develop capacity for ACSM interventions at national and subnational levels.

Establish inclusive national partnerships to more effectively conceptualize, plan and implement, and also create an enabling environment for all stakeholders to contribute to ACSM.

Consider constituting technical working groups or committees at country level to provide guidance and oversight of ACSM plans in countries.

Strongly consider branding of services, including use of a logo, for universal recognition of TB services.

Incorporate elements of the patient-centred approach and the patient's charter into trainings on interpersonal communication.

Utilize behavioural surveys and available targeted tools (eg. patients' costing tool, QUOTE Light etc.) to guide ACSM interventions to better understand the specific barriers, and to identify appropriate interventions to improve both health-seeking behaviour and treatment adherence.

Adopt indicators that more accurately and objectively measure progress at process, outcomes and impact levels.

Promote operational research into innovative models for ACSM and disseminate the outcomes from successful approaches for wider replication.

For WHO SEARO and technical partners:

Finalize and disseminate the Regional Framework on ACSM, including to civil society partners.

Engage more actively with NTPs to identify technical assistance for the development, implementation and monitoring of national plans for ACSM.

Create a roster of experts; coordinate and provide sustained technical assistance for planning and monitoring of ACSM; adapt standardized training materials to build capacity in countries.

Help facilitate national-level workshops to build capacity for ACSM interventions in countries; give special attention to strengthening monitoring and evaluation of ACSM components.

Compile and disseminate best practice examples from around the Region to facilitate the uptake of effective interventions for ACSM.

12. Workshop evaluation

The workshop evaluation completed by participants confirmed that the workshop met their expectations as reflected by their high motivation and active engagement in workshop activities. Throughout the four days, they interacted with participants from other countries, and stated that they found sharing country experiences very valuable. They also had the opportunity to provide peer feedback on the respective national plans. Participants also noted that the workshop provided an excellent opportunity for NTP and non-NTP programme staff to work together, better understand each other's needs and develop networks and working relationships.

They particularly highlighted the use of the Cough-to Cure Pathway as an important tool to determine barriers as well as how to design appropriate ACSM activities targeting those barriers, and the process of reviewing and modifying specific ACSM objectives and activities. However, the majority of the participants noted the short time given to ACSM as an area which needs to be changed, with expansion to at least five days for future workshops.

As a way of continuing to build ACSM capacity, the opportunity of this workshop was taken to mentor some of the participants to build their facilitating skills and conduct similar trainings in their own countries.

Annex 1

Regional Director's Message

The WHO South-East Asia Region has the highest burden of tuberculosis in the world. While good progress has been made in Member States towards achieving the targets set for TB control, further improvements in and expansion of the scope of TB services are required to reach those who have not benefited from the efforts made so far.

It has become increasingly evident that focusing on diagnostic and treatment services without addressing the social and cultural determinants that facilitate transmission of TB, as well as hampers those affected from benefiting from available services, will not lead to effective TB control.

A mix of approaches is therefore required. This would include integrating TB control programmes into primary health care approaches, and linking them with other programmes such as those addressing HIV and maternal and child health, among others, besides mobilizing communities to improve the quality and scope of care to reach all TB patients including the poor, who are the most affected. TB control also calls for a wider intersectoral approach to ensure equitable access to services.

Strong and sustained political commitment and financing by governments both at the national and local level, are the key for all TB control interventions. Political commitment is also needed to foster national and international partnerships among different stakeholders to contribute to the long-term strategic plans for TB control in countries. These partnerships are also required to implement poverty reduction strategies and effect improvements in health systems, without which TB control cannot be achieved.

From the programme perspective, the need to pay special attention to population groups that are at a higher risk of contracting TB and are least able to benefit from services available, cannot be overemphasized. These groups include internally displaced people, immigrants, crossborder populations, ethnic minorities and other marginalized groups. Among these people, social networks are disrupted adding to the effects of poverty and altering both health-seeking behaviour as well as access to services. In order

to bring quality TB care to these groups, collaboration with non-traditional stakeholders including representatives of these groups themselves, will be required.

Strong advocacy is required to enhance political commitment to help mobilize the necessary resources for TB control; communication is essential to create awareness regarding TB and its cure and to reduce stigma, while social mobilization helps to empower people to express their needs and ensure that both civil society at large, as well as providers, become more responsive to their needs.

Advocacy, communication and social mobilization are therefore all key activities to support the broader interventions required for preventing and controlling tuberculosis.

Countries of the Region vary widely in social, economic and demographic profiles; this poses different challenges and needs in terms of the approaches to be adopted.

Over the years, national TB programmes in the Region have advocated for their needs to policy-makers and other stakeholders to mobilize commitment and resources, with some success. Since the introduction of the DOTS strategy in the early 1990s, a number of approaches to inform various population groups have been developed, recognizing that the lay community needs to be aware of tuberculosis and of the services available for its cure in order to use them. The need to also extend services for treatment on a closest-to-home basis led many programmes to explore the use of community volunteers and community-based organizations to provide and follow up treatment for TB patients. Many of these efforts, particularly community-based approaches have been documented over the years, but have remained fragmented in their application and limited in scale.

I am therefore happy that this workshop is being organized to review experiences in countries in applying various approaches, and to determine ways to strengthen the capacity of TB control programmes and various stakeholders in planning, implementation, and monitoring of advocacy, communication and social mobilization activities for TB control. Innovative approaches need to be developed and applied, based on realities in countries, to define effective approaches and interventions.

I would encourage you to use this forum not only for interaction and consensus building on newer approaches, but also to outline country strategies and plans in this area. This in turn would foster clearer articulation and inclusion of effective interventions for advocacy, communication and social mobilization in future proposals to donors, as well as better utilization of available funding for these activities.

This workshop could then indeed contribute significantly towards effective implementation of interventions to combat tuberculosis in the Region.

I wish you all fruitful deliberations and a pleasant stay in Colombo.

Annex 2

Programme

(1) Inaugural session

(2) Workshop expectations, objectives

(3) Progress in TB control in SEAR Region and Regional Framework on ACSM for TB Control

(4) Country presentations on ACSM

(5) "Cough-to-Cure Pathway": Analysing the barriers

(6) The role of ACSM in TB control

(7) Gaps and opportunities for ACSM

(8) Planning advocacy, communication and social mobilization

(9) Monitoring and evaluation of ACSM activities

(10) Introduction to new tools

(11) Country action plans

(12) Determining technical assistance needs

(13) Conclusions and recommendations

Annex 3

List of participants

Country Participants

Bangladesh

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A good progress has been made in TB control in the Region. For further improvements and expansion of scope of TB services to reach those who do not benefit from current efforts, a higher level of advocacy and more effective communication for greater understanding, commitment and resources for TB control activities in countries, social mobilization for TB patients to access services effectively is necessary. With this background, the World Health Organization (WHO) South East Asia (SEA) Regional Office organized a Regional Workshop on Advocacy, Communications and Social Mobilization (ACSM) for TB control in collaboration with PATH, and KNCV, from 14 to 17 September, 2010, in Colombo, Sri Lanka. The focus of the workshop was to share regional and country TB programme updates; review ACSM concepts; develop and apply practical skills using ACSM techniques and tools; and develop country specific ACSM action and follow-up plans.

National TB Control Programmes (NTPs) were recommended to finalize national plans and to organize workshops to plan and develop capacity for ACSM interventions; establish inclusive national partnerships for effectively conceptualize, plan, implement, and create an enabling environment for all stakeholders to contribute to ACSM. WHO and technical partners were recommended to finalize and disseminate the Regional Framework on ACSM; with NTPs to identify technical assistance for the development, implementation and monitoring of national plans for ACSM; to adapt standardized training materials to build capacity in countries and disseminate best practice examples from around the Region to facilitate the uptake of effective interventions for ACSM.

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