Operational Handbook on Advocacy, Communication, and Social Mobilization (ACSM) for RNTCP

Central TB Division,
Ministry of Health and Family Welfare
March 2014
# Table of Contents

Acknowledgement.............................................................................................................................. 6
Abbreviations ........................................................................................................................................ 7
About This Handbook.......................................................................................................................... 9
Chapter 1: ACSM - Background and Context.................................................................................. 11
  1.1. TB Scenario in India.................................................................................................................. 11
  1.2. Revised National TB Control Programme ............................................................................... 11
  1.3. Advocacy, Communication, and Social Mobilization......................................................... 12
  1.4. ACSM in RNTCPs New Strategic Vision (2012–2017)....................................................... 13
Chapter 2: ACSM - Concept and Strategy..................................................................................... 14
  2.1. Need for Conceptual Clarity ................................................................................................... 14
  2.2. Strategic Framework.............................................................................................................. 15
Chapter 3: Developing ACSM Strategy.......................................................................................... 20
  3.1. Key Steps and Process for Developing ACSM Strategy................................................... 20
Chapter 4: ACSM Planning and Need Assessment..................................................................... 23
  4.1. Conducting Situation Analysis............................................................................................... 23
Chapter 5: Developing ACSM Objectives and Approach............................................................. 27
  5.1. Developing ACSM Objectives ................................................................................................ 27
  5.2. Developing the ACSM Approach.......................................................................................... 29
Chapter 6: Selection of Channels.................................................................................................... 30
  6.1. Guidelines to Determine What Channel(s) to Use............................................................ 30
Chapter 7: Message Designing........................................................................................................ 36
  7.1. The ‘Must Follow’ Communication Principles ..................................................................... 36
  7.2. Key Messages......................................................................................................................... 36
  7.3. Pre-testing Messages and Design........................................................................................ 38
Chapter 8: ACSM Capacity Building............................................................................................... 40
  8.1. Need for Capacity Building in ACSM ................................................................................... 40
  8.2. ASCM Training and Capacity Building Plan........................................................................ 40
  8.3. Capacity Building Workshops.............................................................................................. 40
Chapter 9: ACSM - Program Implementation Plan........................................................................ 43
  9.1. Planning at District and State Level....................................................................................... 43
  9.2. Key Components of PIPs........................................................................................................ 43
Chapter 10: Toolkit for Conducting ACSM Activities ................................................................. 45
  10.1. World TB Day ........................................................................................................ 45
  10.2. Media Engagement .............................................................................................. 46
  10.3. Community Mobilization .................................................................................... 48
  10.4. School Activities ................................................................................................ 52
  10.5. Folk Performances ............................................................................................... 53
  10.6. Patient-Provider Meetings .................................................................................. 55

Chapter 11: Monitoring and Evaluation .............................................................................. 57

Chapter 12: Documenting Lessons and Results .................................................................. 62

References .......................................................................................................................... 64

Annexures .......................................................................................................................... 65
  Annexure 1: ACSM framework ..................................................................................... 65
  Annexure 2: ACSM planning format ............................................................................. 66
  Annexure 3: Sample pre-test questions ....................................................................... 69
  Annexure 4: Format for monitoring planned vs. actual performance of ACSM activities (example) ................................................................. 70
  Annexure 5: Approaches to engage media .................................................................. 71
Acknowledgement (will be included later)
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACSM</td>
<td>advocacy, communication, and social mobilization</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ANM</td>
<td>auxiliary nurse midwife</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>ASHA</td>
<td>accredited social health activist</td>
</tr>
<tr>
<td>BCC</td>
<td>behavior change communication</td>
</tr>
<tr>
<td>CBCI</td>
<td>Catholic Bishops’ Conference of India</td>
</tr>
<tr>
<td>CBO</td>
<td>community-based organization</td>
</tr>
<tr>
<td>CTD</td>
<td>Central TB Division</td>
</tr>
<tr>
<td>DMC</td>
<td>Designated Microscopy Centre</td>
</tr>
<tr>
<td>DOTS</td>
<td>directly observed treatment short-course</td>
</tr>
<tr>
<td>DR-TB</td>
<td>drug-resistant tuberculosis</td>
</tr>
<tr>
<td>DTC</td>
<td>District Tuberculosis Centre</td>
</tr>
<tr>
<td>DTO</td>
<td>District Tuberculosis Officer</td>
</tr>
<tr>
<td>FBO</td>
<td>faith-based organization</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education, and communication</td>
</tr>
<tr>
<td>IHBP</td>
<td>Improving Healthy Behaviors Program</td>
</tr>
<tr>
<td>IMA</td>
<td>Indian Medical Association</td>
</tr>
<tr>
<td>IPC</td>
<td>interpersonal communication</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>multidrug-resistant TB</td>
</tr>
<tr>
<td>MMU</td>
<td>mobile medical unit</td>
</tr>
<tr>
<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
</tr>
<tr>
<td>MOTC</td>
<td>Medical Officer - Tuberculosis Control</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NHM</td>
<td>National Health Mission</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
</tr>
<tr>
<td>PIP</td>
<td>program implementation plan</td>
</tr>
<tr>
<td>PLHIV</td>
<td>people living with HIV</td>
</tr>
<tr>
<td>PP</td>
<td>private practitioner</td>
</tr>
<tr>
<td>PPP</td>
<td>public-private partnership</td>
</tr>
<tr>
<td>PRI</td>
<td>Panchayati Raj Institution</td>
</tr>
<tr>
<td>PWB</td>
<td>patient-wise box</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Programme</td>
</tr>
<tr>
<td>SBCC</td>
<td>social and behavior change communication</td>
</tr>
<tr>
<td>SHG</td>
<td>self-help group</td>
</tr>
<tr>
<td>SIECO</td>
<td>State IEC Officer</td>
</tr>
<tr>
<td>STLS</td>
<td>Senior TB Laboratory Supervisor</td>
</tr>
<tr>
<td>STO</td>
<td>State TB Officer</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>STS</td>
<td>Senior Treatment Supervisor</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TOT</td>
<td>training of trainers</td>
</tr>
<tr>
<td>TU</td>
<td>Tuberculosis Unit</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VHSNC</td>
<td>Village Health Sanitation and Nutrition Committee</td>
</tr>
<tr>
<td>XDR-TB</td>
<td>extensively drug-resistant TB</td>
</tr>
</tbody>
</table>
About This Handbook

Clinical approaches alone are not enough to achieve the goals of tuberculosis (TB) prevention and cure. The role of advocacy, communication, and social mobilization (ACSM) is widely recognized, with ACSM being seen as distinct but mutually supporting interventions that are designed to support the goals of improving TB case detection, adherence to treatment, and treatment outcomes (TB cure) to make India TB free.

The Handbook on Advocacy, Communication, and Social Mobilization for RNTCP aims to provide momentum and build ACSM capacity by clearly describing the processes involved in planning and implementation of ACSM activities in support of TB control and prevention. It seeks to help the reader better understand the significance of ACSM in TB-control interventions under the Revised National TB Control Programme (RNTCP). The handbook provides practical guidelines and describes the ‘nuts and bolts’ of operational activities with examples of planning and implementing different ACSM programs and activities.

This handbook has been based on the assessment of the ACSM situation in the five states viz, Gujarat, Uttar Pradesh, Bihar, Karnataka and Meghalaya conducted during 2012, and key recommendation outlines in the ACSM status report. This document is a dynamic and living document and will be updated with inputs from the field during its operationalization at state and district level.

The handbook has been organized into five parts:

Part 1 of the handbook describes the background and context of TB-related ACSM in India and provides conceptual clarity on and strategy framework of ACSM as distinct but mutually supporting interventions for TB prevention and cure.

Part 2 outlines the strategy and explains step-by-step processes of ACSM situation analysis to prepare robust, evidence-based program implementation plans (PIPs).

Part 3 describes ACSM implementation planning and approach, selection of cost-effective channels/vehicles of message delivery to targeted audiences, design of appropriate messages, and ACSM capacity building.

Part 4 discusses the preparation of program implementation plans at district and state levels as well as describes various ACSM activities with practical operational details for implementation.

Part 5 emphasizes the need for rigorous monitoring and evaluation (M&E) and provides simple guidelines for conducting M&E to make ACSM activities more effective in support of RNTCP.

This handbook on ACSM aims to serve as a guide and support the staff that plan, organize, supervise, and execute TB control activities at national, state, district, sub-district, and peripheral health institutions under RNTCP. It is primarily intended for use by the national-level staff, State IEC Officers (SIECOs), District Tuberculosis Officers (DTOs), Communication Facilitators, and others responsible for ACSM activities. However, those handling medical/technical tasks under the TB control program will also benefit from this guide.

The development process

The Operational Handbook was developed with series of consultative processes. Inputs from state IEC officers and ACSM officer were taken during media training workshop, during the consultation inputs were taken to understand how IEC officers visualize the operational handbook and its utility? A working group comprising of CTD ACSM consultants, State IEC officer, WHO RNTCP consultant was formed under leadership of Dr. Niran Kulshrestha, Additional DDG TB, CTD, MoHFW. The first draft was circulated to ACSM expert from National Advisory committee on ACSM, and USAID for inputs. A larger consultative workshop will be organized to gather inputs from partners, civil society organization as a final stage of the development process.
Part 1

Chapter 1. ACSM - Background and Context

Chapter 2. ACSM - Concept and Strategy
Chapter 1: ACSM - Background and Context

This chapter briefly discusses the TB scenario in India and the national RNTCP that was launched in 1997 in response to India’s staggering TB burden. It provides the reader a broad understanding of the background and context of ACSM in India’s TB control program.

1.1. TB Scenario in India

TB is an infectious disease caused by bacillus *Mycobacterium tuberculosis*, which normally attacks lungs but other human organs as well. It spreads through air when an infected person coughs. Hitherto known as ‘poor man’s disease’, TB actually affects people across socioeconomic boundaries and geographies.

TB has emerged as one of the biggest public health problems India faces. About 40 percent Indians have latent TB, which is not infectious but has the risk of developing into active TB. India accounts for one-fifth of global active TB cases\(^1\). Each year nearly 1.8 million people in India develop TB, and 370,000 die of it annually\(^2\) — 1,000 every day, that is, two patients succumb to TB every three minutes\(^3\).

TB is also associated with social stigma and fear. Men and women infected with TB have to deal with stigma at their workplace, in the community, and in the household. Even matrimonial alliances become difficult if it becomes public that the boy/girl, or even someone in the family, has TB.

The emergence of multidrug-resistant TB (MDR-TB) and HIV-TB co-infection, along with the increase in diabetic cases, are the new serious challenges plaguing India’s TB control program. While MDR-TB is a result and symptom of TB patients’ poor management, TB is among the most common opportunistic infections among people living with HIV (PLHIV).

1.2. Revised National TB Control Programme

Based on internationally recommended directly observed treatment short-course (DOTS) strategy, RNTCP was formally launched in 1997 and expanded across the country in a phased manner with support from the World Bank and other development partners.

The evolution and progress of TB eradication in India have been aligned with global efforts. RNTCP’s approach is in line with WHO’s Stop TB Strategy (2006–2015), addressing HIV-TB and MDR-TB, involving private practitioners (PPs), and encouraging the public private partnership (PPP) model. It has a detailed M&E mechanism, with guidelines, tools, and reporting formats at all levels.

RNTCP has a nationwide administrative and organizational structure, with the Central TB Division (CTD) as the national-level body that guides activities through various state-level units. It has successfully established over 2,700 Tuberculosis Units (TUs) and 13,000+ Designated Microscopy Centres (DMCs) in 662 RNTCP districts. Over 2,325 NGOs and 13,997 PPs, 150 corporate hospitals, and 297 medical colleges have been involved in implementing RNTCP. The program has a

---

\(^1\) www.whoindia.org/en/section3/section123.html, accessed on December 12, 2113.


\(^3\) Baseline IEC document-RNTCP II-CTD; page 5; 2007, accessed on December 14, 2013.
successful partnership with Indian Medical Association (IMA), Catholic Bishops’ Conference of India (CBCI), PATH, The Union, and World Vision India.⁴

RNTCP provides free, quality-assured anti-TB drugs for the full course of treatment to patients in individual patient-wise boxes (PWBs), which are earmarked for each patient so that once a patient starts treatment, there is no shortage of medicine throughout the course of treatment. Decentralized treatment is ensured through a network of about 7,00,000 DOTS providers, who offer patients treatment as close to their homes as possible. Special pediatric patient boxes are designed for children according to dosages for different weight bands.

The Government of India envisions ‘TB-free India’, with reduction in the burden of disease until it is no longer a major public health problem. To achieve this vision, the program has now adopted a new goal — ensuring universal access to quality diagnosis and treatment for all TB patients across the country.

RNTCP defines overarching guidelines and processes to be followed in all phases of TB control and prevention, starting with multiple channels of identifying TB suspects, followed by diagnosis of TB by conducting appropriate lab tests, beginning DOTS treatment, emphasizing adherence, and monitoring.

a. Suspect identification involves creating mass awareness and seeking support and involvement of various public health stakeholders. These include doctors at public health institutions (PHIs), health workers like accredited social health activists (ASHAs) and auxiliary nurse midwives (ANMs), PPs, specialists, chemists, and rural practitioners. These stakeholders disseminate information about TB diagnosis and treatment process and motivate suspected cases to visit public or private labs for appropriate tests. Various incentive schemes have been devised for health workers, NGOs, PPs, etc., to encourage them to actively identify TB suspects.

b. Diagnosis of TB involves sputum collection, transportation, lab microscopic examination, and reporting of results within 72 hours of sample collection. A key goal of RNTCP is to ensure that all symptomatic suspects get diagnosed and the TB-positive cases get registered as TB patients for treatment.

c. Treatment for TB follows diagnosis and registration, where after trained public DOTS providers put all TB patients on DOTS treatment as per RNTCP guidelines. Regular follow-up visits, treatment adherence, and patient monitoring are the responsibility of all stakeholders, especially DOTS providers. Adherence to DOTS is key to the successful cure of TB.

1.3. Advocacy, Communication, and Social Mobilization

ACSM is an important component of the TB-control strategy to ensure long-term, sustained impact. Advocacy seeks to ensure strong commitment to TB control. Policy advocacy informs politicians and administrators about how the 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, putting issues on the public agenda and encouraging the media to cover TB-related topics regularly and in a responsible manner so as to raise awareness of the problem and its possible solutions. Communication aims to favorably change knowledge, attitudes, and practices among various groups of people. Social mobilization brings together community members and other stakeholders to strengthen community

⁴ TB India 2013 Annual Status Report, Government of India
participation for sustainability and self-reliance. The key objective of ACSM in RNTCP is to generate demand for quality TB diagnosis and treatment and increase treatment adherence, leading to cure of all diagnosed TB cases. ACSM helps to improve health communication by bringing about awareness and changes in health perceptions and health seeking behaviors.

ACSM’s goals for TB control are:

a. Mobilizing political commitment and resources for TB
b. Improving case detection and treatment adherence
c. Widening the reach of services
d. Combating stigma and discrimination
e. Empowering people affected by TB and the community at large

ACSM aims to increase case detection, adherence to DOTS, and effective implementation of the TB control program in India. ACSM is not an end by itself.


RNTCP’s key vision for TB control is to achieve universal access, i.e., all TB patients in the country should have access to early and good quality diagnosis and treatment services in a manner that is affordable and convenient to patients in time, place, and person. All affected communities must have full access to TB prevention, care, and treatment, including women and children, elderly, migrants, homeless people, alcohol and other drug users, prison inmates, PLHIV, and those with other clinical risk factors. The program’s ACSM strategy will complement every other program initiative for achieving universal access, and be used for better demand generation, early diagnosis and treatment, as well as improved supply of quality care. The major components of ACSM strategy are:

1. Advocacy for administrative and political commitment and to keep TB control high on health and development agenda
2. Communication for demand generation and stigma reduction; audience segmentation, targeted behaviour-change interventions, and community mobilization will focus on increasing demand
3. Community ownership and mobilization for case finding and support to TB patients; on the supply side, multiple stakeholders, including various groups of health care providers, media, policymakers, NGOs, community-based organizations (CBOs), faith-based organizations (FBOs), other vibrant community groups, local self-governments, etc., will be targeted for improved provision of care

---

5 National strategic plan 2007-2012, Central TB Division, MOHFW
6 Zero TB Deaths Stop TB in my Life; TB India 2013 Annual Status Report, Government of India
7 Universal access to TB care in India http://www.tbcindia.nic.in/pdfs/Universal_accesssto_TB_Care.pdf, accessed on December 12, 2013
8 National strategic plan 2007-2012, Central TB Division, MOHFW
Chapter 2: ACSM - Concept and Strategy

This chapter introduces the concepts of advocacy, communication, and social mobilization and their role in RNTCP. It provides examples to demonstrate the differences and inter-relationships between each of the components. Later in the chapter, the broad strategic framework of ACSM and the different ACSM activities along with their expected outcomes are discussed in brief.

2.1. Need for Conceptual Clarity

ACSM strategy and its attendant activities contain three key elements:

2.1.1. Advocacy

Advocacy refers to activities that seek to influence the influencers and decision makers, so as to make TB more central as a public health agenda and enlist their (influencers’) support to create an enabling environment in support of RNTCP to control TB. Advocacy fosters political will, increases financial and other resources on a sustainable basis, and holds authorities accountable to ensure that pledges are fulfilled and results achieved.

Advocacy is a broad set of coordinated efforts designed to: (1) place TB higher on the political agenda; (2) strengthen government commitment to implement or improve TB-related policies; and (3) increase and sustain financial and other resources for TB.\(^9\)

The techniques of advocacy include lobbying, partnership meetings, parliamentary debates, political events, petitions, letter/email campaigns, and sensitization workshops. Advocacy can be discussed under three broad heads:

a) **Policy advocacy** works with senior politicians and administrators on the impact of the issue at the national level and the need for action. Policy advocacy lobbies with national or local political leaders and administrators to increase funding for TB programs and institute policy changes to support the implementation environment.

b) **Program advocacy** reaches out to decision-makers and community partners to boost their participation in local actions and program decisions in support of TB services. Program advocacy is used at the local community level to convince opinion leaders about the need for local action.

c) **Media advocacy** puts TB issues on the public agenda to generate support from governments and donors and validate the relevance of a subject. It encourages the media to cover TB-related issues regularly and in a responsible manner to raise awareness of TB as a problem and its solutions. In the process, media advocacy helps in creating a more favorable environment for individual and community action to control TB.

2.1.2. Communication

In this context, communication is a process people use to exchange information about TB through media, including such channels of communication as mass media, mid-media, and interpersonal communication (IPC). Much of the communication effort on TB is concerned with transmitting a series of messages to the people affected by TB through mass media and mid-media, which are necessary

but not sufficient. As ‘participation’ and ‘dialogue’ are necessary for effective communication, IPC occupies a place of vital importance.

Communication aims to improve knowledge about TB and TB services and change attitudes and practices to encourage people to seek care and complete TB treatment.

Communication generally falls into three categories:

- **Mass media** includes channels and campaigns that reach a general audience or a large target group, such as radio or television advertising campaigns, Internet websites, and special events. Behavior change communication (BCC) campaigns often fall into this category but can target smaller audiences as well.

- **Mass media** uses more targeted channels, like brochures, posters, mobile phones, photography, video, interactive theatre, and testimonials, to reach specific groups. These are often referred to as information, education, and communication (IEC) approaches.

- **Interpersonal communication** (IPC) includes counseling, one-on-one education sessions, skills trainings, and presentations often targeted at health workers and direct supporters of TB patients and families.

### 2.1.3. Social mobilization

Social mobilization is the process of bringing together different stakeholders and building partnerships to prevent, detect, and cure TB. It targets different sections of the targeted population, say a village community, a ward, or other small groupings, and raises awareness of and demand for the TB control program. The emphasis here is on community participation and involvement in TB case detection and cure.

Social mobilization aims to:

- Increase awareness of the disease (TB) and the demand for diagnosis and treatment services
- Expand service delivery through community-based approaches
- Enhance sustainability, accountability, and community ownership of TB services

Under RNTCP, partner NGOs play an important role in social/community mobilization. Community mobilization generates dialogue, negotiation, and consensus, engaging a range of players in interrelated and complementary efforts while taking into account people's needs. Social and community mobilization, integrated with other communication approaches, has been a key feature of numerous communication efforts worldwide. The polio eradication campaign in India is a success story in social mobilization.

Social mobilization activities include group and community meetings, school activities, traditional media group performances, rallies and road shows, home visits, etc. Here, IPC and group communication are the main channels of communication for disseminating TB-related key messages. Leaflets, posters, pamphlets, videos, and other communication aids in local language/dialects are often used to make communication contextual, easy, and comprehensible to the local community. Media materials like leaflets and pamphlets are often given to take home for repeated exposure.

Within the overarching concept of ACSM, there are, thus, these three interconnected, overlapping, and complementary communication strands — advocacy, communication, and social mobilization. Although advocacy, communication, and social mobilization are different sets of activities with different objectives, they are interlinked, mutually reinforcing, and most effective when used together. For example, advocacy to change a health policy can be more persuasive if multiple stakeholder groups have been mobilized to call for that change. Similarly, social mobilization needs communication strategies to deliver a motivating message to communities.

Notably, the terms IEC, BCC, and ACSM are often interchangeably used in the field.
2.2. Strategic Framework

Many model of strategic communication and social and behavior change communication (SBCC) have been developed globally. The essence of these frameworks lies in key strategies focused on three elements — advocacy, communication, and social mobilization.

The strategic framework keeps the “individual” at the center and brings family, community, and society under its purview to bring about desired changes in health (TB) perceptions and behavior. Strategic

\[\text{Figure 1: ACSM is interlinked}\]

\[\text{Figure 2: SBCC framework}\]

\[\text{Source: Adapted from McKe, N. Social Mobilization and Social Marketing in Developing Communities (1992)}\]

\[\text{Source: PATH training curriculum on advocacy, communication, and social mobilization}\]
inclusion of family, community, and society facilitates and encourages behavioral changes. ACSM uses a mix of communication approaches, including large-scale mass media and local field-level communication interventions using mid-media and IPC, to their full potential.

**Figure 3: ACSM area of influence**

![ACSM Area of Influence Diagram]

**ACSM indicated actions at different levels:**

**Individual:** Design specific interventions to ensure sustained engagement of people/individuals in maintaining positive behaviors/changing to desired behaviors through positive messages, acquiring skills, and experiencing/demonstrating ‘benefits’ of positive behavior.

**Family:** Motivate in creating an enabling environment for promoting positive behavior development/change, developing necessary skills, and fostering a given health behavior.

**Community:** Mobilize toward a common goal, create an enabling environment for individuals to adapt/practice/sustain positive behaviors, raise local resources, and foster support for bringing about wider awareness on a set of quality-of-life/TB prevention and treatment issues. An example could be building enabling community support and environment for promoting a new vaccine.

**Society:** Advocate rights-based and socially inclusive approach and seek support for the TB program (legislation, policy, partnerships, and resources).

Individuals need to be informed and made aware of the different health issues related to TB, enabling them to take necessary steps like lab testing if suspected of having TB. In other words, their perception/attitude and behavior toward TB must be changed, a task easier said than done. Various constrains and barriers hinder such change in attitudes and behaviors. Each individual is part of his/her family, community, and society, whose perceptions and behaviors influence and shape his/her own perceptions and behaviors. Changing individuals requires a change in their families and vice-versa. Similar interdependent relationships extend to communities and the society at large.

Aimed at individuals, families, communities, and the society, varied ACSM activities are undertaken at national, state, district, and community levels to create awareness and an enabling environment, build capacities to bring about desired changes in TB-related health behavior, and sustain positive behavior. Specific interventions are designed to ensure sustained engagement of people/individuals through positive messages, acquiring skills and experiencing/demonstrating the ‘benefits’ of healthy behavior.
**Figure 4: Snapshot of ACSM activities at central, state, district, and community levels**

<table>
<thead>
<tr>
<th>Level</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>To achieve consensus on ACSM/TB (health communication objectives &amp; goals) and to support health &amp; communication sectors in delivery of public messages (Enabling Policy, Environment and Adequate Resources)</td>
</tr>
<tr>
<td>State</td>
<td>To engage, plan, inform and support health officials and stakeholders in managing and delivering high quality ACSM/TB messages (Advocacy, Capacity building, Material &amp; Logistics Resources)</td>
</tr>
<tr>
<td>District</td>
<td>To engage, inform, build capacities and support health officials, in managing and delivering high quality focused &amp; accurate TB messages</td>
</tr>
<tr>
<td>Sub-District/Block</td>
<td>To deliver the message on a sustained basis and to enhance their capacities for accurate dissemination of information / messages</td>
</tr>
<tr>
<td>Village/Family</td>
<td>To disseminate the key TB message and facilitate families / community members’ comprehension of the same to promote health seeking behaviours</td>
</tr>
</tbody>
</table>
Part 2

Chapter 3. Developing ACSM Strategy

Chapter 4. ACSM Planning and Need Assessment
Chapter 3: Developing ACSM Strategy

3.1. Key Steps and Process for Developing ACSM Strategy

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 patients
- DOTS providers
- Health service providers
- Government, NGO partner,
- Families, friends, peers
- Community leaders, health care providers
- Individual

Figure 5: Audience segmentation
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’. (See Table 5 for more guidance on strengths and weaknesses of channels.)

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.

STEP 7: 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 PRI members before a community-level meeting or complex preparation and arrangements for World TB Day. (Detailed guidance on conducting some common ACSM activities is presented in Chapter 10.)

STEP 8: Monitoring and evaluation
Often overlooked, M&E for ACSM is a crucial element to consider and implement. It provides an opportunity for making necessary course corrections in planned ACSM activities and ensures adequate quality. Evaluation focuses on the ‘outcome’ of different programs and activities under ACSM and helps in assessing their relevance, efficiency, and effectiveness. It allows an insightful understanding of what worked and what did not work as planned, the difficulties encountered, and the lessons learnt.
Chapter 4: ACSM Planning and Need Assessment

Preparation of a research and evidence-based program implementation plan (PIP) is vital for conducting effective ACSM activities under RNTCP. CTD has designed appropriate templates to this end. This chapter outlines the steps for identifying key program issues in TB control at district and state levels as well as the ACSM activities, with approximate budget estimates, that can address these issues. The approach relies on situation analysis at TU/DMC, block, district, and state levels.

4.1. Conducting Situation Analysis

Situation analysis should start at the TU level. The Senior Treatment Supervisor (STS) should take the initiative, under the guidance and supervision of the DTO, to examine the monitoring/reporting data on: (1) case detection, (2) case adherence, and (3) private notification. Available at TU/DMC level, this data for the past year should be examined in detail to study patterns, based on geographical location or seasons/months. Noticeable variations in TU data must be explained and reasoned out. Both ‘low’ and ‘high’ performances (in case detection, DOTS adherence, and HIV/AIDS) should be explained and understood carefully through interaction with the concerned staff. Low performance could result from lack of information and awareness, cultural beliefs, stigma associated with TB, poor service availability, etc. Reasons for high performance must similarly be explained. Based on such analysis, priority areas (location - village/block) for RNTCP, in terms of program activities, should be identified, which should be further verified by actual field visits and discussions with local staff and targeted audiences.

4.1.1. Steps in Situation Analysis/Need Assessment for ACSM

STEP 1: Identify priority population/geographic area

a. Prepare a performance matrix for all TUs and DMCs in the district on the basis of the following indicators (as shown in Table 1 below):
   i. Case detection
   ii. Case adherence
   iii. Private notification

<table>
<thead>
<tr>
<th>TU/DMC</th>
<th>Case notification %</th>
<th>Case adherence %</th>
<th>Private notification %</th>
</tr>
</thead>
<tbody>
<tr>
<td>TU 1</td>
<td>75</td>
<td>80</td>
<td>85</td>
</tr>
<tr>
<td>DMC 1</td>
<td>45</td>
<td>54</td>
<td>40</td>
</tr>
<tr>
<td>DMC 2</td>
<td>67</td>
<td>80</td>
<td>78</td>
</tr>
<tr>
<td>DMC 3</td>
<td>98</td>
<td>84</td>
<td>78</td>
</tr>
<tr>
<td>TU 2</td>
<td>89</td>
<td>80</td>
<td>76</td>
</tr>
<tr>
<td>DMC 4</td>
<td>78</td>
<td>75</td>
<td>77</td>
</tr>
<tr>
<td>DMC 5</td>
<td>56</td>
<td>60</td>
<td>53</td>
</tr>
</tbody>
</table>

b. Highlight all the low-performing DMCs and identify these as the DMCs that need consideration for ACSM activities.
c. Prioritize the low-performing DMCs of all the TUs in a district, keeping in mind the likely budget and time constraints for ACSM intervention in the current financial year and in the next two years or so.

d. Sustain ACSM activities in other DMCs.

**STEP 2: Identifying key program challenges**

Ascertain the main program issues in the low-performing DMCs that have been identified as priority areas by asking the following guiding questions to Medical Officer - Tuberculosis Control (MOTC), Senior TB Laboratory Supervisor (STLS), and other concerned health staff like ASHA.

a. What are the reasons for low case detections?
   i. Lack of awareness about TB
   ii. High stigma and discrimination
   iii. Poor access to services

b. What are the reasons for low case adherence?
   i. Economic hardship
   ii. Lack of care and support
   iii. Lack of awareness about importance of completing treatment

c. What are the reasons for low private notification?
   i. Lack of information about the need for TB notification
   ii. Lack of knowledge about TB, its diagnosis, and treatment
   iii. Lack of motivation and fear of patient loss

Responses to these questions will help in identifying the various program challenges and in planning appropriate ACSM activities.

The *Cough to Cure Pathway* barrier analysis is a useful tool to discuss key barriers at every level in the journey from symptom to treatment. This approach is suitable to differentiate the barriers at individual, group, and system level. (see Figure 6)

In the process, we should identify villages/slums/communities under each DMC/TU with more TB suspects/vulnerable, who need to be covered under RNTCP on a priority basis in the current year and in the next two years or so. In each of these communities, we should identify the key TB control related program issues.

Till this stage you identified the priority areas as well as key challenges in RNTCP that need to be addressed with specific ACSM interventions. Details on what ACSM activities can be used for the identified specific challenges are more elaborately discussed in Chapter 10.
STEP 3: Identifying and defining the target audience

Based on the identified barriers and challenges before the program, identify the target audience(s) for ACSM. Table 2 presents some examples of the target audience for ACSM activities.

Table 2: Target audience for ACSM activities

<table>
<thead>
<tr>
<th>Target audience</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>Decision-makers at national, regional, and district levels (NRHM official, MD NRHM, District Magistrate, CEO Janpat, RNTCP leadership)</td>
</tr>
<tr>
<td></td>
<td>Policy-makers</td>
</tr>
<tr>
<td></td>
<td>Professional groups</td>
</tr>
<tr>
<td></td>
<td>Funders</td>
</tr>
<tr>
<td></td>
<td>Media</td>
</tr>
<tr>
<td>Communication</td>
<td>General public, including different vulnerable groups, health care workers (i.e., primary health care providers, allopath and AYUSH doctors, private health care providers, traditional healers, etc.)</td>
</tr>
<tr>
<td></td>
<td>TB patients currently on treatment as well as cured TB patients</td>
</tr>
<tr>
<td></td>
<td>Contacts of patients with active TB</td>
</tr>
<tr>
<td></td>
<td>People at high risk of developing TB</td>
</tr>
<tr>
<td>Social mobilization</td>
<td>Communities</td>
</tr>
<tr>
<td></td>
<td>Community groups, e.g., <em>mahila mandals</em>, youth groups</td>
</tr>
<tr>
<td></td>
<td>National and local level leaders</td>
</tr>
<tr>
<td></td>
<td>Local NGOs, youth organizations, CBOs</td>
</tr>
</tbody>
</table>
Part 3

Chapter 5. Developing ACSM Objectives and Approach
Chapter 6. Selection of Channels
Chapter 7. Message Designing
Chapter 8. ACSM Capacity Building
Chapter 5: Developing ACSM Objectives and Approach

Having identified and prioritized the areas and target audiences for ACSM intervention as per the process described in Chapter 3, we will now discuss the approach, the strategy, and the suggested ACSM activities to address different program issues and challenges. Interventions must be planned keeping in view the reasons/root causes of challenges and specific communication objectives. For ACSM to be effective, it should take cognizance of the specific context of audiences and respond with appropriate communication channels/media.

5.1. Developing ACSM Objectives

Once situation analysis, barrier identification, and audience analysis have been carefully conducted, the next step is to define communication objectives. ACSM objectives provide direction by mainly answering the following key questions:

- What do you want your audience to change? (Note: Objectives should be based on your audience.)
  (For example, you may want private providers to refer symptomatic TB cases to DMCs.)
- Why is it not already happening (that is, what are the barriers)?
  (For example, there may be lack of information about the available services, lack of trust on government health systems, and untrained private providers.)
- Which of these barriers will you address with communication?
  (For example, lack of information and lack of trust are the key barriers to address.)

Communication objectives are more than specific desired behaviors — they are ways to address barriers in order to achieve the desired changes in policies, social norms, or behavioral determinants.

Communication objectives should address:

- Specific policies, services, social norms, and/or behaviors for each audience
- Information, motivation, ability to act, and norms the program should address
- Exactly what the program wants the intended audience to know, feel, or do after being exposed to activities and materials

Designing SMART communication objectives is important. SMART is an acronym for the five qualities of effective goals — specific, measurable, achievable, realistic, and time-based.

Specific:
Specific means the objective has a single focus or result and does not overlap with other objectives. It describes exactly what we will accomplish, with whom, where, and when.

Key question: Does the objective specify what it aims to achieve? Does it cover only one activity versus multiple activities?
**Measurable:**

An objective should be measurable, meaning we can actually quantify a change, attach a number to that change, or observe something new.

*Key question:* Can the objective be measured or counted in some way?

**Attainable:**

Objectives should be attainable, achievable, and easy to put into action based on our resources.

*Key question:* Is the objective feasible? Can the program attain it?

**Realistic:**

Objectives should connect to larger RNTCP goals and objectives and be worthwhile and important to the work being done.

*Key question:* Can the program realistically achieve the objective with the resources and time available?

**Time-bound:**

Objectives should be time-bound. A timeline or “due date” will keep our activities moving and we will know when to expect the change to happen.

*Key question:* Does the objective indicate when it will be achieved?

---

**Table 3: Examples of SMART ACSM objectives**

<table>
<thead>
<tr>
<th>RNTCP Objectives</th>
<th>ACSM Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal access to TB</strong></td>
<td>Raise knowledge of TB symptoms and TB services to increase by 30 percent the number of people in district X seeking care for TB symptoms at DOTS centers by December 2017</td>
</tr>
<tr>
<td>Early detection and treatment of at least 90 percent of all types of estimated TB cases in the community, including drug-resistant and HIV-associated TB</td>
<td>Mobilize at least 20 percent of the private chemists/pharmacies in district X by March 2014 to refer people with TB-like symptoms to DOTS facilities for screening</td>
</tr>
<tr>
<td>Successful treatment of at least 90 percent of new TB patients, and at least 85 percent of previously-treated patients</td>
<td>By mid-2015, improve TB knowledge of primary health care providers in 20 medical facilities of the five provinces</td>
</tr>
<tr>
<td>Reduction in default rate of new TB cases to less than 5 percent and re-treatment TB cases to less than 10 percent</td>
<td>Increase by 50 percent the number of cured TB patients by the end of March 2015</td>
</tr>
</tbody>
</table>

**Tips for writing effective communication objectives:**

- Use action verbs to help break down desired changes into doable and realistic communication objectives.
- Use verbs like know, have a positive attitude toward, consider discussing, talk about, feel confident in, practice, use skills, etc.
5.2. Developing the ACSM Approach

Now that we are clear about ACSM objectives, the next step is to determine the ACSM approach to achieve these objectives. There are two parameters to determine: (1) what ACSM activities to conduct and (2) what channels of communication to use. Channel selection will be discussed in detail in Chapter 6. Currently we will focus on what kind of ACSM activities can be carried out, with examples. The list of activities can be exhaustive, depending upon the ACSM objectives of the state and the district.

(Refer to Chapter 10 to understand how to conduct specific types of ACSM activities, like community meetings, patient-provider meetings, school activities, etc.)

Table 4: ACSM approaches

<table>
<thead>
<tr>
<th>RNTCP Objectives</th>
<th>ACSM Objectives</th>
<th>Activities and Channels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain political and administrative commitment</td>
<td>Increase participation and support from government and political representatives, with commitment to implement RNTCP</td>
<td>Seminars and briefing meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Print information (letters, factsheets)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Events around World TB Day and other occasions</td>
</tr>
<tr>
<td>Improve case detection</td>
<td>Raise knowledge of TB symptoms and TB services, to increase by 30 percent the number of people seeking care for TB symptoms at DOTS centers by December 2014</td>
<td>Formative research to determine best messages and approaches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mass media campaigns, including radio and television</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distribution of print materials at community meetings or events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training in interpersonal communication and counseling for health workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community mobilization activities</td>
</tr>
<tr>
<td>Increase treatment success rate</td>
<td>Increase awareness and support for TB treatment among TB patients by 2014</td>
<td>Training in interpersonal communication and counseling for health workers</td>
</tr>
<tr>
<td></td>
<td>Form and strengthen community structures (patient groups, etc.) to support TB patients</td>
<td>Mass media campaigns, including radio and television</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensive distribution of print materials at health care facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community mobilization activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer education at community or interest group meetings</td>
</tr>
</tbody>
</table>

Remember: Communication objectives are not program objectives. With communication objectives, we measure how we are addressing barriers to change (or behavioral determinants) and not specific behaviors or health outcomes. Communication objectives add up to help achieve program/behavioral objectives.
Chapter 6: Selection of Channels

Selection of communication channels is vital to the effective delivery of appropriate health messages to the intended audience(s). Making the correct selection requires a clear understanding of the ‘strengths’ and ‘weaknesses’ or ‘limitations’ of different channels of communication in relation to different audiences and contexts. Generally, media mix works out to be a cost-effective approach. Nonetheless, it is advisable to seek experts’ help for media planning to optimize resources. Keeping in view the strengths and weaknesses of different communication channels and their respective reach in the targeted area, a media planner can devise a cost-effective media plan. (Refer to Table 5 for more insight on the strengths and weaknesses of different communication channels.)

6.1. Guidelines to Determine What Channel(s) to Use

As you determine the communication channels that are most suitable to reach your audience, keep in mind the following:

1. Complexity of the issue
   a. There is no one ‘super’ medium or channel that can do everything.
   b. Using a combination of linked and mutually supportive channels is the most effective approach.
   c. All the materials should be recognizable as originating from the program and tied together by a logo/tagline and a uniform design identity.
   d. Passive audiences learn little. Engage the audiences through your materials and media.
   e. Channels should not be considered separately from the overall program design.
   Integrate selected channels with other program activities and service delivery. For example, do not begin a communication campaign on case detection without ensuring that the nearest DMC is functional.

2. Program’s desired reach
   a. Programs that aim at national or regional coverage often use mass media.
   b. Media can reinforce and extend face-to-face communication, but cannot replace it.
   c. Make sure mass media exposure is repeated enough times for the audience to hear the message, understand it, and try it. Ensure sufficient repetition of the campaign but do not overplay spots or shows to avoid audience fatigue.

3. Prevailing social norms and sensitivity about the issue being addressed
   a. Various target audiences have different openness and willingness to address issues like sex and family planning. You must consider the audience’s socioeconomic category, education, gender, age, etc.
   b. Mass media may not be ideal for highly sensitive issues; interpersonal channels may instead prove more effective.

4. Media habits and preferences of target audiences
   a. Tailor programming to the audience’s preferred listening times and favorite stations, programs, and media.

5. Budget for the communication campaign
   a. The cost of communication channels varies by type.
   b. Remember, less is more. Quality pays off in communication, and, hence, it is better to do one thing well than to undertake many different activities that people do not remember because they were poorly implemented.
   c. Channel selection is important, but budgeting for production quality determines success.

Every media has its own strengths and weaknesses. It is most important to have clarity about the specific context of an audience while looking at a combination of channels. The matrix below provides a snapshot of the strengths and weaknesses of different communication channels.
Table 5: Strengths and weaknesses of different communication channels

<table>
<thead>
<tr>
<th>Channels/Tools</th>
<th>Audiences Reached</th>
<th>Strengths</th>
<th>Weaknesses/Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mass Media Channels</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Television** | Households, families | Most effective medium as it:  
  • Direct reach in homes; about 60 percent households have TV but actual penetration is higher as TV viewing is done at the community level in rural and poor urban areas  
  • Messages delivered with audio-visual elements and motion for maximum impact  
  • High visibility and recall  
  • Celebrity status of characters can facilitate change by serving as role models | Expensive production costs  
  • Prime-time slots are usually more expensive for airing  
  • Irregular power supply in many parts  
  • Expectation is primarily entertainment; people pay less attention to educational programs unless the contents are infotainment  
  • Less reach among rural and migrant populations, who are vulnerable to TB |
| **Radio** | Individuals, households, families | | No visual display, which helps in relating oneself to key messages  
  • Airing of messages during peak times would be expensive  
  • Radio is mostly used only for listening to film songs/music programs  
  • Radio listening is no more popular; TV viewing is more popular |
| **Newspapers and magazines** | Educated individuals, households | According to the Indian Readership Survey (2011), 350 million Indians read newspapers/magazines; of these, 53 percent are from rural areas, where 65 percent of the country’s population lives. This is a significant development.  
  • Growing regional and vernacular media; Hindi | Not useful for the illiterate population; even 280 million literate Indians do not read newspapers  
  • Women have less exposure to newspapers and magazines  
  • Short lifespan of newspapers and magazines  
  • People read newspapers for news about political developments, crime, etc., and not for |
<table>
<thead>
<tr>
<th>Channels/Tools</th>
<th>Audiences Reached</th>
<th>Strengths</th>
<th>Weaknesses/Limitations</th>
</tr>
</thead>
</table>
| Posters       | Individuals      | • Good for identification  
• Strong pictorial description of the message  
• Useful in high-traffic areas  
• Good for visibility | • Brief messages  
• Short lifespan |
| Pamphlets     | Individual       | • Good for communicating core messages with illustration/visual support  
• Mass distribution and a kind of take-home message  
• Not very expensive  
• Can be used for repeated exposure and to reinforce messages broadcasted through mass media | • Generally useful for the literate population, but can be used by the illiterate people as well, it has been observed that if the pamphlet looks attractive enough, it is taken home and contents are deciphered with the help of literates or children at home/in the neighborhood |
| Brochures     | Individuals, groups | • Useful for effectively communicating detailed information/instructions with illustrations/visuals/graphs, etc. | • Production cost may be relatively high |
| Flip charts   | Individuals      | • Good support in counseling sessions | • Production cost may be relatively high |
| Wall writings/hoardings | Individuals, households | • Useful in high-traffic areas  
• Good for identification  
• Pictorial description  
• Useful for reinforcing a message | • Only for the literate population  
• Message retention is low  
• Can be cluttered and have an overloading of the key messages |
| Kiosks        | Individuals      | • Face-to-face communication along with audio-visual communication for better message retention  
• Useful in dispelling myths and practices | • Expensive to scale up  
• Requires trained staff  
• Relatively small reach |
| Mobile vans and videos on wheels | Groups, community | • Entertaining and can grab audience attention  
• Audio-visual display helps with message retention | • Expensive to implement  
• Expensive to scale up  
• Relatively small reach  
• Requires precision of timing |
| Folk dramas   | Groups, community | • Entertaining and can grab audience attention | • Relatively small reach  
• Expensive to scale up |
<table>
<thead>
<tr>
<th>Channels/Tools</th>
<th>Audiences Reached</th>
<th>Strengths</th>
<th>Weaknesses/Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audio-visual display helps with message retention</strong>&lt;br&gt;<strong>Can touch an emotional chord with individuals/households; useful for sensitization</strong></td>
<td></td>
<td><strong>Requires precision of timing</strong>&lt;br&gt;<strong>Requires good artists with prior training</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Interpersonal Communication (IPC)** | | |
| **Counseling** | Individuals | **Credible source due to face-to-face communication**<br>**Allows detailed explanation of key health messages**<br>**Can help dispel myths and check wrong practices** | **Time taking to build reach**<br>**Small reach (individual)**<br>**Costly to scale up**<br>**Requires special training** |
| **Home visits** | Households | **Credible source due to face-to-face communication**<br>**Allows detailed explanation of key health messages**<br>**Can help dispel myths and check wrong practices**<br>**Useful for rapport building** | **Time taking to build reach**<br>**Small reach to target audience**<br>**Requires adequate capacity building** |

| **Community Dialogue** | | |
| **Seminars, workshops, and Parliament questions** | Policy-makers, implementers, urban population | **Brainstorming of key stakeholders**<br>**Identification of key communication challenges**<br>**Key inputs from experts and academicians** | **Not timely**<br>**High cost of implementation**<br>**Time taking to bring about change**<br>**Difficulty in mobilizing key stakeholders** |
| **Public meetings and gatherings** | Key influencers, individuals, households | **Emphasis on key messages by influencers/stakeholders**<br>**Useful for addressing different segments of the target audience together** | **Intermittent in occurrence**<br>**High organizing cost**<br>**Only verbal communication involved**<br>**Reach is relatively small** |
| **Working with groups** | Households, individuals | **Dissemination of key messages among communities**<br>**Word-of-mouth communication** | **Low frequency**<br>**Only verbal communication involved** |
| **Social Media** | Individuals | **Targets individuals but has a wide/mass reach**<br>**Effective method of reaching a large number**<br>**High visibility among decision-makers** | **Only limited people have access to Internet accounts on Facebook, and an even smaller number has blogs** |

Now that we know the types of ACSM activities to use and the advantages and disadvantages of different communication channels, we can develop an ACSM framework, as shown in Table 6 below.
Table 6: Examples of ACSM program/activities implementation

<table>
<thead>
<tr>
<th>Causes of Program Issues</th>
<th>ACSM Objectives</th>
<th>Target Audience</th>
<th>Communication Channels</th>
<th>Key Messages</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| Program Issues/Challenges - Poor case detection | • Lack of awareness  
• Poor knowledge of TB symptoms  
• Poor risk perception  
• Misconceptions about costs  
• Faith in non-DOTS treatment  
• Testing not necessary to get medicine | • Raise knowledge of TB symptoms and TB services, to increase by 30 percent the number of people seeking care for TB symptoms at DOTS centers by December 2014 | • General public  
• Vulnerable groups, communities | • Advertisements in media – newspapers, magazines, local cable TV  
• Mid-media - wall writings, pamphlets, folk performances | • Create mass awareness about the following symptoms:  
• 2-week cough  
• Fever  
• Weight loss | • Increased awareness  
• Improved case detection |
| Program Issues/Challenges - Poor adherence to DOTS | • Stigma | • Reduce stigma toward TB among the general public and health care workers | • General public  
• Community opinion leaders | • Community meetings, supported by advocacy materials | • Remove stigma with the slogan “anyone can have TB” | • People start talking freely about TB |
| Program Issues/Challenges - Poor referral | • Misconception that symptoms (cough) gone means cured  
• Lack of knowledge that non-adherence can lead to recurrence of TB and drug-resistant TB | • Increase awareness and support for TB treatment among TB patients by 2014 | • General public  
• TB patients and DOTS providers | • Advertisement in media – newspapers, magazines, local cable TV  
• Mid-media - wall writings, pamphlets, folk performances  
• TB patients’ and DOTS providers’ meetings  
• Meetings with DOTS providers and other health service providers | • Mass awareness that absence of symptoms after a small period of medication does not mean TB is cured  
• Address concerns of TB patients | • Greater adherence to DOTS regime and completion of the course |
| Program Issues/Challenges - Poor referral | • Lack of awareness and commitment | • Increase awareness of TB notification and private sector partnerships | • Government and private doctors  
• Other health services providers | • Advocacy workshop | • Advocacy  
• Consequences of TB for public health | • Increased referral from PPs |
### Causes of Program Issues

**ACSM Objectives**

<table>
<thead>
<tr>
<th>Program Issues/Challenges - MDR-TB and HIV-TB co-infection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of motivation, commitment, and discipline</strong></td>
</tr>
<tr>
<td>• Increase awareness, motivation, and support for MDR-TB and HIV-TB patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB patients</td>
</tr>
<tr>
<td>DOTS providers</td>
</tr>
<tr>
<td>Service providers</td>
</tr>
<tr>
<td>Influencers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication Channels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive and extended counseling</td>
</tr>
<tr>
<td>Build/strengthen counseling abilities of service providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build confidence, motivation, and discipline</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduction in MDR-TB and HIV-TB co-infection cases</strong></td>
</tr>
</tbody>
</table>
Chapter 7: Message Designing

The correct message and its effective delivery to intended audiences is key to the success of ACSM. Content is the most important aspect of communication. It is necessary to keep in mind both the basics of communication for designing appropriate messages as well as the strengths and weaknesses of the particular vehicles/channels of message delivery. This chapter discusses certain communication principles that are necessary for designing appropriate messages and implementing cost-effective health communication.

7.1. The ‘Must Follow’ Communication Principles

Communication is two-way, selective, and contextual. It is always selective at the exposure level — one sees, reads, and listens selectively; at the interpretation level — one draws meanings from messages his/her own way; and at the usage level — one may or may not act on the message.

The meaning of a message is not entirely in the message itself. The receiver of messages draws meanings from the message based on her/his own background and needs.

Therefore, in today’s message-cluttered world, an effective TB-related message must:

- Draw and retain attention; it should be attractive enough to draw attention
- Should be short and simple for easy comprehension
- Localized to the extent possible to enable audience’s identification with the message
- Sustain interest for the unfolding ‘story’
- Appealing; targeted audience must perceive it as beneficial
- Lead to the desired action for behavior change in audience’s self interest

Designing appropriate messages requires good understanding of both the issues being faced by the TB eradication program and the socio-psychographic profile of the target audiences. This understanding must of course be matched by creativity on the part of the message designer.

7.2. Key Messages

A message brief should be developed before creating the actual communication message. The message brief calls for inputs from the program staff and the IEC Officer, based on the communication strategy. This brief informs the message content on what will be said?

Messages in rough form represent ways of presenting the information to the intended audiences. Key messages guide the development of the actual messages to be used for communication. Key messages contain the essential themes that should be included for all communication channels, and they also work as a message brief for the design agency during the creation of the actual message.

Remember: Key message should not only be facts and information. Be mindful of what you want your audience to do. Consider how your messages will overcome the barriers and lead to desired change.

Table 7: Key messaging questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Answer (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the desired change?</td>
<td>TB patient should complete DOTS treatment.</td>
</tr>
<tr>
<td>What are the barriers?</td>
<td>Lack of information about the side effects of the medicine</td>
</tr>
<tr>
<td></td>
<td>Poor knowledge about the need to complete treatment</td>
</tr>
<tr>
<td>What are the communication objectives?</td>
<td>Create knowledge among TB patients about the</td>
</tr>
</tbody>
</table>
**Handbook on Advocacy, Communication, and Social Mobilization for RNTCP**

| What do the key promise and support statement say? | “There are minor side effects like nausea, vomiting, joint pains, and itching. But don’t worry; we will support you in completing the treatment.” |
| What are the important themes? | Treatment adherence and completion |
| What are the most important points or information? | There are minor and major side effects of TB drugs. Consult your doctor for help; don’t stop treatment on your own. |

Some examples of key message are presented below.

**Example of key messages**

1. **General message**
   - Cough lasting more than two weeks may be TB. Go to the nearest DMC for a sputum test.
   - TB is completely curable.
   - TB diagnosis and treatment is free at all government health facilities.
   - Good quality drugs for treating TB are available at government health facilities.
   - Medicines should be taken for 6–8 months.
   - Medicines should be taken under the supervision of a DOTS provider.
   - Not a single dose should be missed, and treatment must be completed to ensure complete cure from TB.

2. **Groups vulnerable to TB**
   - The general message should be provided at the community level through targeted intervention activities.

3. **TB cases registered for treatment**
   - Messages on treatment adherence and completion must be reinforced.
   - All TB cases should know their HIV status.
   - Approach health care facilities if there are any side effects.

4. **HIV-TB cases registered for treatment**
   - All HIV-TB cases should receive antiretroviral therapy (ART) from the ART centres of NACP at government health facilities.

5. **MDR-TB cases registered for treatment**
   - Motivate by reinforcing messages on treatment adherence and completion to ensure cure.
   - Duration of treatment is between 24–27 months.
   - Approach healthcare facilities if you have any side effects.

You must also be cognizant of the operational basics of communication while planning and executing ACSM in support of RNTCP. Effective messages have some specific characteristics, as presented in Table 8. See Table 9 for examples of good TB-related messages.
Table 8: Characteristics of effective messages

<table>
<thead>
<tr>
<th>Key Characteristics of a Good Message</th>
<th>Guidance and Tips</th>
<th>Checklist for Developing Effective Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commands attention</td>
<td>The message should catch attention and generate interest among the audience.</td>
<td>The message stands out to your audience. The message is believable.</td>
</tr>
<tr>
<td>Has clarity</td>
<td>Clear messages contain as few technical terms as possible and eliminate information that the audience does not need for responding to the message.</td>
<td>The message is simple and direct. It focuses only on what the audience needs to know. It provides the strongest points at the beginning of the message.</td>
</tr>
<tr>
<td>Communicates a benefit</td>
<td>Audiences should be able to perceive the benefit of adopting the suggested desirable behavior. <em>(How do I directly benefit by changing to the suggested behavior?)</em></td>
<td>The message clearly states what the audience gets in return for taking an action. The message conveys that the benefits outweigh the barriers.</td>
</tr>
<tr>
<td>Is consistent</td>
<td>Scientific findings about health often change with new research. Messages from your program should attempt to convey consistent and accurate information.</td>
<td>Key messages are used appropriately and ensure consistency and support for all of the program’s materials.</td>
</tr>
<tr>
<td>Caters to the head and the heart</td>
<td>Depending on the topic, messages should have the desired tone to have the desired impact on the target audience. For example, the tone may be reassuring, alarming, challenging, or straightforward.</td>
<td>The message uses an appropriate tone for the audience. The appeal is appropriate as laid out in the creative brief.</td>
</tr>
<tr>
<td>Creates trust/credibility</td>
<td>Information should be believable and have a credible source, as determined by your audience research.</td>
<td>The information comes from a credible source.</td>
</tr>
<tr>
<td>Calls to action</td>
<td>TB-related messages should have a sense of urgency and deliver a call to action.</td>
<td>The call to action clearly states what the audience should do after seeing the communication. The call to action is realistic.</td>
</tr>
</tbody>
</table>

7.3. Pre-testing Messages and Design

In rush of work we often forget/neglect to pre-test the developed communication messages. Pre-testing can significantly improve the efficacy of designed and developed messages. Identify the materials you will need for your communication activities, say a poster/leaflet, and develop appropriate messages to be conveyed to the specific target audience. It is worthwhile to spend some time and resources in pre-testing the messages and materials before going in for bulk production and
mass distribution. One level of pre-testing is showing it around to colleagues for their feedback and suggestions for improvements. Perhaps even more appropriate would be to also pre-test these materials with audiences for whom these have been developed. The messages and materials should be tested on the following parameters:

- Accuracy
- Completeness
- Relevance
- Appropriateness in format, style, and readability level

Your message should convey the exact statement or precise point you want to communicate. An example of a pre-testing question guide is available in Annexure 3.

Table 9: Examples of good TB messages

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>Message Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>General knowledge about TB</td>
<td>• TB is an infectious disease.</td>
</tr>
<tr>
<td></td>
<td>• TB is caused by a bacterium called <em>Mycobacterium tuberculosis</em>.</td>
</tr>
<tr>
<td></td>
<td>• A TB patient can infect 10–15 people in a year.</td>
</tr>
<tr>
<td></td>
<td>• Two persons die of TB every three minutes in India.</td>
</tr>
<tr>
<td>Prevention of TB</td>
<td>• TB is completely curable with DOTS.</td>
</tr>
<tr>
<td></td>
<td>• We can all contribute to stopping the spread of TB.</td>
</tr>
<tr>
<td></td>
<td>• If you have persistent cough, weight loss, and night sweats, you should get tested for TB.</td>
</tr>
<tr>
<td></td>
<td>• Anyone can contract TB.</td>
</tr>
<tr>
<td></td>
<td>• Open the doors and windows in your house to let in fresh air.</td>
</tr>
<tr>
<td></td>
<td>• Cover your nose and mouth while coughing and sneezing, and wash your hands.</td>
</tr>
<tr>
<td></td>
<td>• Go to the health care facility and get TB care.</td>
</tr>
<tr>
<td>Detection of TB</td>
<td>• Early detection and treatment can prevent long-term disability and Death from TB.</td>
</tr>
<tr>
<td></td>
<td>• Early detection and treatment is important to stop the spread of TB infection to your family and community members.</td>
</tr>
<tr>
<td></td>
<td>• Go to your local health center if you have a cough for more than two weeks.</td>
</tr>
<tr>
<td></td>
<td>• A simple sputum test will identify if you have TB.</td>
</tr>
<tr>
<td></td>
<td>• TB diagnosis and treatment are free.</td>
</tr>
<tr>
<td>Treatment of TB</td>
<td>• You will only be cured if you complete your treatment, which takes 6–8 months.</td>
</tr>
<tr>
<td></td>
<td>• Interruption of TB treatment can lead to multidrug-resistant TB, which is difficult to treat and takes up to two years.</td>
</tr>
<tr>
<td></td>
<td>• Do not stop taking the medicine until you have completed your DOTS treatment.</td>
</tr>
<tr>
<td></td>
<td>• Keep your house/room airy by keeping the windows open.</td>
</tr>
<tr>
<td>Care of TB patients</td>
<td>• Support family, friends, and community members who have TB.</td>
</tr>
<tr>
<td></td>
<td>• DOTS supporter can help cure TB by providing treatment every day.</td>
</tr>
<tr>
<td></td>
<td>• If you were cured of TB, share your experience by letting other TB patients know the importance of treatment adherence.</td>
</tr>
<tr>
<td>Addressing stigma</td>
<td>• TB is curable.</td>
</tr>
<tr>
<td></td>
<td>• DOTS cured me. It will cure you too.</td>
</tr>
<tr>
<td></td>
<td>• DOTS: TB cure for all.</td>
</tr>
<tr>
<td></td>
<td>• TB anywhere is TB everywhere.</td>
</tr>
</tbody>
</table>
Chapter 8: ACSM Capacity Building

8.1. Need for Capacity Building in ACSM

Effective implementation of planned ACSM activities requires building the capacity of RNTCP staff and partner organizations. All RNTCP staff carry some responsibility for ACSM implementation. Likewise, other partners and stakeholders, including NGOs and CBOs, also have an important role to play. Hence, it is important to develop a capacity building plan for both RNTCP staff and other stakeholders.

The table below lists some of the important groups/audiences for ACSM - training and capacity building plan.

Table 10: Groups/audiences for the ACSM training and capacity building plan

<table>
<thead>
<tr>
<th>Key Audience</th>
<th>State level</th>
<th>District level</th>
<th>Block level</th>
<th>Village level</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNTCP program staff</td>
<td>State IEC Officers, state officials</td>
<td>Medical Officers, STS/STLS</td>
<td>Medical Officers, STS/STKS, Communication Facilitator</td>
<td></td>
</tr>
<tr>
<td>General health staff</td>
<td>Medical Officers</td>
<td>Medical Officer, general nursing and midwifery (GNM) staff</td>
<td>ASHA, ANM, AWW</td>
<td></td>
</tr>
<tr>
<td>Other stakeholders</td>
<td>NGO partners, media professionals</td>
<td>Media professionals, private sector bodies like AYUSH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.2. ASCM Training and Capacity Building Plan

The following are the steps for preparing an effective ACSM capacity building plan:

- Prepare cadre-wise line lists of staff to be trained
- Prepare a training calendar and include it in the district annual action plan and the state annual action plan
- Coordinate with state training and demonstration centers
- Conduct field testing
- Monitor the training activities

8.3. Capacity Building Workshops

Capacity building workshops should be conducted for different stakeholders involved in ACSM activities. The table below presents some examples of possible capacity building workshops on ACSM. The participants, objectives, duration, and methodology/tools to be used in each of such workshops should be clearly defined.
## Table 11: Examples of capacity building workshops on ACSM

<table>
<thead>
<tr>
<th>For Whom</th>
<th>Key Objectives</th>
<th>Methodology</th>
<th>Tools/Materials</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy makers</td>
<td>Seek policy and financial support</td>
<td>Sensitize and seek their commitment to the TB control program with facts and figures, PowerPoint presentations (PPTs), interactive discussions, and supportive reading materials</td>
<td>One day</td>
<td></td>
</tr>
<tr>
<td>Program personnel</td>
<td>Build commitment and motivation</td>
<td>Sensitize and seek their commitment to the TB control program with facts and figures, PPTs, interactive discussions, and supportive reading materials</td>
<td>One day</td>
<td></td>
</tr>
<tr>
<td>Media professionals</td>
<td>Sensitize and seek their cooperation in responsible reporting on TB and related issues</td>
<td>Sensitize them on TB and related issues through PPTs, interactive discussions, and supportive materials</td>
<td>One day</td>
<td></td>
</tr>
<tr>
<td>Private practitioners</td>
<td>Seek their cooperation for referring suspected TB cases to testing</td>
<td>Sensitize and seek their cooperation through interactions, discussions, PPTs, and supportive materials</td>
<td>Half day</td>
<td></td>
</tr>
<tr>
<td>ACSM staff</td>
<td>Provide conceptual clarity and discuss implementation of the different planned activities</td>
<td>Work out the detailed timeline for implementation of different ACSM activities and the materials required (procured or to be prepared)</td>
<td>Two days</td>
<td></td>
</tr>
<tr>
<td>Field staff</td>
<td>Provide training on organizing:</td>
<td>Train on:</td>
<td>Two days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community mobilization</td>
<td>• How to select the community?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• World TB Day events</td>
<td>• How to mobilize the community?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• School activities</td>
<td>• How to identify the vulnerable in the community who need special attention?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Part 4

Chapter 8. ACSM – Program

Chapter 9. Implementation Plan

Chapter 10. Toolkit for Conducting ACSM Activities
Chapter 9: ACSM - Program Implementation Plan

9.1. Planning at District and State Level

State PIP is a document states prepare annually to help them in identifying and quantifying their targets for program implementation during the year. This takes a bottom-up participatory approach that promotes need-based and decentralized planning. Preparation of district- and state-level PIPs is an important component of RNTCP under the umbrella of National Health Mission (NHM); it is included in the section on National Disease Control Program in the PIP.

(Annexure 2 provides examples of district- and state-level ACSM planning format and guidelines under NHM.)

The step-by-step process for PIP preparation is given below.

1. Planning at sub-district level
   - Planning at sub-district level starts as a bottom-up approach where inputs are taken from all implementing levels — DMC, PHI, and TUs.

2. District PIP
   - The District PIP should be prepared by the DTO in consultation with the district team and partners, based on situation analysis of TUs and the district as a whole.
   - The District PIP should prioritize and identify DMCs and TUs for ACSM intervention in the coming year as well as in the next two years.
   - The district PIP should also identify and prioritize the different TB program issues/challenges emerging from TUs and the interventions needed in the district under RNTCP.
   - In the process, it should prioritize both the program challenges and the target audiences that require ACSM intervention in a given district.

3. State PIP
   - The state PIP should be prepared by the SIECO in consultation with the State TB Officer (STO), DTOs, and other concerned staff at state headquarters.
   - Draft district PIPs are discussed in groups of 4–5 districts and ‘finalized’ as district PIPs.
   - The district PIPs are consolidated into one document as the draft state PIP by the IEC officer, in consultation with the STO and other concerned staff. Here, ACSM interventions for the state are prioritized for the planned financial year as well as for the next 2–3 years.
   - In the process, the district PIPs the state PIP are finalized and sent to CTD for approval.
   - Once the state ACSM PIP and budget is approved by the CTD, the SIECO should rework the state and district PIPs to reprioritize ACSM activities.

9.2. Key Components of PIPs

This section briefly discusses the following components of PIPs:

1. Activity
2. Timeline
3. Budget
4. Justification

Activity
The ACSM activities planned during the period are listed down. Some of the common activities listed in the format include community meetings, patient-provider meetings, school activities, and outreach activity. The number of planned activities is mentioned against the timeline (for every quarter).

**Timeline**

The timeline is very important in planning, as communication activities need to be consistent and regular if they are to have a larger impact on behavior change. Planning timelines are divided into four quarters, but one must ensure that activities spread across all the quarters and not be aggregated in the last quarter of January–March.

**Budget and resource mobilization**

Budgeting is a crucial component in planning ACSM activities. Budgeting for ACSM activities should cover materials, events, training, monitoring and evaluation, etc. It is equally important to understand and follow the ACSM financial guidelines, which are issued by CTD. (Refer to annexure 2.1 for details on the ACSM financial guidelines.)

Both ACSM financial guidelines and the previous year’s budget utilization should be kept in view as only 10–15 percent increase in budget allocation is the general norm. Bigger increases are uncommon and have to be explained with full justification. Hence, it is important to prioritize ACSM activities and prepare a realistic plan and budget estimation.

**Justification**

The reason/purpose for undertaking the ACSM activities is recorded in the last column of the PIP format.

**Table 12: Example of implementation plan format**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
<th>Budget</th>
<th>Justification/Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td></td>
<td>Apr–June</td>
<td>(July–Sep)</td>
<td>(Oct–Dec)</td>
</tr>
</tbody>
</table>
Chapter 10: Toolkit for Conducting ACSM Activities

In this chapter we will discuss how some common ACSM activities can be conducted in an effective manner to meet our communication objectives. While this chapter presents guidance on carrying out ACSM activities, states can innovate and customize an activity as per their requirement.

10.1. World TB Day

The World TB Day is a worldwide event celebrated each year on March 24. Different countries and regions choose locally relevant activities and messages to mark and focus on TB as a major public health issue. In India also, different events and activities are organized at national, state, district, and community levels to draw public attention to TB as a major health problem and the efforts that are being made under RNTCP to control and eradicate the disease and make India a TB-free country.

The World TB Day represents a worldwide call to action as well as a means of mobilizing political and social commitment at the national level. In India, the major part of ACSM activities and budget is planned for World TB Day, making it necessary to plan it well to get the maximum mileage.

As a major media event, the World TB Day provides a good opportunity to draw public attention to:

- The good work that has been done under RNTCP
- The local/regional/national TB scenario to inform and emphasize the urgency
- The gaps and what more needs to be done
- The role different sections of society and service providers can play to bridge the gaps

World TB Day events should aim to:

- Increase understanding of the prevailing TB scenario among the general public
- Increase commitment from local leaders/health managers/administrators to fight TB
- Attract media attention/coverage to emphasize the urgency of TB control for wider understanding, support, and commitment
- Mobilize support of stakeholders
- Co-opt new groups as partners, such as businesses, private practitioners, NGOs, and professional bodies, that are important in the fight against TB

Start preparations for World TB Day early, preferably a month in advance. The following preparatory work must be accomplished well before March 24, the World TB Day.

Constitute a small committee of 5–10 key active stakeholders for planning World TB Day activities. These individuals must be willing to take responsibility for preparing the necessary documents and media materials. The committee members may come from among program managers, opinion leaders from the community, media persons, as well as TB patients who have been cured or are on DOTS. The committee should:

- Set reasonable objectives for World TB Day, keeping in view the budget and other resources
- Consider mobilizing external resources by associating with businesses/industries as partners
- Develop interesting and relevant activities and events
- Ensure accomplishment of the following suggested tasks within timelines:
1. **Prepare a list of events**/activities to be organized and prioritize them on basis of importance, relevance, and cost-effectiveness. These may include seminar/conference or a rally.

2. **Work out the details** for the selected activities, for example, who will participate, participant numbers, venue, duration, detailed program, materials required, cost, etc.

3. **Prepare a list of VIPs/celebrities** to be invited to the events; they should be informed well in time and their consent obtained.

4. **Prepare a list of journalists**, along with their contact details, to cover the events.

5. **Prepare a backgrounder/briefing document/fact sheet**, describing the TB situation in your area, district, state, national as well as global level and highlighting the good work accomplished in the fight against TB in your area/region and some success/human interest stories.

6. **Prepare a speech** for the occasion, with PPT, graphs/charts, photographs, etc., for display at the event venue.

7. **Prepare audio-visual and print materials** required for mass publicity of the event, like flexi banners, posters, radio/TV spots and programs, print advertisement, etc.

8. **Prepare a press release** for print and electronic media to facilitate proper coverage.

9. **Assess the outcome** of the different events and the lessons learnt.

**10.2. Media Engagement**

Effective media engagement is necessary for greater support and mobilization in favor of the RNTCP program. Media can, in many ways, be our target audience, helping to generate public awareness and momentum for change. However, media engagement is akin to a double-edged sword, and the IEC Officer must, therefore, strategically plan the program’s engagement with media.

**10.2.1. Understanding the media environment**

Often we forget that media personnel are not health programmers, and are primarily interested in stories and events that will attract the attention of their readers and listeners. They will not attend an event or write about a program just because you ask them to. Hence, you must know the media’s likes and dislikes to understand their perspective.

**Media likes:**
- Stories with audience appeal
- Issues that stimulate debate, controversy, or conflict
- Stories that create higher ratings and bring in larger audiences
- Fresh angles or twists on issues that will attract public interest
- Accurate background information

**Media dislikes:**
- Covering old topics
- Duplicating stories reported by competitors
- Reporting inaccuracies or an incomplete picture
- Receiving numerous calls while on a deadline
- People who persist when a story idea is rejected
- People who believe their story is interesting simply because it is theirs or who have the attitude that the importance of the story is obvious
After understanding what the media likes/dislikes, it is important to understand what the media environment is like. Think about the following:

- What do the media outlets in your area report on? Does the media report on your health topic (TB) or area of interest? How frequently? How accurately?

To answer these questions, the program should:

- Monitor the media to see what they cover, how often, and the actual content
- Make a list of media outlets (e.g., stations, newspapers, bloggers) who might be interested in your program
- Compile a list of people to contact for your media events

10.2.2. Determining how to engage the media

There are many ways of engaging media, some of which are listed below. Nonetheless, as IEC Officers and government employees, you must remember to follow the ministry’s rules and program protocols when engaging media.

- Press conference/media briefing/campaign launch
- Interviews
- Opinion pieces
- Letter to editor
- Create publicity-generating events

Refer to Annexure 5 for methods and tips on engaging media.

10.2.3. Organizing a press conference

As a best practice, keep the media informed about the various developments in the fight against TB. This would improve mass awareness, inspire public debate, and create a favorable environment to control TB and make India TB free. In addition to World TB Day, create other occasions and opportunities to interact with media persons and provide them information about the challenges, the good work done, and success/human-interest stories relating to RNTCP.

The following steps and tips are essential for organizing a successful press conference/event:

- Prepare a list of media persons reporting/writing on health and development issues for print and electronic media at local, district, state, and national levels.
- Invite politicians, celebrities, and NGOs to the press conference.
- Prepare an invitation letter clearly indicating the time, place, key person(s), and political leaders/celebrities/senior officials who will address the conference.
- Ensure that the press conference/event venue is convenient to reach. It could also be a place that showcases some activity/facility related to the fight against TB as these are ‘news’ in themselves.
- Along with the invitation, send the media more information about the planned event, indicating the participation/involvement of politician/celebrities.

---

11 Adopted from SBCC campaign toolkit of the Improving Healthy Behaviors Program, FHI 360
• Also send background materials, with statistics/fact sheets/videos/slides about the prevailing TB scenario, the work being done to fight TB, success/human-interest stories, etc., so that the media persons can come prepared to ask questions or seek clarifications/more information.
• Prepare a press release giving a new angle on the TB situation to make it newsworthy.

10.2.4. Preparing a Press Release

News reporting follows an inverted pyramid format, where the most important and interesting information features on top in the widest part and the other information and facts of diminishing importance taper at the bottom of the news story. Your press release should also follow this format to structure and prioritize information. Consider the following tips for creating a good press release:

• A well-crafted press release must have a catchy headline that is interesting, eye-catching, and shows urgency to fight TB. However, it should not sensationalize the situation/event.
• The most important information should be contained in the first few sentences/paragraphs, followed by less important information/facts in a descending order, like a quote from a celebrity/VIP, details about the TB situation in your area or region, latest facts/statistics, program highlights, some human interest angle/story, and other significant facts or statements.
• The press release should preferably be accompanied by a document/backgrounder on the fight against TB, the current situation, challenges, the work being done, and success and human-interest stories supported by statistics/fact sheets/graphs/photographs, etc.
• It should also carry contact details of the person who may be contacted for clarification or further information.

10.3. Community Mobilization

As you are aware, social mobilization is about seeking cooperation and support from different stakeholders in general and the community in specific. Social mobilization activities include group and community meetings, school activities, traditional media group performances, rallies and road shows, home visits, etc. IPC and group communication are the main channels of communication for disseminating TB-related key messages. This section discusses the necessary steps/actions required for effective and meaningful community mobilization.

A community group is a group of local collected people belonging to the same area, like a village or a town. These could be yuva mandals (youth clubs), mahila mandals (women’s clubs), self-help groups (SHGs), schools, religious groups, or similar groups. The program must mobilize, sensitize, and advocate with these existing community groups through regular meetings at the village level to address myths and misconceptions and help persons with TB symptoms seek timely and appropriate care or referrals. Some community groups the ACSM strategy could target include:

• Village Health Sanitation and Nutrition Committees

In each Gram Panchayat, Village Health Sanitation and Nutrition Committees (VHSNCs) have been formed at the village level under National Rural Health Mission (NRHM). These committees are entrusted with community-level planning and implementation of health and sanitation, and have representation from the local government, local health center, and the local community. Our primary aim should be to engage VHSNCs, so that its members can prioritize TB in their meetings and village plans.
Yuva mandal/mahila mandals (Youth/women’s clubs)
Some groups are community-level federations of young boys/girls/women, sometimes even comprising several women SHGs. These groups act as a bridge for disseminating information in the village about government’s TB-related schemes and facilities.

Self-help groups
An SHG is a group of individuals with a homogenous social and economic background, who voluntarily come together to regularly save small amounts of money and contribute to a local fund to meet the members’ emergency needs on a mutual help basis. These groups collectively manage their payments and ensure proper use of credits. Many NGOs currently engaged in the project are involved in formation/registration of these SHGs. It would be advisable to involve these NGOs for ease of implementation.

Community-based organizations
A CBO is a small group of people from a community, who come together for a particular purpose. It may be a local association of people mobilized around water conservation, mother and child care, sustainable agriculture, education, or adolescent health; a group of social service persons; or any other such active group in a village.

Panchayat Raj Institution (PRI) members
PRI refers to local self-government at the village level. The village pradhan (head) and members of the Panchayat are elected members of the Gram Panchayat. They are the key people who can, after sensitization, mobilize the community for TB care and control and make allocations for TB patients’ nutrition and travel requirements.

10.3.1. Conducting Community Meetings

The key aspects of organizing community meetings are briefly described below:

Facilitators: Community meetings are organized by the STS/partner NGOs and conducted under the supervision of the Medical Officer.

Purpose: The purpose of these meetings is to create awareness about the signs and symptoms of TB, availability of free diagnosis and treatment at health facilities, and availability of good quality drugs under the direct observation of the DOTS provider. The option of becoming a community DOTS providers can also be highlighted in these meetings.

Target group: General public, community leaders/people’s representatives, SHGs, NGOs, community volunteers, traditional healers, people practicing other systems of medicine, etc., form the target group for these meetings. The meetings should be attended by at least 20–25 key people of the village and the general population.

Place: These meeting are to be organized at the village or slum level. They can be organized in the community center or any other suitable common place in the community, as suggested by the people. If the village/slum are large, these meetings can be planned at more than one location to ensure participation from all sections of the village/slum.
Duration and frequency: These meetings can be organized once a month in a village/slum; each meeting could last one to two hours. (Multiple meetings in a village/slum would still be considered as one meeting.)

Identifying a community: The communities/villages should be identified across the district on the basis of situation analysis, as discussed in Chapter 4. Once the communities are selected, the partner NGOs/STS should:

- Prepare the profile of the community in terms of population/households, socioeconomic category, caste groups, and TB suspected vulnerable groups/households.
- Prepare a list of influencers, including members of the elected Panchayat, schoolteachers, representatives of clubs, SHGs, VHSNCs, and other CBOs.

Steps in planning a community meeting:
1. Identify villages/slums in the marginalized and vulnerable population areas, and share this information with NGOs/volunteers.
2. Plan the community meeting along with:
   - VHSNC meetings (Note: VHSNC meetings are conducted in each state on specific days known as Village Health Nutrition Days. The meetings dates are available with BPMU of each block.)
   - Mobile medical unit (MMU) visit (The MMUs visit most of the vulnerable and marginalized populations.)
   - Reproductive and child health camps or family planning camps (when these camps are conducted in specific block or village).
   
   This approach can help synergize efforts for TB care and control in the block/district.
3. STS/NGOs must visit the identified villages/slums before conducting the community meeting, meet with key people in the village/slum, and finalize the date and the venue for the community meeting. If possible, individually inform all the key influencers and make a public announcement about the community meeting schedule (date and time) to discuss the TB scenario and efforts to control it.
4. Involve the identified volunteers to inform community members about the planned community meeting.
5. Prepare a list of the events/activities to be carried out during the course of the community meeting.
6. On the day of the community meeting, STS/partner NGO team should go well prepared to carry out the planned activities, which may include:
   - Make a public announcement with a handheld loudspeaker; this can be done by one of the team members who should preferably be dressed like a clown and wearing the TB logo, urging people to assemble at the designated place. The costume will help draw attention.
   - Once people have assembled, a senior team member should introduce the other team members and address the audience about TB; the gravity of the situation in terms of health, loss of wages, lose of money in treatment, and loss of life; work being done under RNTCP; and DOTS as a free and sure cure for TB.
   - Make the interaction participatory, especially encouraging women and people from weaker and vulnerable sections to speak up and shares their concerns.
   - At the venue of the meeting, display posters, charts/illustrations, photographs, etc., to create an ambience and set the context for your presentation.
   - Use the local language, preferably the local dialect, for your presentation to aid in identification and easy comprehension.
Distribute handbills/leaflets with basic information on the fight against TB to supplement your talk and as a take-home for further dissemination of information and repeated exposure. The participants may also be provided small refreshments (tea, snacks).

**Messages:**

The meeting should dispel fear and stigma associated with TB and create urgency for proper testing at the designed facilities. The following messages should go to the community members loud and clear:

- TB is curable.
- Anyone, rich or poor, can be infected by the TB bacteria.
- Anyone having a cough for more than two weeks should go in for proper testing.
- Testing and treatment are free.
- Follow DOTS for sure cure of TB.
- Complete the treatment under DOTS.
- Absence of symptoms after treatment for some time does not mean TB is cured.
- Leaving DOTS treatment in between can lead to drug-resistant TB, which can be a more serious health issue.

(These may be shared in the course of the discussion/lecture, followed by the question-answer session.)

**Health communication materials and things to carry for the community meeting:**

- Flip charts
- Sufficient handbills carrying basic TB information in the local language
- Banner with paper label (date and place)
- About 100 referral slips (only use RNTCP referral slips)
- Adequate number of sputum cups and collection bags

**Outcome:**

- Community's increased awareness of TB
- Dissemination of information on TB diagnostic and treatment services
- Support to TB patients through social acceptance and by reducing/overcoming stigma
- Support to TB patients in treatment adherence
- Inclusion of TB care and control measures in the village’s health plans
- Discussion about TB on Village Health and Nutrition Days

The community meeting should also result in identification of some active men and women as volunteers in the fight against TB. These TB volunteers should be given the responsibility of carrying on awareness campaigns and motivating TB suspects to go for testing and, if found TB positive, obtain complete treatment under DOTS.

The STS/NGO partner should monitor the progress in community mobilization and case detection by visiting the community or speaking with TB volunteers over the phone.

**Report writing:**

At the end of each meeting, a report may be prepared by the STS, stating the date/time of the meeting, the number of attendees, name of facilitators, and the topics covered along with the major concerns shared. A list of persons who attended the meeting may be attached with the report.

The STS/NGO partner should indicate the organization of these meetings in their tour diary, mentioning the place, number of persons, presence of MO at the meeting, and the main points that were discussed. These details may be submitted by the STS to the MOTC on a monthly basis for onward submission to the DTO and inclusion in the quarterly project management report (PMR) report.
10.4. School Activities

School is another major vehicle for social mobilization of young students to fight against TB. In an effort to catch them young, in 2012 CTD issued directions to all the states to conduct TB awareness campaigns in schools. Addressing the school assembly/class and holding painting competitions, rallies, and road shows are the common ‘school activities’ undertaken to create awareness about TB among children. This section presents some guidelines/steps that can make the school activities more effective.

Steps for organizing school activities

Step 1: The first and the foremost thing to do is to establish contact with the department of school education at national/state/district level and bring it on board in the fight against TB.

Step 2: The next step is to enlist all the schools and colleges in the district.

Step 3: Organize training of trainers (TOT) for schoolteachers, who will in turn conduct school activities in a planned and coordinated manner to maximize impact.

Step 4: Display and distribute appropriate support materials, like posters/charts/videos/pamphlets, etc., in local language that may be provided by the state government and for which the prototype may have been prepared by the center.

Step 5: Help the schools utilize the opportunity innovatively by involving students in group activities like paintings competitions, dramas/plays, and road shows, etc.

Figure 7: ACSM activities at schools

School activities could prove very effective, provided they are planned well and fully involve teachers through the education department. Young children can play an important role in awareness generation and removing the stigma associated with TB in their homes and neighborhoods.
10.5. Folk Performances

A variety of entertainment-centered folk performances are prevalent and popular in rural areas. Offering popular entertainment, they have a strong identification and emotional appeal with the local populace. These can be co-opted in the fight against TB, especially in rural areas and urban slums. This section outlines the steps to maximize the efficacy of folk performances as a tool for social mobilization in rural areas.

As a first step, the partner NGO/Communication Facilitator should list the different folk forms of entertainment and identify the better-known teams for the purpose of social mobilization in an area/district/state. Short orientation workshops may be organized to sensitize the performers about the key issues related to TB and the messages that can address these issues, enabling them to creatively incorporate these in their presentations and performances.

India has a rich tradition of performing arts and theatre, which bring together storytelling, mime, poetry, song, puppetry, magic, drama, and dance in many forms. The country’s cultural diversity, fairs, festivals, and seasons account for an incomparable richness of folk traditions. Despite the great variations in themes, forms, and styles, the one common characteristic of folk traditions is their interactive style, a participatory approach between the actors, performers, and the audience.

In rural India, performances are recognized as community events enjoyed by all sections regardless of economic class, caste, and creed. In these communities and rural societies, which have low literacy, folk forms provide a special opportunity. The entertainment value associated with these traditional forms; their ability to use local folklore, dialects, costumes, and music; and their immense popularity makes them a powerful tool to deliver messages and an effective communication medium to reach out to the rural masses.

Given its rich regional variations, folk is the only medium that allows communication to be need-based, localized, and region-specific, thereby ensuring a much greater impact. There is a word of caution as well, related to the challenges this medium faces in two areas: (1) training the performers and building capacity to integrate TB-related messages with entertainment while keeping the right balance and (2) tackling the logistics and organizational challenges of conducting the performances in the field.

10.5.1. Script writing and capacity building

For each folk form, it is important that experts create exclusive scripts keeping in mind the various messages that need to be communicated and the myths dispelled. In order to bring uniformity in message content and effective message delivery, all the identified/selected troupes should also undergo rigorous training, which includes developing scripts with the troupes and practicing them.

Training workshops for performance troupes should involve complete orientation of the troupes on RNTCP objectives and sensitizing them about the nature of messages required. These capacity building workshops are not only a training ground for troupes but also an opportunity to integrate them into ongoing RNTCP campaigns while retaining their individual styles. The scripts usually center around story ideas that are rich in entertainment value and interspersed with RNTCP messages. Prior preparation of scripts ensures standardization of messages, their quality, and duration of performances. The workshops provide the participants an opportunity to work on the scripts and encourage improvisation to add flavor of local dialects and folklores. In this participatory process and group work, the scripts are modified, refined, and finalized for use in the field. Finer details like tune, costumes, and props are also discussed for each script. Emphasis is laid on striking a balance between entertainment and education.

10.5.2 The planning process

Folk media implementation follows a systematic planning process involving various activities like selection of troupes, development of scripts, planning the logistics for conducting folk shows, using NGOs and village key personnel (PRI members, SHG members, ANMs, ASHAs, Anganwadi workers) as local facilitators for folk troupes, monitoring, and feedback. Some key steps are presented in the figure below.
10.5.3. Troupe selection

Based on their specialization/style, troupes are registered into various categories by the Director of Information in the state and the Song and Drama Division of the Government of India. These agencies also fix the fee to be paid to the troupes for each performance. You must select troupes from among the registered ones, based on popular local styles. An audition must then be carried out, aided by local experts and the SIECO. Two key members from each shortlisted troupe will then be invited to attend a workshop on script writing.

The selection process must keep in mind the need to select troupes from different parts of the state so that they can be assigned performances close to their home base. This would reduce time and cost on troupe movement as well as ensure that troupes perform in the particular dialects, costumes, and folklores of a particular region.

10.5.4. Route mapping

Villages in remote locations and having a population size of e.g. (1000-4000 populations) and limited mass media reach are selected. This mapping may be done in close collaboration with the block MOs and TUs. The list of villages in a district should be compiled in the prescribed format and carry details of logistics. A sample is presented below for reference.

<table>
<thead>
<tr>
<th>Name of District:</th>
<th>Name of Block:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of performance</td>
<td>Name of village</td>
</tr>
<tr>
<td>Time of performance</td>
<td>Distance from block</td>
</tr>
<tr>
<td></td>
<td>Distance from the previous village</td>
</tr>
<tr>
<td></td>
<td>Name of contact person for the village</td>
</tr>
</tbody>
</table>
This standardized format with details like the location of a village and distances between villages are shared with the troupe, the TUs, the DTO, and NGOs for local facilitation and monitoring and to look at the suitability of a particular folk form, dates of festivals, and local conditions. This is used to allocate villages to each folk troupe and develop a route plan. If the troupe is not able to perform at the prescribed location on the allocated date because of unforeseen circumstances, the troupe will carry on to the next area and follow the prescribed route plan on the prescribed dates; the left-out villages may be covered on new dates in consultation with key stakeholders.

10.5.5. Coordination meeting

A coordination meeting is organized at the district level between the TU staff, NGOs, and folk troupe to orient them all on quality issues like stage lighting, sound systems, choice of venue, pre-publicity, and minimum standard for each troupe. Each of these stakeholders must be briefed to keep in mind the comfort level of women viewers and weaker sections and the monitoring system. Apart from ironing out various logistics issues, these meetings also trigger feelings of ownership about the folk performances among TU staff and NGOs, which in turn helps in efficient implementation. It is important to ensure that the village community is informed and mobilized for arrangements before the troupe reaches the village. On the day of the performance, information about the performance can be disseminated through announcements or by beating of drums, etc.

10.5.6. Important points to remember

**Location/venue:** Holding the performance at a central place, which is within the reach of all communities, ensures better attendance.

**Time:** Performances must be organized in evenings when people are free from their daily chores.

**Pre-publicity:** Proper publicity of the performance a day before helps in crowd mobilization and increases attendance.

**Balance of entertainment and education:** Ensuring a right balance of entertainment and intended messaging is crucial for a successful performance. The ability to attract and hold the audience’s attention with entertainment without diluting the message content depends on the skill of the troupe.

**Display of IEC materials:** In order to reinforce the intended messages, the troupe should be provided with IEC materials for display on the stage and to answer audience queries on TB.

**Introduction of local service providers:** Calling the local DOTS provider, health care service provider, and TB volunteer on the stage and introducing them to the audience is vital for increasing the providers’ self-esteem as well as establishing their identity in the community.

**Linkages with the services/service providers:** Announcing the nearest DMC, diagnostic facility, and treatment facility is important. Names of service providers and their contact details may be shared with the audience. Onsite referrals can also be made for accessing services.

10.6. Patient-Provider Meetings

ACSM activities are not an end by themselves, but means to an end. Increased case detection and adherence to DOTS is crucial to the success of RNTCP. Patient-provider meetings play a very important role to this end. Such interactions at various stages of the process help in: convincing TB suspects (persons having cough for more than two weeks) to go to DMC for proper testing; if found positive, putting him/her on DOTS; and ensuring adherence to the DOTS regime to complete the course for sure cure. This section briefly lists some ways of making patient-provider meetings more effective.

Patient-provider meetings use IPC and group communication techniques. All field-level staff who engage in patient-provider meetings at different levels must have well-honed soft skills. To ensure this, special short courses in soft skills may be organized if necessary. They field staff must:

- Have the ability to establish rapport and build relations
- Understand the group dynamics in patient’s social network
- Possess counseling abilities - should have the patience to listen carefully and address the points/issues raised by the patient in an assuring and encouraging manner and not critically
- Share success stories of cured TB patients to motivate and boost the morale of patients
- Address related health issues
Part 5

Chapter 11. Monitoring and Evaluation

Chapter 12. Documenting Lessons and Results
Chapter 11: Monitoring and Evaluation

Monitoring and evaluation is a necessary component of ACSM planning and implementation. Monitoring helps to keep an eye on the ‘output’ of ACSM and provides feedback on implementation of different activities — what was planned and what it accomplished. It provides an opportunity for making necessary course corrections and ensures adequate quality. Evaluation focuses on the ‘outcome’ of different programs and activities under ACSM. It helps in assessing the relevance, efficiency, and effectiveness of different ACSM programs and activities — what worked and what did not work as planned, the difficulties encountered, and the lessons learnt. This chapter outlines simple methods and techniques for monitoring and evaluating ACSM activities.

Why is monitoring of ACSM activities important?

As an RNTCP professional, you need to understand how monitoring of ACSM implementation is useful. Monitoring ACSM activities goes beyond merely counting the number of activities planned and achieved. It ensures quality implementation of the activities planned and takes the necessary corrective action. Some practical benefits of monitoring are discussed below:

- Ensures that materials and media are distributed as planned (e.g., after they are sent to the district government office, they get distributed in the community as directed)
- Ensures that materials are used appropriately (e.g., job aids are carried and used during ASHA counseling sessions and not left at home)
- Ensures that IPC and mid-media activities are implemented in a quality way (e.g., regular field supervision is occurring; checklists are used)
- Changes the sites where the graphic material is displayed for greater effectiveness (e.g., posters placed in a space where your audience will see it), broadcast in other media and/or at more appropriate times (e.g., if your audience listens to the radio at 11:00AM, air the message at 11:00AM)
- Delays the broadcast launch if a product has not been produced, has not been delivered, or is not available at all the promised sites
- Reshapes training sessions (e.g., if not delivering on their intended objectives)
- Improves distribution systems
- Changes elements of message strategy
- Makes mid-course corrections during implementation
- Shifts internal workloads or responsibilities

As we now know of some benefits of monitoring ACSM activities, it is important to understand how we can monitor ACSM activities. In order to develop a comprehensive monitoring plan for ACSM, the program needs to:

1. Define and decide what will be monitored
2. Develop monitoring indicators and targets
3. Develop monitoring methods and tools

Let us look at these in greater detail.

1. Define what will be monitored

Defining what will be monitored requires us to first define the key ACSM activities and materials used in the program. The focus here could be on program reach, program quality, and program output.

To define what will be monitored, we need to determine what questions need to be answered, as shown in the table below.
### Table 13: Key monitoring questions and tips

<table>
<thead>
<tr>
<th>What to Monitor</th>
<th>Example Questions to Ask</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advocacy activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy with district magistrate and CMHO to get support in addressing TB-related issues</td>
<td>Are the advocacy materials developed and used?</td>
<td></td>
</tr>
<tr>
<td>Advocacy meeting with PRI officials to increase local and political support for TB-related activities</td>
<td>Do sensitization meetings have clear objectives and agenda?</td>
<td></td>
</tr>
<tr>
<td><strong>Communication activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mass media broadcasting</td>
<td>Are the spots being broadcasted at specified time on selected stations?</td>
<td>To monitor mass media, specified people should listen/watch during the contracted time slots to determine whether the materials are being broadcast as scheduled.</td>
</tr>
<tr>
<td></td>
<td>Are the stations following the mass media plan?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the campaign reaching the intended audience?</td>
<td></td>
</tr>
<tr>
<td>Mid-media activities</td>
<td>Are the scripts being followed?</td>
<td>To monitor mid-media, develop questions and tools to ensure that the events are not only implemented according to schedule, but also that there is quality implementation.</td>
</tr>
<tr>
<td></td>
<td>Are key messages consistent?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the target audience members attending these events?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the events being held at the scheduled time and location?</td>
<td></td>
</tr>
<tr>
<td>Interpersonal communication</td>
<td>Are the key messages given to patients, their family members, and community consistent?</td>
<td>To monitor IPC, develop questions and tools to interview patients and groups to ensure quality implementation.</td>
</tr>
<tr>
<td>Exposure</td>
<td>Is the campaign reaching your intended audience well enough?</td>
<td>If your materials are not reaching your intended audience, consider another station, location, or channel.</td>
</tr>
<tr>
<td></td>
<td>Has the audience been exposed to the campaign?</td>
<td></td>
</tr>
<tr>
<td><strong>Social mobilization activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitization meeting with PRI representatives and local bodies</td>
<td>Do the meetings have clear objectives and agenda?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the communication materials for sensitization being used?</td>
<td></td>
</tr>
<tr>
<td>Annual World TB Day activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distributions of print materials</td>
<td>Are your materials placed where your audience can see and read them?</td>
<td>These types of questions can help you find out if the materials are reaching the target audience in a timely and effective manner.</td>
</tr>
<tr>
<td></td>
<td>Have your materials reached their intended audience?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the materials being used?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are audience members taking home the materials?</td>
<td></td>
</tr>
<tr>
<td>Logistics</td>
<td>Are the program components, such as print materials and supplies, being delivered on time, to the right place, by the right people, and to the right audience?</td>
<td>This is the minimum level of monitoring required to ensure that your efforts and the money spent is reaching the intended people and places, at the times, and with the quality you planned for.</td>
</tr>
</tbody>
</table>
2. Develop monitoring indicators and targets

Once we develop the key questions to be asked for monitoring ACSM activities, it is important to understand how to measure them, that is, defining key indicators to measure the process or the quality of the implemented activities. Refer to the table below for examples of monitoring indicators and tools that one can use.

Table 14: Monitoring indicators and tools

<table>
<thead>
<tr>
<th>Measuring What</th>
<th>Process/Output Indicator</th>
<th>Tools/Methods to Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advocacy activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy with district magistrate and CMHO to get support in addressing TB-related issues</td>
<td>Number of district officials sensitized on TB-related issues</td>
<td>Minutes of the meeting with key decision and actions taken</td>
</tr>
<tr>
<td></td>
<td>Number of meetings conducted</td>
<td></td>
</tr>
<tr>
<td>Advocacy meeting with PRI officials to increase local and political support for TB-related activities</td>
<td>Number of PRI representatives attending the advocacy meeting</td>
<td>Minutes of the meeting</td>
</tr>
<tr>
<td></td>
<td>Number of PRI representatives willing to support TB-related issues in the community</td>
<td>Regular participation of RNTCP officials in such meetings</td>
</tr>
<tr>
<td><strong>Communication activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mass media broadcasting</td>
<td>Spot or program is aired on schedule</td>
<td>Listening to broadcast to ensure media messages are aired at the contracted hours</td>
</tr>
<tr>
<td></td>
<td>Extent to which a news release was covered accurately, positively framed, or strategically placed</td>
<td>Review when broadcast airs according to the media plan</td>
</tr>
<tr>
<td></td>
<td>Percentage of target audience who saw/heard/read the material (announcement, news article, radio program, etc.)</td>
<td>Program logs to capture coverage statistics of media sources, web matrix, etc.</td>
</tr>
<tr>
<td></td>
<td>Number of unique website page views of messages/material</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of materials downloaded</td>
<td></td>
</tr>
<tr>
<td>Mid-media activities</td>
<td>Number of activities where scripts are followed and key messages are consistent</td>
<td>Observation notes and supervisor notes to document the quality of interaction</td>
</tr>
<tr>
<td></td>
<td>Number of mid-media activities conducted as planned</td>
<td>Mystery client visit</td>
</tr>
<tr>
<td></td>
<td>Number of community members who participated in dialogues during sessions</td>
<td>Participant feedback form</td>
</tr>
<tr>
<td></td>
<td>Level of peer educator/ASHA/provider—audience interaction during contacts</td>
<td>Participant focus group discussion</td>
</tr>
<tr>
<td></td>
<td>Percentage of target audience satisfied with peer educator/ASHA/provider contact</td>
<td>Reach and recall surveys to capture exposure and perception</td>
</tr>
</tbody>
</table>
### Measuring What

<table>
<thead>
<tr>
<th>Measuring What</th>
<th>Process/Output Indicator</th>
<th>Tools/Methods to Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal communication</td>
<td>Increased ability of community members</td>
<td></td>
</tr>
<tr>
<td><strong>Exposure</strong></td>
<td>Percentage of target audience who saw/heard/read the material (announcement, news article, radio program, etc.)</td>
<td>Program logs to capture coverage statistics from media source, web metrics obtained via Google software, participants’ attendance in community meetings</td>
</tr>
<tr>
<td></td>
<td>Number of community members who participated in communication activity during sessions</td>
<td>Household or telephone survey with target audience in the catchment area to determine exposure</td>
</tr>
<tr>
<td></td>
<td>Percentage of the target audience who saw the billboards/posters</td>
<td>Reach and recall study to capture exposure and perception</td>
</tr>
<tr>
<td></td>
<td>Percentage of target audience who were able to recall the message of the health communication material/media (radio, TV, billboard/poster, print material)</td>
<td></td>
</tr>
<tr>
<td><strong>Social mobilization activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empower former TB patients to become DOTS providers</td>
<td>Number of former TB patients trained as DOTS providers</td>
<td>Training registers</td>
</tr>
<tr>
<td></td>
<td>Number of DOTS provider training sessions held</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of TB patients treated by DOTS providers (cured TB patients)</td>
<td></td>
</tr>
<tr>
<td>Sensitization of local and religious leaders on TB and related stigma in the community</td>
<td>Number of materials developed</td>
<td>Meeting reports of sensitization meeting with leaders</td>
</tr>
<tr>
<td></td>
<td>Number of sensitization meetings held</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of religious leaders sensitized on TB and TB stigma</td>
<td></td>
</tr>
<tr>
<td>Distributions of print materials</td>
<td>Type of media source airing or disseminating the material (print media, radio, TV, Internet)</td>
<td>Regular audit of materials at health facility, block, district, and state levels</td>
</tr>
<tr>
<td></td>
<td>Number of hoardings/posters disseminated in the catchment area</td>
<td>Program logs to capture records on the type of media source and the number and types of materials disseminated by the channel</td>
</tr>
<tr>
<td></td>
<td>Number of materials disseminated by peer educators, ASHAs by type (e.g., educational pamphlets)</td>
<td>Regular field trips to distribution sites to check on the availability of products or materials</td>
</tr>
<tr>
<td>Logistics</td>
<td>Number of campaign components implemented according to schedule</td>
<td>Review of media plan and schedule with tracking sheet</td>
</tr>
<tr>
<td></td>
<td>Number of materials delivered on time, to the right place, by the right people, and to the right audience</td>
<td></td>
</tr>
<tr>
<td>Training plan</td>
<td>Number of trainings conducted</td>
<td>Training log to capture number of trainings and participants</td>
</tr>
<tr>
<td></td>
<td>Number of participants trained</td>
<td>Pre-test and post-test</td>
</tr>
<tr>
<td></td>
<td>Number of participants with increased skills/knowledge</td>
<td>Follow-up survey on use and transfer of skills</td>
</tr>
<tr>
<td></td>
<td>Number of participants using or transferring skills</td>
<td></td>
</tr>
</tbody>
</table>
3. Develop monitoring methods and tools

It must be ensured that ACSM monitoring is carried out with appropriate tools and mechanisms. ACSM activities can be monitored through routine monitoring mechanisms under RNTCP. Some of the regular monitoring activities under RNTCP are:

- Conducting monitoring visits at:
  - District level
  - State level
  State-level internal evaluations are regularly conducted by states. The SIECO must be part of the committee monitoring ACSM activities in the state.

- Holding review meetings at:
  - District level
  - State level
Chapter 12: Documenting Lessons and Results

Documenting lessons and results of ACSM is important to RNTCP’s objectives for many reasons. Firstly, such an exercise helps the program to review the successes as well as challenges in implementing ACSM activities. Secondly, it makes it easier for the program to share results, lessons, and challenges with other states, districts, and partners.

Not all ACSM interventions achieve positive results. Disappointing results may occur due to many reasons. Sometimes, even circumstances or poor decisions beyond the control of planners and implementers may put a hurdle. Learning about successes and failures in TB control is important. Failures provide the most useful information for future planning.

It is useful to know what aspect of the ACSM activity needs to be documented and what ACSM activity results should be documented. Some guiding questions are shared below:

1. To what extent have ACSM activities achieved their objectives in your area?
2. How much did the activity/activities cost?
3. What worked? What did not work?
4. What should have been done differently? What will be done differently in the future?
5. What assumptions were made that were not true when evaluated?
6. What questions remain to be answered?
7. What new questions have emerged?
8. What would an outsider want to know about this activity/activities?
9. What is the value of the ACSM activity/activities?

What is a best or promising practice?

A “best practice” is commonly defined as a technique or methodology that has, through experience and research, proven reliable in leading to a desired result. It is not about perfection or ideal, but merely brings forth the elements or parts of activity/practice that have worked well in one situation and hold promise to do well in other similar situations, that is, they can be replicated and are worth sharing with others. In fact, what has not worked well and why is also worth sharing as a best practice so that others can learn from the experience and not repeat the same mistakes.

Documenting and sharing best practices provides one the opportunity to acquire knowledge about lessons learned; facilitates continued learning about how strategies and activities can be to improved, and enables reflection and analysis to implement larger-scale, sustained, and more effective interventions. A commitment to using a best practice is a commitment to using the body of knowledge and technology at one’s disposal to ensure success.

The ACSM teams at district and state levels should identify and analyze some of the ACSM programs and activities that have, according to their judgment, worked well and were successful from the perspective of TB control. To be identified as a best practice, a practice must fulfill the following three criteria:

---

Effectiveness: This is a fundamental criterion implicit in the definition. The practice must work and achieve results that are measurable.

Efficiency: The proposed practice must produce results with a reasonable investment of resources and time.

Relevance: The proposed practice must address the priority concerns of RNTCP.

The ACSM team should properly document any such best practices in detail, with the context, process, and outcome/success in addressing specific TB control issues/concerns under RNTCP. It should offer detailed descriptions with visual support, where possible. Such best practices should be shared with those engaged in TB control as well as with other stakeholders.
References

1. TB WHO Global Tuberculosis Report 2012
   http://health.india.com/diseases-conditions/world-tuberculosis-day-2012-facts-about-tuberculosis-you-should-know/

2. Baseline IEC document-RNTCP II-CTD; page 5; 2007

3. Zero TB Deaths Stop TB in my Life; TB India 2013 Annual Status Report, Government of India


5. WHO: Guidelines for Social Mobilization; Planning World TB Day

6. WHO: Advocacy Communication and Social Mobilization for TB Control - Collection of country level good practices

7. Handouts “Cough to cure pathway”


9. TB India annual status report 2013
   http://www.tbcindia.nic.in/pdfs/tb%20india%202013.pdf

10. National Strategic Plan RNTCP (2012-2017), Central TB Division MoHPFW

11. Universal access to TB care in India
    http://www.tbcindia.nic.in/pdfs/Universal_access_to_TB_Care.pdf

12. A guide to monitoring and evaluation of ACSM, Stop TB partnership

13. Behavioral barriers in tuberculosis control; a literature review
## Annexures

### Annexure 1: ACSM framework

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Audience</th>
<th>Key Objective</th>
<th>Methodology</th>
<th>Tools/Materials Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>• Policy-makers&lt;br&gt;• Program managers&lt;br&gt;• Media professionals and other influencers</td>
<td>To advocate and influence them to solicit their active support for RNTCP, in terms of policy, budget allocation and program implementation</td>
<td>• Meetings&lt;br&gt;• Discussions&lt;br&gt;• Sensitization and orientation workshops</td>
<td>• Background reading materials&lt;br&gt;• Fact sheet&lt;br&gt;• Case studies of successes&lt;br&gt;• PPT</td>
</tr>
<tr>
<td>Communication</td>
<td>All stakeholders e.g.:&lt;br&gt;• TB suspects&lt;br&gt;• TB patients&lt;br&gt;• Service providers&lt;br&gt;• Public at large</td>
<td>To create awareness through specific messages</td>
<td>Use of:&lt;br&gt;• Mass media,&lt;br&gt;• Mid-media&lt;br&gt;• IPC</td>
<td>Press ads, TV and radio spots, posters, leaflets, booklets, wall writings, hoardings, folk performances, flip charts, and other audio-visual aids</td>
</tr>
<tr>
<td>Social mobilization</td>
<td>• All stakeholders&lt;br&gt;• Community, especially vulnerable groups such as slum dwellers&lt;br&gt;• Schools/colleges&lt;br&gt;• Factory workers, etc.</td>
<td>Reinforce awareness and motivation and mobilize for specific action</td>
<td>Group meetings, with more specific targeted information and interaction to address participants’ concerns</td>
<td>Audio-visual aids, posters, banners, charts</td>
</tr>
</tbody>
</table>
Annexure 2.1 Revised financial norms for ACSM

The financial norms for ACSM activities at state and district level are following:

**State level**

- Population up to 10 million: Rs. 10 Lakhs
- Population of 10 to 30 million: Rs. 14 Lakhs.
- Population of over 30 million: Rs. 20 Lakhs.

IEC Agency and Activity cost (apart from above) for local need based ACSM state level initiatives: Rs. 0.40 lakh per million populations

**District level**

- Rs 1.88 lakh per million populations per year.
- For more focused targeting already identified urban cities with more than 1 million population the norms is higher at Rs 3.38 lakh/million population per year.
- For all other urban areas with municipal corporations / councils Rs. 2.33 lakh per million population per year.
**Annexure 2.2: ACSM planning format**

**State Level**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State Level ACSM Officer - Remuneration</td>
<td>0</td>
<td>#DIV/0!</td>
<td>0</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>State-level ACSM</td>
<td>1000000</td>
<td></td>
<td>0</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>District-level ACSM</td>
<td>0</td>
<td></td>
<td>0</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
## Handbook on Advocacy, Communication, and Social Mobilization for RNTCP

### District Level

#### 4. Advocacy, Communication and Social Mobilization

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-provider meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Name of the Activity

<table>
<thead>
<tr>
<th>Name of the Activity</th>
<th>Number of Activities Undertaken in 2012-13</th>
<th>Number of Activities Undertaken in 2013-14 (till Sep 2013)</th>
<th>Number of Activities Proposed in 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr-Jun</td>
<td>Jul-Sep</td>
<td>Oct-Dec</td>
</tr>
<tr>
<td>Community meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-provider meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Annexure 3: Sample pre-test questions

1. What is the main idea of this brochure, radio spot, or other type of material?
2. Is this material for people like you or for other people?
3. Is there anything about the material or product that might confuse, offend, or embarrass some people? What in particular?
4. Is there anything in the material that you really like? Which part? Why?
5. Is there anything in the material that you do not like? Which part? Why?
6. Is the information/scenario/story believable? Why or why not?
7. Do you think the material is attractive or appealing? Why or why not?
8. What do you think can be done to make the material better?
9. Do you think this material will help people? How?
Annexure 4: Format for monitoring planned vs. actual performance of ACSM activities (example)

List all the ACSM activities as output indicators planned for the year, and monitor the actual performance against each of these activities and reasons for shortfall, if any.

<table>
<thead>
<tr>
<th>Output Indicators</th>
<th>Planned</th>
<th>Actual Performance</th>
<th>Remarks/Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio spots</td>
<td>X</td>
<td>Y</td>
<td>----</td>
</tr>
<tr>
<td>TV spots</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Print advertisements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy workshops</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Policy makers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Program executives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Media professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community mobilization meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-provider meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoardings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wall writings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaflets/pamphlets</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annexure 5: Approaches to engage media

<table>
<thead>
<tr>
<th>Methods/Approaches</th>
<th>Tips</th>
</tr>
</thead>
</table>
| **Press conference/media briefing/campaign launch** | • Have a high-ranking official or someone who is respected attend so that the event is seen as newsworthy.  
• Schedule the event early in the week before other events and stories have taken priority.  
• Consider involving community members and other stakeholders.  
• Identify key spokespersons available for follow-up interviews.  
• Make sure the entire event does not only involve speeches.  
• Ensure there is an appropriate mix of activities, such as screenings of spots, drama, Q&A.  
• Consider allowing media to teleconference in.  
• Holding a press event requires a lot of effort (planning) and expense. |
| • Plan events with enough time for media personnel to ask questions. Sometimes, host a panel of experts.  
• Ensure events are appropriate, up-to-date, and newsworthy, such as campaign launches or significant program updates.  
• Ensure that you are clear as to what information will be given out and the purpose of the event.  
• Invite your guests and panel (if you have one) early and form an agenda.  
• Prepare and disseminate a press release and media advisory at least a week in advance.  
• Make promotional materials and media kits available. | |
| **Interviews**                          | • When invited to be interviewed, ask if it will be live or taped, if there are call-in questions, and what other guests might be featured.  
• Learn as much as you can about the host and the program.  
• Write down powerful anecdotes and personal stories that might be shared.  
• Remain calm during the interview; do not get defensive.  
• Present messages from the media plan as quickly and precisely as possible.  
• Refer the audience to campaign materials/activities for additional information instead of detailing them out during the interview. |
| • Participating in radio and television talk shows can allow IEC Officers to talk about the program’s goals and experiences concerning a health topic.  
• Interviews can increase interest in the campaign’s goals and reach audiences that might not typically be reached.  
• Interviews can be low cost ways of promoting the campaign. | |
| **Opinion pieces**                      | • Ask local supporters to sign letters sent to their local media outlet.  
• Ask a prominent person or expert or a group of organizations to write the opinion piece.  
• Say something new or provide a fresh view.  
• Avoid criticizing others and only stating problems; offer some recommendations and solutions. |
| • These are used to express a strong opinion about an issue with local impact.  
• These are great ways to draw attention to an important issue, respond to criticism, correct false information, or recognize community support for an event or issue related to your campaign. | |
| **Letter to the editor**                | • Keep letters short, concise, and fresh.  
• Do not repeat and reinforce negative information.  
• Consider using this format to reinforce a positive, accurate story about the health topic.  
• Be professional. |
| • They allow comment on a specific news story, editorial, or letter.  
• They can be used to respond to an article on a health topic you are interested in.  
• They can also be used to praise balanced and accurate coverage provided by a newspaper.  
• They can point out and correct important mistakes. | |
| **Publicity-generating events**         | • They can be used to recruit or educate people to whom your target audience listens and turn them into spokespeople for your campaign.  
• Carefully consider the use of this type of event, as it requires careful design, planning, and implementation. |
| • Various events, from roundtable conferences to concerts, can generate publicity and excitement.  
• These are often designed by a public relations firm in collaboration with an event planner. | |