OPERATIONAL HANDBOOK ON ACSM

सत्यमेव जयते
Ministry of Health and Family Welfare
Government of India

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

Central TB Division, Ministry of Health and Family Welfare

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Foreword

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MBBS. MD
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सत्यमेव जयते

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Government of India
केन्द्रीय टीबी प्रभाग
Central TB Division
स्वास्थ्य सेवा महानिदेशालय
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The overall vision of Revised National Tuberculosis Control Program (RNTCP) is "A TB free India". The central theme is the "Universal Access" to quality assured TB diagnosis and treatment with quality assured drugs made available free of cost to all TB patients in the community including those of Drug Resistant, HIV and other co morbidity associated TB. Undiagnosed and mistreated cases continue to drive the epidemic. This entails finding unreached TB cases before they can transmit infection, and treating all of them more effectively.

Advocacy Communication and social Mobilization (ACSM) initiatives generate demand leading to early diagnosis and correct treatment as per Standards of TB Care in India. ACSM also reduce stigma which is critical for universal access. The Global plan to Stop TB (2006-15) and the Post 2015 Strategy of WHO also highlights the importance of ACSM as integrated and crucial component to achieve the goals and objectives of the Program.

To ensure effective community based ACSM program delivery, Program includes a well-defined component of ACSM capacity development of available Human Resource involved in TB control while implementing ACSM plan across the country. This **'Operational Handbook for ACSM'** is step towards strengthening capabilities at state, district and field level.

The Operational Handbook on ACSM has been developed with series of consultations and inputs from various ACSM experts from national and state levels both from public and private sectors. This document is a dynamic document and will be periodically updated for its effectiveness in the field.

This will enable them to develop feasible evidence based ACSM plan as per available resources and implement the planned ACSM activities with adequate Monitoring and supervision to ensure quality. This handbook will also be useful for state and district teams to understand and address the challenges & gaps in implementation of ACSM program.

We sincerely acknowledge support from USAID funded IHBP project of FHI 360 for their support in development of this handbook.

(Dr. Niraj Kulshrestha)

New Delhi
04th September 2014

Table of Contents

Acknowledgement

Further to the finding of ACSM status report, and its recommendation, there was a felt need for a handbook on ACSM that will act as a ready reckoner on ACSM. A guide that explains the effective planning, implementation, monitoring and evaluation of ACSM activities at the state, district and block levels. The operational handbook is realization of this need towards effective ACSM under RNTCP.

Operational handbook on ACSM is an outcome of all efforts put together by various stakeholders with lead from Central TB Division, Ministry of Health and Family Welfare, Government of India and Improving Healthy Behavior Program (IHBP), FHI 360. The initiative was possible with funding support from USAID.

First of all our sincere thanks to Dr. R.S Gupta, Deputy Director General, CTD, Dr. Niraj Kulshrestha, ADDG TB, and his senior colleagues for providing their guidance the support throughout the process. Special thanks to USAID/ New Delhi for funding support and guidance to project.

We acknowledge the contribution from all experts including State IEC officers, who provided inputs on how the document should be shaped? We also express special gratitude to all experts from the National ACSM Advisory Committee members, who have provided their technical inputs and suggestion to the handbook.

Under the leadership of Dr. Niraj Kulshrestha, ADDG TB, the following members from the working committee were responsible in writing and framing the document. Dr. J. S Yadav, Dr. Prashant Bhatt, Mr. Shiva Shrestha, Ms. Rina Sinha, Ms. Anukampa Sangwan, and Mr. Sanjeev Jain.

The draft guidelines have been reviewed and valuable comments have been provided by a group of experts comprising of Dr. Geeta Bamzai, Dr Jayshree Mathani, Mr. Bobby Ramakant, Mr. Sanjeev Kumar, Mr. Mukesh Jain, Mr. Sunil Verma, Dr. Nalini Krishnan, Ms. Sushma Cornelius, Dr. Mathiyazhagan, and Dr. Sarabjit Chadda.

Sincere thanks to Mr. Sunil Verma, Deputy Chief of the Party, and Ms. Tara Appachu Sharma , Chief of the Party, IHBP, for overall supervision and coordination in development of the Operational Handbook

Abbreviations

ACSM	Advocacy, Communication, and Social Mobilization
AIDS	Acquired Immunodeficiency Syndrome
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral therapy
ASHA	accredited social health activist
BCC	behavior change communication
CBCI	Catholic Bishops' Conference of India
CBO	community-based organization
CSO	civil society organization
CTD	Central TB Division
DMC	designated microscopy centre
DOTS	directly observed treatment short-course
DR-TB	drug-resistant tuberculosis
DTC	District Tuberculosis Centre
DTO	District Tuberculosis Officer
FBO	faith-based organization
IEC	information, education, and communication
IHBP	Improving Healthy Behaviors Program
IMA	Indian Medical Association
IPC	interpersonal communication
IRL	Intermediate Reference Laboratory
MAS	Mahila Arogya Samitee
MDR-TB	multidrug-resistant TB
MMU	mobile medical unit
MOHFW	Ministry of Health and Family Welfare
MOTC	Medical Officer-Tuberculosis Control
NACP	National AIDS Control Programme
NGO	nongovernmental organization
NHM	National Health Mission
NRHM	National Rural Health Mission
NRL	National Reference Laboratory
NUHM	National Urban Health Mission
PIP	program implementation plan
PLHIV	people living with HIV
PP	private practitioner
PPP	public-private partnership
PPM	public private mix
PRI	Panchayati Raj Institution
PWB	patient-wise box
RNTCP	Revised National Tuberculosis Control Program
SBCC	social and behavior change communication
SHG	self-help group
SIECO	State IEC Officer
STLS	Senior TB Laboratory Supervisor
STO	State TB Officer
STS	Senior Treatment Supervisor
TB	tuberculosis
TOT	training of trainers
TU	Tuberculosis Unit
USAID	United States Agency for International Development
USHA	urbansocial health activist
VHSNC	Village Health Sanitation and Nutrition Committee
XDR-TB	extensively drug-resistant TB

About This Handbook

This Handbook on ACSM is to serve as a guide and support to staff that plan, organize, supervise and execute TB control programs and activities at national, state, and district level under RNTCP. It is intended primarily for the staff-State IEC officer, District Tuberculosis Officer, Communication Facilitator- responsible for ACSM activities but others handling medical / technical tasks under TB control program will also benefit from it.

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.

The experience of assessing the ACSM scenario in five states, viz., Gujarat, Uttar Pradesh, Bihar, Karnataka, and Meghalaya, conducted by IHBP during 2012, came useful in developing this handbook. This document remains a dynamic and living document that will be updated with inputs from the field during its operationalization at state and district levels.

The handbook has been organized into seven parts:

PART 1 of the handbook describes the background and context of TB-related ACSM in India and provides conceptual clarity on the 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 objectives, approach, and implementation plan.

PART 4 discusses the selection of channels and messages based on the 'strengths' and 'weaknesses' of different channels to enable selection of cost-effective channels/vehicles of message delivery to targeted audiences and design of appropriate messages.

PART 5 describes the different tools that could be used for ACSM activities and preparation of PIPs at district and state levels as well as describes various ACSM activities with practical operational details for implementation.

PART 5 outlines the processes and targeted staff for ACSM capacity building.

PART 6 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 to plan, organize, supervise, and execute TB control ACSM activities at national, state, district, sub-district, and peripheral health institutions under RNTCP. It is primarily intended for use by State ACSM/IEC Officers, District Tuberculosis Officers (DTOs), and other partners responsible for ACSM activities. Those handling medical/technical tasks under the TB control program will also benefit from this guide.

The development process

The Operational Handbook is based on ground experience of ACSM situation assessment in five states, namely, Gujarat, Uttar Pradesh, Bihar, Karnataka, and Meghalaya, conducted by IHBP in 2012, followed by a series of consultative processes. Inputs were taken from State IEC Officers (SIECOs) and ACSM Officers during the media training workshop. A working group comprising Central TB Division's (CTD) ACSM consultants, SIECOs, WHO's RNTCP consultant, and representatives from IHBP was formed under the leadership of Dr. Niraj Kulshrestha, Additional Deputy Director General(ADDG) TB,CTD, Ministry of Health and Family Welfare (MOHFW). The first draft was circulated to the ACSM expert from the National Advisory Committee and USAID for inputs. A larger consultative workshop will be organized to gather inputs from partners and civil society organizations at a final stage of the development process.

Part-1

Concept and Context

- 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 Revised National Tuberculosis Control Programme (RNTCP), which 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

Tuberculosis (TB) is one of the oldest diseases afflicting mankind and causing immense physical, social, and economic loss to societies. TB is an infectious disease caused by bacillus *Mycobacterium tuberculosis*, which normally attacks lungs but other human organs as well. It spreads through the air droplets that are produced when an infected person coughs. Hitherto known as a '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 carries the potential risk of developing into active TB. India accounts for one-fifth of global active TB cases[1]. Nearly 2 million people in India develop TB every year, and 300,000 die of it annually[2] —approximately1,000 every dayside., 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 of TB patients 'poor management, TB is among the most common opportunistic infections and cause of death among people living with HIV (PLHIV).

1.2 Revised National TB Control Program

TB was declared a global health emergency in 1993, and India established RNTCP as a small pilot project, which was later scaled up nationwide during 1998–2006. RNTCP is based on internationally recommended directly observed treatment short-course (DOTS) strategy.

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

[1] www.whoindia.org/en/section3/section123.html, accessed on December 12, 2113.

[2] TB WHO Global Tuberculosis Report 2012, accessed on December 11, 2013.

[3] Baseline IEC document-RNTCP II-CTD; page 5; 2007, accessed on December 14, 2013.

(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 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 Centers (DMCs) in 690 RNTCP districts. Over 2,325 NGOs and 13,997 PPs, 150 corporate hospitals, and 320 medical colleges have been involved in implementing RNTCP. The program has a 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 diagnosing TB through 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 symptoms, diagnosis, and treatment process and motivate suspected cases to visit public/private labs for appropriate tests immediately after identifying symptoms. 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 and transportation to laboratory for microscopic examination, and reporting of results within 48 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.

[4] TB India 2013 Annual Status Report, Government of India

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, resulting in behavioral change among various groups of people. **Social mobilization** brings together community members and other stakeholders to strengthen community participation for sustainability and self-reliance.[5] 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:[6]

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.

[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

1.4 ACSM in RNTCP's New Strategic Vision (2012–2017)

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, 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, alcohol and other drug users, prison inmates, PLHIV, and those with other clinical risk factors[7]. The program's ACSM strategy will complement every other program initiative for achieving universal access, and be used for better demand generation of, early diagnosis and treatment, as well as improved supply of quality care services. 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 behavior-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[8]

[7] Universal access to TB care in India http://www.tbcindia.nic.in/pdfs/Universal_accessto_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.

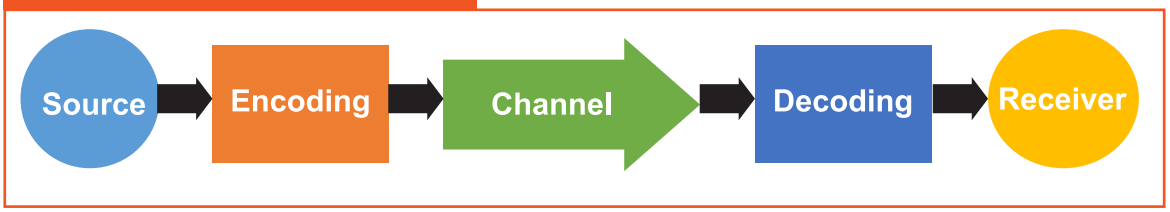
c) *Media advocacy* puts TB issues on the public agenda to generate support from governments and donors and validate the relevance of a subject. It encourages the media to cover TB-related issues regularly and in a responsible manner to raise awareness of TB as a problem and its solutions. In the process,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

[9] A guide to monitoring and evaluation of ACSM http://www.path.org/publications/files/TB_acsm_me_guide.pdf, accessed on March 3, 2013

2.1.2 Communication

In this context, communication is a process people use to exchange information about TB through media, mid-media, and interpersonal communication (IPC). The communication process is made up of four components — encoding, medium (channel) of transmission, decoding, and feedback.

Figure 1: Communication process



Much of the communication effort for 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 at the right time 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.
- Mid-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- to-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.

Figure 2: ACSM is interlinked

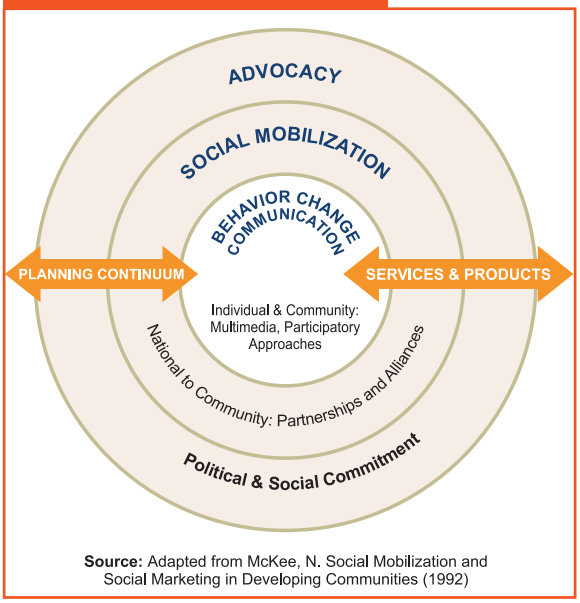
Source: PATH training curriculum on advocacy, communication, and social mobilization[10]

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

Figure 3: SBCC framework

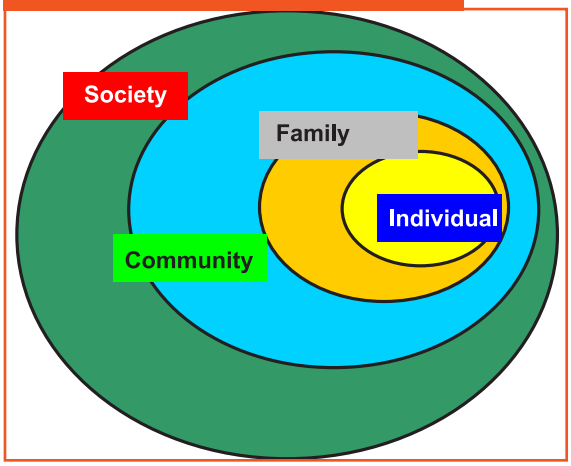


Source: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

[10] Training curriculum on Advocacy Communication and Social Mobilization (ACSM) http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM%20Training%20Curriculum.pdf, accessed on December 10, 2013

purview to bring about desired changes in health (TB) perceptions and behavior. Strategic 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 4: ACSM area of influence



2.3 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.

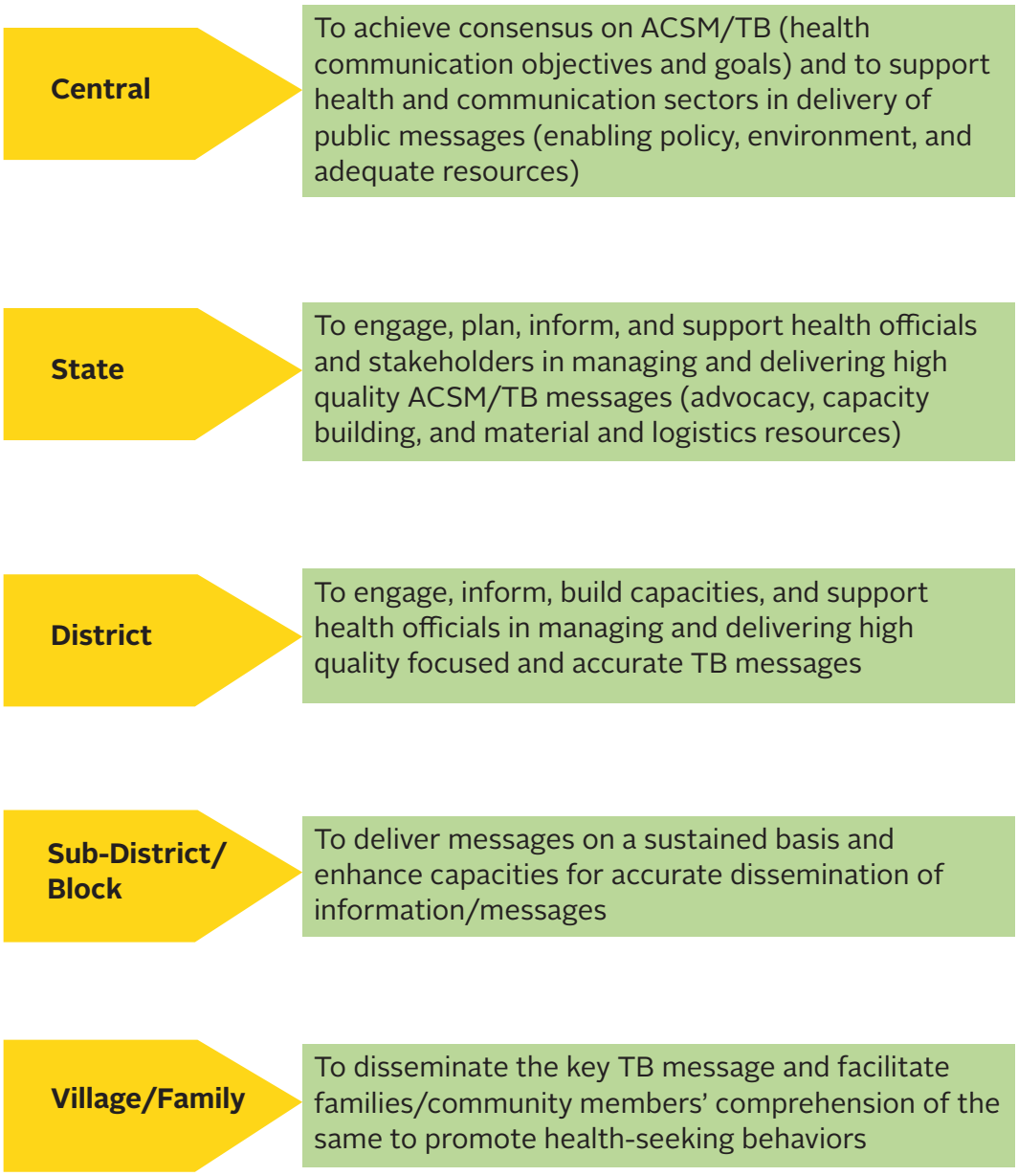
Community: Mobilize toward a common goal, create an enabling environment for individuals to adapt/practice/sustain positive behaviors, raise local resources, and foster support for bringing about wider awareness on a set of quality-of-life/TB prevention and treatment issues. An example could be building 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 constraints 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 5: Snapshot of ACSM activities at central, state, district, and community levels



PART-2

ACSM Strategy and Need Assessment

- CHAPTER 3: Developing ACSM Strategy
- CHAPTER 4: ACSM Need Assessment and Planning

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.

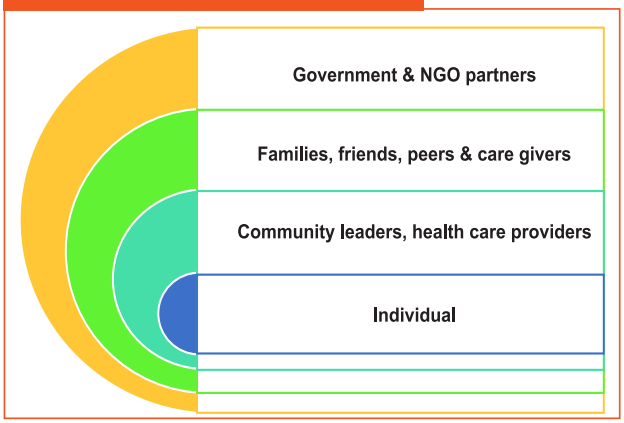
Prioritizing helps to determine what audiences we should focus on.

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:

- Community, general public, specific community
- Providers, health workers, DOTS providers
- Family members and care givers
- TB patients

Fig 6 Audience Consultation



STEP3: 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 (i.e., 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.

STEP5: 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 7 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 9.)

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 Need Assessment and Planning

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.

4.2 Steps in Situation Analysis/Need Assessment for ACSM

STEP 1: Identifying 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. Notification

TABLE 1: Example of performance matrix (district X in state Y)

TU/ DMC	Case notification %	Case adherence %	Notification %
TU 1	75	80	85
DMC 1	45	54	40
DMC 2	67	80	78
DMC 3	98	84	78
TU 2	89	80	76
DMC 4	78	75	77
DMC 5	56	60	53

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 constrains 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
   iv. Availability of poor 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
   iv. Time, place, and quality barriers

c. What are the reasons for low 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
   iv. Fear of patient loss in private sector
   v. Non-availability of platform for notification

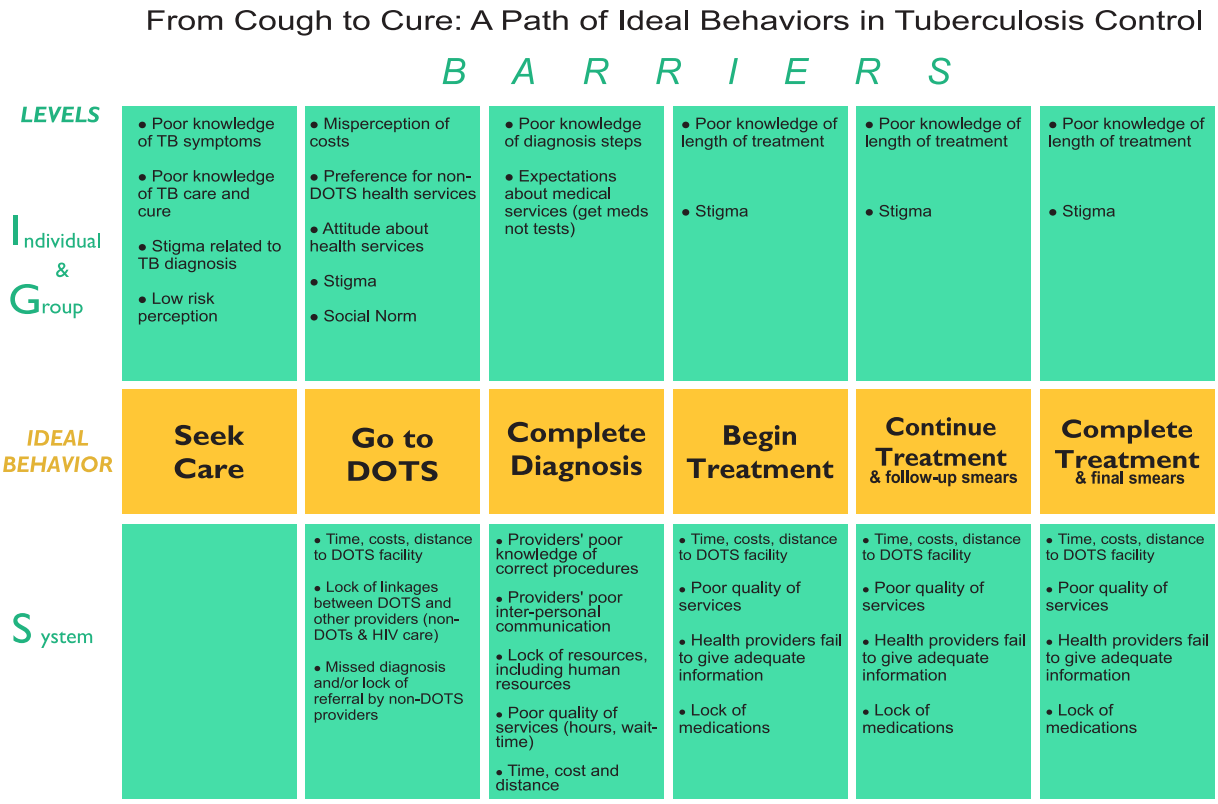
Responses to these questions will help in identifying the various program challenges and in planning appropriate ACSM activities.

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 levels.(see Figure 7)

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 9.

Figure 7: Cough to Cure Pathway as a planning tool in ACSM



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

	Target Audience
Advocacy	• Decision-makers at national, regional, state and district levels (NRHM official, MD NRHM, District Magistrate, CEO Janpat, RNTCP leadership) • Policy-makers • Professional groups • Funders • Media
Communication	• 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.) • TB patients currently on treatment as well as cured TB patients • Contacts of patients with active TB • People at high risk of developing TB
Social mobilization	• Communities • Community groups, e.g. ,mahila mandals, youth groups • National and local level leaders • Local NGOs, youth organizations, CBOs

Part-3
ACSM Objectives, Approach, and Planning

- CHAPTER 5: Developing ACSM Objectives and Approach
- CHAPTER 6: ACSM Program Implementation Plan

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 4, 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 the 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(i.e., 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-bound.

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 vs. 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

RNTCP Objectives	ACSM Objectives
Universal access to TB Early detection and treatment of at least 90percent of all types of estimated TB cases in the community, including drug-resistant and HIV-associated TB Successful treatment of at least 90 percent of new TB patients, and at least 85 percent of previously-treated patients Reduction in default rate of new TB cases to less than 5 percent and re-treatment TB cases to less than10 percent.	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 March 2015
	Mobilize at least 20 percent of the private chemists/pharmacies in district X by March 2015 to refer people with TB-like symptoms to DOTS facilities for screening
	By March -2015, improve TB knowledge of primary health care providers in 20 medical facilities of the five provinces

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.

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.

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 7.

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

TABLE 4: ACSM approaches

RNTCP Objectives	ACSM Objectives	Activities and Channels
Gain political and administrative commitment	Increase participation and support from government and political representatives, with commitment to implement RNTCP	Advocacy, seminars and briefing meetings Print information (letters, factsheets) Events around World TB Day and other occasions
Improve case detection	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 2015	Formative research to determine best messages and approaches Mass media campaigns, including radio and television Distribution of print materials at community meetings or events Training in IPC and counseling for health workers Community mobilization activities
Increase treatment success rate	Increase awareness and support for TB treatment among TB patients by 2015 Form and strengthen community structures (patient groups, etc.) to support TB patients	Training in IPC and counseling for health workers Mass media campaigns, including radio and television Extensive distribution of print materials at health care facilities Community mobilization activities Peer education at community or interest group meetings

ACSM approach can be further strengthened by identifying the program issues that need attention / to be fixed, reasons/ causes of each such issue, and specific ACSM activity that can help in resolving the program issue. The district /state PIP should step by step identify different TB program issues/ challenges in the district / state that needed interventions under RNTCP, objectives of each intervention/ activities, required ACSM inputs, specific communication objectives of each ACSM activity and the likely time line and the cost involved.

Program Issues / Challenges	Reasons	ACSM Intervention objective	Target audience	Suggestive Media	Time line & costs
Poor case detection	Lack of awareness, stigma	Create mass awareness	General public	Advertisement in district level media; newspaper/ magazines local cable TV	
			Vulnerable groups/ communities	Mid-media; wall writings, pamphlets, folk performance	
	Poor referral	Advocacy	Govt./private Doctors & other health services providers	Advocacy workshop	

TABLE 5: ACSM framework

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

Media advocacy is critical and can serve as a great partner to the programme.

Mass media campaigns have short life but engagement with media/journalists pays long term dividends.

Chapter 6
ACSM Program Implementation Plan

6.1 Planning at District and State Level

State PIP is a document states prepare annually to help them identify and quantify their targets for program implementation during the year. It 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.

(Table 6 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:

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.

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.

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 states are prioritized for the planned financial year as well as for the next 2–3 years.
- In the process, the district PIPs and 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.

6.2 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 are spread across all quarters and not 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 1 for details on ACSM financial guidelines.)

Both ACSM financial guidelines and the previous year's budget utilization should be kept in view as only10–15 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.

Additional Resource Mobilization

It will be good to associate and link ACSM programmes and activities with other related health and development issues like HIV /AIDS, diabetics, general fitness and wellbeing programs and also with development and living conditions. This will help in mainstreaming RNTCP.

Further, in age of Corporate Social Responsibility, it will worth the efforts to involve the corporate and business houses to give their helping hand to RNTCP as a part of their social responsibility for wellbeing of their employees and cut loss due absents due to their illness.

TABLE 6: Example of planning format (PIP format)

State Level

Advocacy, Communication, and Social Mobilization								Analysis			Justification/ Remarks	Budget Proposed						
Activity	Budget Proposed in Last Annual Action plan (2012-13)	Amount Available under this head (Opening balance+ received) (2012-13)	Amount Spent (2012-13)	Approved ACSM Plan for 2013-14	Amount spent in 2013-14 (till Sep 2013)	Permissible Budget as per Population Norm for 2014-15	Budget Proposed for 2014-15 (2014-15)	% of Expenditure Planned and Actually Spent in Last Financial Year				2014-15					2015-16	2016-17
												Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Total		
State Level ACSM Officer - Remuneration								#DIV/0!								0		
State-level ACSM					1000000	0		#DIV/0!								0		
District-level ACSM					0			#DIV/0!								**0**		
Total	**0**	**0**		**0**		**1000000**	**0**	**#DIV/0!**								**0**		
												0	**0**	**0**	**0**	**0**	**0**	**0**

District Level

4. Advocacy, Communication, and Social Mobilization									Justification/ Remarks
Activity	Budget Proposed in Last Annual Action plan (2012-13)	Amount Available in this Head (Opening balance+ released by the state) (2012-13)	Amount Spent by District (2012-13)	Approved ACSM Plan for 2013-14	Amount Spent in 2013-14 (till Sep 2013)	Permissible Budget as per Population Norm for 2014-15	Budget Proposed for 2014-15		
Total						0			

Name of the Activity	Number of Activities Undertaken in 2012-13	Number of Activities Undertaken in 2013-14 (till Sep 2013)	Number of Activities Proposed in 2014-15					Budget Proposed for Next FY 2014-15
			Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	TOTAL	
Community meeting							0	
Patient-provider meeting							0	
School activity							0	
Outreach activity							0	
CME							0	
							0	
							0	
							0	
Total	0	0	0	0	0	0	0	0

Part-4

Channels and Message

- CHAPTER 7: Selection of Channels
- CHAPTER 8: Message Designing

Chapter 7
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'/'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, media planners can a devise a cost-effective media plan. (Refer to Table 7 for more insight on the strengths and weaknesses of different communications channels.)

7.1 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:

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.

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.

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.

Media habits and preferences of target audiences

a. Tailor programming to the audience's preferred listening times and favorite stations, programs, and media.

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 don't 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 combination of channels. The matrix below provides a snapshot of the strengths and weaknesses of different communication channels.

TABLE 7: Strengths and weaknesses of different communication channels

Channels/ Tools	Audiences Reached	Strengths	Weaknesses/ Limitations
Mass Media Channels			
Television	Households, families	Most effective medium as it: • Has 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

Channels/ Tools	Audiences Reached	Strengths	Weaknesses/ Limitations
Radio	Individuals, households, families	• Radio production is simple and much less expensive than TV • Radio/transistor sets are cheap and poor can easily afford them • One can carry it around; does not depend on electricity supply • One can listen to radio programs on mobile phones as well • One can listen individually or in groups • Flexible and can be interactive, as community radio is localized and effective medium of dialogue and discussion among community members • Reinforces any visual messages from TV or outdoor media • Relatively wider reach than TV among rural and migrant populations	• 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
Newspaper 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 factor. • Growing regional and vernacular media; Hindi publications account for 53 percent of the newspapers sold and English for 17 percent only. • Timely and fixed schedule of dissemination • Pictorial description of message	• 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 advertisements per se, unless the advertisement is attractive and eye catching enough

Channels/ Tools	Audiences Reached	Strengths	Weaknesses/ Limitations
Mid-Media-Outdoor Publicity Materials and Folk Arts/Dramas			
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

Channels/ Tools	Audiences Reached	Strengths	Weaknesses/ Limitations
Folk dramas	Groups, community	• Entertaining and can grab audience attention • Audio-visual display helps with message retention • Can touch an emotional chord with individuals/ households; useful for sensitization	• Relatively small reach • Expensive to scale up • Requires precision of timing • Requires good artists with prior training
Interpersonal Communication (IPC)			
Counseling	Individuals	• Credible source due to face-to-face communication • Allows detailed explanation of key health messages • Can help dispel myths and check wrong practices	• Time taking to build reach • Small reach (individual) • Costly to scale up • Requires special training
Home visits	Households	• Credible source due to face-to-face communication • Allows detailed explanation of key health messages • Can help dispel myths and check wrong practices • Useful for rapport building	• Time taking to build reach • Small reach to target audience • Requires adequate capacity building
Community Dialogue			
Seminars, workshops, and Parliament questions	Policy-makers, implementers, urban population	• Brainstorming of key stakeholders • Identification of key communication challenges • Key inputs from experts and academicians	• Not timely • High cost of implementation • Time taking to bring about change • Difficulty in mobilizing key stakeholders
Public meetings and gatherings	Key influencers, individuals, households	• Emphasis on key messages by influencers/stakeholders • Useful for addressing different segments of the target audience together	• Intermittent in occurrence • High organizing cost • Only verbal communication involved • Reach is relatively small
Working with groups	Households, individuals	• Dissemination of key messages among communities • Word-of-mouth	• Low frequency • Only verbal communication involved

Channels/ Tools	Audiences Reached	Strengths	Weaknesses/ Limitations
		Social Media	
• Facebook, blogs, YouTube, SMS	Individuals	• Targets individuals but has a wide/mass reach • Effective method of reaching a large number • High visibility among decision-makers	• Only limited people have access to Internet accounts on Facebook, and an even smaller number has blogs
Mobile* Phones	Individuals/groups	Targets individuals but can reach large number through SMS Large number of people including in rural India now have access to mobile phones.	Only voice and text messages as most mobile sets are low end, but the 3G visuals would be possible

*Mobile Phone:

Mobile phone penetration is increasing by the day. With 3G and internet access mobile phones will be in greater use for information dissemination, sharing specific instructions, greater bonding and more effective patient counselling ensuring adherence and completion of DOTS treatment. There is tremendous scope for use of mobile phone technology in ACSM in coming years. Hence there is a need for innovative use of available mobile phone technology to suit the local and regional needs

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 8.

TABLE 8: Example of ACSM program framework

Causes of Program Issues	ACSM Objectives	Target Audience	Communication Channels	Key Messages	Expected Outcome
Program Issues/Challenges-Poor case detection					
• Lack of awareness • Poor knowledge of TB symptoms • Poor risk perception • Misconception 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	• Ads in media -newspapers, magazines, local cable TV • Mid-media - wall writings, pamphlets, folk performances	• Ads in media -newspapers, magazines, local cable TV • Mid-media - wall writings, pamphlets, folk performances	• Increased awareness • **Improved case detection**
• Stigma	• Reduce stigma around 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 adherence to DOTS					
• 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	• Ads in media -newspapers, magazines, local cable TV • Mid-media - wall writings, pamphlets, folk performances	• 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

Causes of Program Issues	ACSM Objectives	Target Audience	Communication Channels	Key Messages	Expected Outcome
			• TB patients 'and DOTS providers' meetings • Meetings with DOTS providers and other health service providers		
Program Issues/Challenges-Poor referral					
• Lack of awareness and commitment	• Increase awareness of TB notification and private sector partnerships in RNTCP	• Government and private doctors • Other health services providers	• Advocacy workshop	• Advocacy • Consequences of TB for public health	• **Increased referral from PPs**
Program Issues/Challenges-MDR-TB and HIV-TB co-infection					
• Lack of motivation, commitment, and discipline	• Increase awareness, motivation, and support for MDR-TB and HIV-TB patients	• TB patients • DOTS providers • Service providers • Influencers	• Intensive and extended counseling • Build/strengthen counseling abilities of service providers	• Build confidence, motivation, and discipline	• **Reduction in MDR-TB and HIV-TB co-infection cases**

Chapter 8
Message Designing

The correct message and its effective delivery to intended audiences are 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.

8.1 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.

8.2 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. These 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 9: Key messaging questions

Question	Your Answer (examples)
What is the desired change?	TB patients should complete DOTS treatment.
What are the barriers?	Lack of information about the side effects of the medicine Poor knowledge about the need to complete treatment
What are the communication objectives?	Create knowledge among TB patients about the side effects of the treatment Motivate TB patients to complete DOTS treatment
What do the key promise and support statement say?	*"There are minor side effects like nausea, vomiting, joint pains, and itching. But do not 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 messages 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 to 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 healthcare 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 centers 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 10. See Table 11 for examples of good TB-related messages.

Table 10: Characteristics of effective messages

Key Characteristics of a Good Message	Guidance and Tips	Checklist for Developing Effective Messages
Commands attention	The message should catch attention and generate interest among the audience.	The message stands out to your audience. The message is believable.
Has clarity	Clear messages contain as few technical terms as possible and eliminate information that the audience does not need for responding to the message.	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.
Communicates a benefit	Audiences should be able to perceive the benefit of adopting the suggested desirable behavior.(How do I directly benefit by changing to the suggested behavior?).	The message clearly states what the audience gets in return for taking an action. The message conveys that the benefits outweigh the barriers.
Is consistent	*Scientific findings about health often change with new research. Messages from your program should attempt to convey consistent and accurate information.*	Key messages are used appropriately and ensure consistency and support for all of the program's materials.
Caters to the head and the heart	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.	The message uses an appropriate tone for the audience. The appeal is appropriate as laid out in the creative brief.
Creates trust/ credibility	Information should be believable and have a credible source, as determined by your audience research.	The information comes from a credible source.
Calls to action	TB-related messages should have a sense of urgency and deliver a call to action.	The call to action clearly states what the audience should do after seeing the communication. The call to action is realistic.

8.3 Pre-testing Messages and Design

In a 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.

Below is an example of a pre-testing question guide you can use to pre-test your message.

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?

TABLE 11: Examples of good TB-related messages

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

PART-5
Toolkit

- CHAPTER 9: Toolkit for Conducting ACSM Activities

Chapter 9
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.

9.1 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 helps mobilize 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, which 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.

9.2 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.

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.

There are a lot of vernacular language media, which need to be catered to as these reach to masses and are effective in creating mass awareness on different issues including health. As far as possible prepare your media material in vernacular language. As such, it is important that a press release is prepared in vernacular languages. Technical terms like MDR commonly used in English need to be carefully translated into regional languages explain these properly to avoid confusion.

At the same time adequate caution/ care must be taken while communicating with the media as information may

get misinterpreted – for example in a scenario where a district/area does a good job of case finding and detects 1000 cases over a given period, the information may get misinterpreted as an increase in TB cases. So proper care must be taken to put present and interpret facts in the right context.

There should be a mechanism for media tracking. The programme should respond to stories that cause concern (negative stories) and connect with journalists who do these stories to get more details/ clarifications. Example –an article that appeared in a local newspaper reported that a mother burnt to death her son who had TB. Information on why this happened was not communicated through the story. It raises questions on whether the reasons for this were personal or did it have something to do with TB? Why did this happen when TB is curable and treatment is free?

Also offer advice on rights based terminology guidelines in all communications – for example, while talking about case finding, instead of saying TB "suspects", say "presumptive TB".

State IEC Officers should be oriented on how to engage with the media especially journalists writing on health. Database of health journalists should be developed and positive stories should be shared with the media on an ongoing basis instead of focusing only on World TB Day. The programme officers should have the list and contact details of the Journalists who cover health and even other beats (topics) in their area.

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 and dislikes, it is important to also 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[11]

[11] Adopted from SBCC campaign toolkit of the Improving Healthy Behaviors Program, FHI 360

Determining how to engage the media

There are many way 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 3for methods and approaches to engaging media effectively.

Organizing a press conference

As a best policy, 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 politicians/celebrities.
- Also send background materials, with statistics/factsheets/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.

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.

Inverted Pyramid Format of News story

Writing a press release is an art and need to carefully cultivated and used for getting mileage from media. Some of the points that may be kept in mind while writing a press release are as follows:

Before start of writing a press release, select the more important news points for use and reject the less important points. Make a list in order of priority / importance for your press release.

Of these important points decide upon the most important news point, the point with highest news value should come first. Start your press not with the point with highest news value and present it into (first para). The second point should follow the first in the second para and third from the second and so on.

Your press release should be short and crisp. It should normally be not more than one type page, shorter is always better. Addition information you may provide as backgrounder for the journalists.

In newspapers, space is one constrain; time is another. As you know well, every day large amount of news fall come to newspapers from different sources, reporters, correspondents, news agencies. Only a small proportion of this becomes 'news', others are just spiked. There is a greater possibility of PR story getting spiked. Keeping this in mind prepare your press release - short and crisps that even if the last one/two sentences or paragraphs are dropped by the chief sub no great damage is done to your news story.

Your story is competing with other stories filled by the staffers and news agencies. If your handout and staffer copy reaches late, the chief sub will prefer staffer copy. So you should send your hand out timely.

Make an assessment on the comparative news value of your news story; is it a first page story or inside pages or city edition; and accordingly plan your strategy.

As stated earlier, space and time in media cost money. The more compact you're the news copy is, the greater is the chance of the copy being used. More ready to use your copy is, that is, it is free from grammatical and typing errors and does not required re-writing, greater is the chances of its being used.

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.

9.3 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 collected local people belonging to the same area, like a village or a town. These could be *yuvamandals* (youth clubs),mahilamandals (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.
- **Yuvamandals/mahilamandals (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 fora 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.

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 provider 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 is 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.Oncethe 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 meeting 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, loss 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 creates 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 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).

9.4 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 student's in-group activities, like paintings competitions, dramas/plays, and road shows, etc.

Figure 8: ACSM activities at schools

ACSM Activities

Essay competition, Drawing competition, During Prayer TB Leaflets reading, exhibitions, Drama, Pictorial Presentation, Quiz, Puzzals, Katputali, show, Leaflets Distributions etc.

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.

9.5 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 make 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.

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.

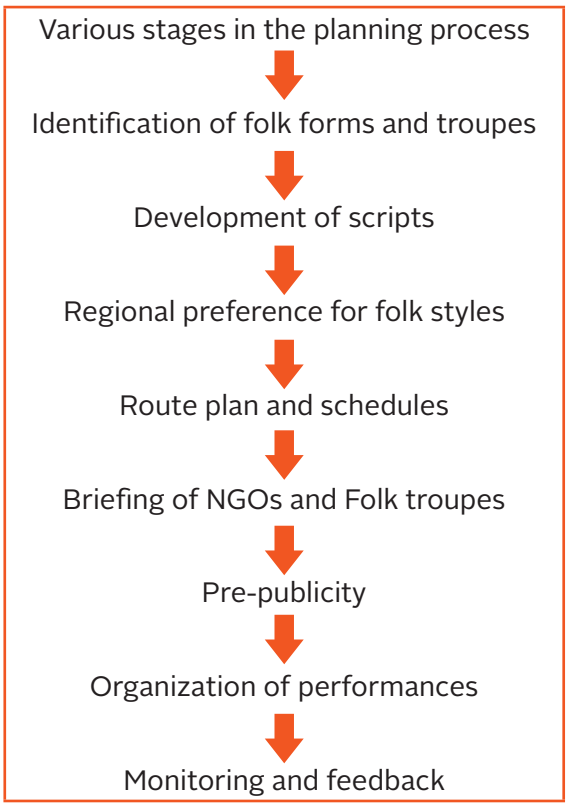
Training workshops for performance troupes should involve complete orientation of the troupes on RNTCP objectives and sensitizing them on the nature of messages required. These capacity building workshops are not only a training ground for troupes but also an opportunity to integrate them into ongoing RNTCP campaigns while retaining their individual styles. The scripts usually center on 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.

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.

Figure 9: The planning process for ACSM folk performances



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.

Route mapping

Villages in remote locations and having a population size of about 1,000–4,000 members 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 12: Sample of the prescribed format for route mapping

Name of District: ..... Name of Block: ..... .

Date of performance	Name of village	Time of performance	Distance from block	Distance from the previous village	Name of contact person for the village

This standardized format with details like the location of a village and distances between villages are shared with the troupes, 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.

Coordination meeting

A coordination meeting is organized at the district level between the TU staff, NGOs, and folk troupes 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.

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 vitalfor increasing the providers'self-esteem as well as establishing their identity in the community.

Linkages with the services/service providers: Announcing about 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.

9.6 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. The field staff must:

- Have the ability to establish rapport and build relations
- Understand the group dynamics inpatient'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

Counseling:

Under RNTCP, counseling plays an important role in case detection, registration of TB positives, putting them on DOTS, and treatment adherence till the patient is fully cured of TB. Research is increasingly finding that the type of therapy used is not as important to outcomes as specific counselor behaviors such as (1) enthusiasm, (2) confidence, and (3) belief in the patient's ability to change.

Nine basic counseling skills

1. **Listening:** While counseling the TB suspect/patient, the counselor should pay full attention to what the patient is saying verbally as well as observe him/her carefully. Researchers estimate that about 80 percent of the communication takes place non-verbally.
2. **Empathy:** This refers to the ability to perceive TB patient's experience and then to communicate that perception back to him/her to clarify and amplify their own experience, reflecting the patient's feelings and implicit messages.
3. **Genuine:** It helps to be genuine and normal with the patients. Any artificiality will show and become a hurdle in convincing the patient to adopt the suggested action or behavior.
4. **Unconditional positive regard:** Respect toward the patient is critical. The counselor should be able to communicate his/her sincere belief that every person possesses inherent strength and capacity, and that each person has the right to choose one's own alternatives and make one's own decisions.
5. **Concreteness:** The counselor should keep communications specific, focused on facts and relevant concerns while avoiding tangents, generalizations, abstract discussions, or talking about the counselor rather than the client.

6. **Open questions:** The questioning process must assist the client in clarifying or exploring thoughts or feelings. The goal is to facilitate exploration, but is not needed if the client is already doing this. The best approach is to follow a response to an open-ended question with a paraphrase or reflection, which encourages the client to share more and avoids repetitive patterns of question-answer, question-answer, and so on.
7. **Counselor self-disclosure:** The counselor could share personal feelings, experiences, or reactions with the client, but it should include relevant content intended to help them. As a rule, it is better to not self-disclose unless there is a pressing clinical need that cannot be met in any other way.
8. **Interpretation:** It refers to any statement to the client that goes beyond what they have said or are aware of. In interpretation, the counselor provides new meaning, reason, or explanation for behaviors, thoughts, or feelings, so that patients can see problems in a new way. Interpretations can help the client make connections between seemingly isolated statements of events, point out themes or patterns, or offer a new framework for understanding. An interpretation may be used to help a patient identify a specific aspect of their problem or provide a goal.
9. **Information giving and removing obstacles to change:** This refers to supplying data, opinions, facts, resources, or answers to questions. Explore with client the possible problems that may delay or prevent the change process. In collaboration with the client, also identify the possible solutions and alternatives.

Part-6
Capacity building

- CHAPTER 10: ACSM Capacity Building

Chapter 10
ACSM Capacity Building

10.1 Need for Capacity Building in ACSM

Effective implementation of planned ACSM activities requires capacity building 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 13: Groups/audiences for the ACSM training and capacity building plan

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

10.2 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

10.3 Capacity Building Workshops

This is an investment and capacity building must be linked to performance. That needs to be mentioned in this chapter. Each capacity building effort must reflect in improvement in the implementation of that subject area – for example training of ASHAs should result in greater referrals/ adherence from the villages they work in.

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.

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

PART-7

Recording and Reporting

- 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.

11.1 Importance of Monitoring ACSM Activities

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 planned activities 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.

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.

What to Monitor	Example Questions to Ask	Tips
Advocacy activities		
Advocacy with district magistrate and CMHO to get support in addressing TB-related issues	Are the advocacy materials developed and used?	
Advocacy meeting with PRI officials to increase local and political support for TB-related activities	Do sensitization meetings have clear objectives and agenda?	
Communication activities		
Mass media broadcasting	Are the spots being broadcasted at specified time on selected stations? Are the stations following the mass media plan? Is the campaign reaching the intended audience?	To monitor mass media, specified people should listen/watch during the contracted time slots to determine whether the materials are being broadcast as scheduled.
Mid-media activities	Are the scripts being followed? Are key messages consistent? Are the target audience members attending these events? Are the events being held at the scheduled time and location?	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.
Interpersonal communication	Are the key messages given to patients, their family members, and community consistent?	To monitor IPC, develop questions and tools to interview patients and groups to ensure quality implementation.
Exposure	Is the campaign reaching your intended audience well enough? Has the audience been exposed to the campaign?	If your materials are not reaching your intended audience, consider another station, location, or channel.
Social mobilization activities		
Sensitization meeting with PRI representatives and local bodies	Do the meetings have clear objectives and agenda? Are the communication materials for sensitization being used?	

What to Monitor	Example Questions to Ask	Tips
Annual World TB Day activities		
Distributions of print materials	Are your materials placed where your audience can see and read them? Have your materials reached their intended audience? Are the materials being used? Are audience members taking home the materials?	These types of questions can help you find out if the materials are reaching the target audience in a timely and effective manner.
Logistics	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?	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.
Training plan	Is the training on schedule and delivered as designed?	Training is time consuming and expensive, so it must be done correctly.

Source: Adopted from SBCC Curriculum, FHI 360

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, i.e., defining key indicators to measure the process or the quality of implemented activities. Refer to the table below for examples of monitoring indicators and tools that one can use.

TABLE 16: Monitoring indicators and tools

Measuring What	Process/Output Indicator	Tools/Methods to Monitor
Advocacy activities		
Advocacy with district magistrate and CMHO to get support in addressing TB-related issues	Number of district officials sensitized on TB-related issues Number of meetings conducted	Minutes of the meeting with key decision and actions taken
Advocacy meeting with PRI officials to increase local and political support for TB-related activities	Number of PRI representatives attending the advocacy meeting Number of PRI representatives willing to support TB-related issues in the community	Minutes of the meeting Regular participation of RNTCP officials in such meetings

Measuring What	Process/Output Indicator	Tools/Methods to Monitor
Communication activities		
Mass media broadcasting	Spot or program is aired on schedule Extent to which a news release was covered accurately, positively framed, or strategically placed Percentage of target audience who saw/heard/read the material (announcement, news article, radio program, etc.) Number of unique website page views of messages/material Number of materials downloaded	Listening to broadcast to ensure media messages are aired at the contracted hours Review when broadcast airs according to the media plan Program logs to capture coverage statistics of media sources, web matrix, etc.
Mid-media activities	Number of activities where scripts are followed and key messages are consistent Number of mid-media activities conducted as planned Number of community members who participated in dialogues during sessions Level of peer educator/ASHA/ provider-audience interaction during contacts Percentage of target audience satisfied with peer educator/ASHA/ provider contact Increased ability of community members	Observation notes and supervisor notes to document the quality of interaction Mystery client visit Participant feedback form Participant focus group discussion Reach and recall surveys to capture exposure and perception
Interpersonal communication		
Exposure	Percentage of target audience who saw/heard/read the material (announcement, news article, radio program, etc.) Number of community members who participated in communication activity during sessions Percentage of the target audience who saw the billboards/posters Percentage of target audience who were able to recall the message of the health communication material/media (radio, TV, billboard/poster, print material)	Program logs to capture coverage statistics from media source, web metrics obtained via Google software, participants' attendance in community meetings Household or telephone survey with target audience in the catchment area to determine exposure Reach and recall study to capture exposure and perception

Measuring What	Process/Output Indicator	Tools/Methods to Monitor
Social mobilization activities		
Empower former TB patients to become DOTS providers	Number of former TB patients trained as DOTS providers Number of DOTS provider training sessions held Number of TB patients treated by DOTS providers (cured TB patients)	Training registers
Sensitization of local and religious leaders on TB and related stigma in the community	Number of materials developed Number of sensitization meetings held Number of religious leaders sensitized on TB and TB stigma	Meeting reports of sensitization meeting with leaders
Distributions of print materials	Type of media source airing or disseminating the material (print media, radio, TV, Internet) Number of hoardings/posters disseminated in the catchment area Number of materials disseminated by peer educators, ASHAs by type (e.g., educational pamphlets)	Regular audit of materials at health facility, block, district, and state levels Program logs to capture records on the type of media source and the number and types of materials disseminated by the channel Regular field trips to distribution sites to check on the availability of products or materials
Logistics	Number of campaign components implemented according to schedule Number of materials delivered on time, to the right place, by the right people, and to the right audience	Review of media plan and schedule with tracking sheet
Training plan	Number of trainings conducted Number of participants trained Number of participants with increased skills/knowledge Number of participants using or transferring skills	Training log to capture number of trainings and participants Pre-test and post-test Follow-up survey on use and transfer of skills

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[12] are shared below:

1. To what extent did 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 these activity/activities?
9. What is the value of the ACSM activity/activities?

12.1 Best or Promising Practices

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, i.e., 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.

[12] Advocacy communication and social mobilization for TB control, a handbook for country programs, WHO & STOP TB partnership http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM_Handbook.pdf, accessed on March 3, 2014

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.

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Annexures


BEST PRACTICES
CONCEPT AND STRATEGY
CONCEPTUAL CLARITY
CAPACITY BUILDING
STRATEGIC FRAMEWORK
PLANNING
PRE-TESTING
ATION ANALYSIS
OBJECTIVES AND APPROACH
MEDIA ENGAGEMENT
TOOLKIT
NTATION
TOOLKIT
MEETINGS
CAPACITY BUILDING
CONCEPTUAL CLARITY
MEDIA ENGAGEMENT
SITUATION ANALYSIS
PROGRAM IMPLEMENTATION
CH
BEST PRACTICES
MEDIA ENGAGEMENT
CONCEPT AND STRATEGY
BEST PRACTIC
SCHOOL ACTIVITIES
CHANNELS
TOOLKIT
COMMUNICATION PRINCIPLES
SITUATION ANALYSIS
ND STRATEGY
COMMUNITY MOBILIZATION
DOCUMENTING
MESSAGE DESIGNING
LES
CHANNELS
PRE-TESTING
TRAINING
DOCUMENTING
TRAINING
ONCEPTUAL CLARITY
FOLK PERFORMANCES
CHANNELS
SCHOOL ACTIVITIES
PLANNING
GS
PLANNING
BEST PRACTICES
MONITORING AND EVALUATION
MEETINGS
DOCUMENTING
NEED ASSESSMENT
STRATEGIC FRAMEWORK
NEED ASSESSMENT
LESSONS AND RESULTS
BEST PRACTICES
CONCEPTUAL CLARITY
NING
MEDIA ENGAGEMENT
COMMUNICATION PRINCIPLES
FOLK PERFORMANCES
MEDIA ENGAGEMENT

Annexure 1

Revised financial norms for ACSM

The financial norms for ACSM activities at state and district levels are following;

State level

- Population up to 10 million: INR 10 Lakhs
- Population of 10–30 million: INR 14 Lakhs
- Population of over 30 million: INR 20 Lakhs

The IEC agency and activity costs (apart from the above) for local, need-based, state-level ACSM initiatives: INR 0.40 lakh per million population

District level

- INR1.88 lakh per million population per year
- For more focused targeting of already identified urban cities with more than 1 million populations, the norm is higher at INR 3.38 lakh per million populations per year.
- For all other urban areas with municipal corporations/councils, the norm is INR 2.33 lakh per million populations per year.

Central level norms:

The Government of India initiated advocacy and advertisement of up to INR 5,000 lakh over 5 years and for other IEC activities up to INR 2,500 lakh over 5 years.

Annexure 2

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.

Output Indicators	Planned	Actual Performance	Remarks/Reasons
Radio spots	X	Y	----
TV spots			
Print advertisements			
Advocacy workshops			
• Policy makers			
• Program executives			
• Media professionals			
Community mobilization meetings			
Patient-provider meetings			
Posters			
Hoardings			
Wall writings			
Leaflets/pamphlets			
Please add indicators as per the agreed PIP			

ANNEXURE 3
Approaches to engage media

Methods/Approaches	Tips
Press conference/media briefing/campaign launch • 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.	• 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.
Interviews • 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.	• 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.

Methods/Approaches	Tips
Opinion pieces • 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.	• 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.
Letter to the editor • 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.	• 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.
Publicity-generating events • 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.	• 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.

Annexure 4

Guiding activities for conducting ACSM at various levels

Activities	National	State	District
Preparation of ACSM plan under Program implementation action plan (PIP) **Roles and responsibilities**	ACSM Consultant at CTD is responsible for compiling all state PIPs and develop ACSM plan at the national level. ACSM Consultant will be the point person to clarify doubts and support the State IEC Officer in preparing ACSM plan under PIP.	State IEC Officer is responsible for preparing the state PIP and compiling all district PIPs based on ACSM needs. State IEC Officer will support STO and RNTCP Medical/Health Consultant in the process. State IEC Officer will provide guidance and support to the district team in preparation of ACSM plan under PIP.	District Public private Mix (PPM)/ACSM coordinator, DTO will lead the preparation of ACSM plan under PIP, taking inputs from RNTCP Medical/Public Health Consultant and State IEC Officer. District ACSM/PPM coordinator should prepare PIP based on specific ACSM needs at the district level. District ACSM needs should be identified and prioritized accordingly for an appropriate ACSM intervention.
Advocacy Activities			
Generate political commitment and resources for RNTCP	CTD and ACSM consultants convene sensitization meetings with ministers, MPs, planners, policy makers, corporates and professional bodies, media, and other stakeholders at the national level.	STO, State IEC Officer, and RNTCP Medical/ Public Health Consultant convene sensitization meetings with ministers, MPs, MLAs, planners, policy makers, corporates and professional bodies, media, and other stakeholders at the state level.	DTO, RNTCP Medical/Public Health Consultant, and State IEC Officer convene sensitization meetings with ministers, MPs, planners, policy makers, corporates and professional bodies, media, and other stakeholders at district level like Zila Parishads, Gram Sabhas, PRIs, etc.

Activities	National	State	District
Medical colleges	ACSM Consultant in CTD should plan advocacy meetings with medical education and nursing policy makers and heads of institutes on specific agendas, including updating and inclusion of TB and RNTCP into the curriculum of medical and nursing education and encourage regular research to support TB control efforts in the country.	STO, State IEC Officer, and RNTCP Medical/ Public Health Consultant convene sensitization meetings with state medical education and research policy makers, directors, and principals of medical colleges on agendas including: • Provision of appropriate diagnostic and therapeutic support to TB patient, including MDR-TB cases • Encouraging research work on TB control for RNTCP • Sensitization of medical students on TB and RNTCP	DTO, RNTCP Medical/Public Health Consultant, and State IEC Officer convene sensitization meetings with directors and principals of medical colleges to provide appropriate diagnostic and therapeutic support to TB patient, including MDR-TB cases and encouraging research work for RNTCP.
Private care providers	CTD and ACSM, PPM Consultant convene sensitization meetings with private providers, IMA, and other professional bodies at the national level to deliberate on TB case notification, case detection, and treatment as per standards of TB care in India.	STO, State IEC Officer, and RNTCP Medical/ Public Health Consultant convene sensitization meetings with private providers, IMA state branch, and other professional bodies at the state level to deliberate on TB case notification, case detection, and treatment as per standards of TB care in India.	DTO, RNTCP Medical/Public Health Consultant, and State IEC Officer convene sensitization meetings with private providers, IMA district chapter, and other professional bodies at the district level to deliberate on TB case notification, case detection, and treatment as per standards of TB care in India.
Communication Activities	CTD and ACSM, PPM Consultant with the help of media agency and/or DAVP roll out 360-degree SBCC campaigns through mass media and mid-media activities.	STO, State IEC Officer, and RNTCP Medical/ Public Health Consultant, with the help of State Media Officer, roll out 360-degree IEC campaigns using mass media (TVCs, audio-visual aids, radio, newspaper) and mid media (folk troupes, etc.). The SBCC campaign will be developed and shared by CTD.	DTO, RNTCP Medical/ Public Health Consultant, and State IEC Officer, with the help of District IEC Officer, roll out 360-degree IEC campaigns using mass media (TVCs, audio-visual aids, radio, newspaper) and mid media (folk troupes, etc.). Interpersonal communication and community activities are to be conducted, including community meetings, patient-provider meetings, and school activities for children.

Activities	National	State	District
Information and message dissemination	Dissemination of information on signs and symptoms of TB for early reporting to health facility and early detection	Dissemination of information on signs and symptoms of TB for early reporting to health facility and early detection	Dissemination of information on signs and symptoms of TB for early reporting to health facility and early detection
	Availability of free diagnostic and treatment services for TB, DR-TB, and HIV-TB	Availability of free diagnostic and treatment services for TB, DR-TB, and HIV-TB in the state	Availability of free diagnostic and treatment services for TB, DR-TB, and HIV-TB in the district
Information and message dissemination	CTD and ACSM, PPM Consultant should share and disseminate: • National ACSM plan with all the stakeholders • Standards of TB care in India • Development of uniform signboards and other information for display at all STCs, DTCs, TUs, DMCs, DOT centers, DR-TB centers, ICTC, National Reference Laboratory(NRL)/ Intermediate Reference Laboratory (IRL), and drug stores across the country • Availability of free diagnostic and treatment services, including those for DR-TB, under RNTCP • Newer initiatives like notification and case-based web system-NIKSHYA	STO, State IEC Officer, and RNTCP Medical/ Public Health Consultant should share and disseminate: • State ACSM plan with all the stakeholders • Standards of TB care in India • Display of signboards and other information at all DTCs, TUs, DMCs, DOT centers, DR-TB centers, ICTC, NRL/ IRL, and drug stores in the state • Availability of free diagnostic and treatment services, including those for DR-TB, under RNTCP in the state • Newer initiatives like notification and case-based web system-NIKSHYA	DTO and RNTCP Medical/ Public Health Consultant should share and disseminate: • District ACSM Plan with all the stakeholders • Standards of TB care in India • Display of signboards and other information at all DTCs, TUs, DMCs, DOT centers, DR-TB centers, ICTC, NRL/IRL, and drug stores in the district • Availability of free diagnostic and treatment services, including those for DR-TB, under RNTCP in the district • Newer initiatives like notification and case-based web system-NIKSHYA
	Development of recording, reporting, and monitoring formats and supervision guidelines	Proper recording of data and timely submission of ACSM report to CTD and feedback to districts	Proper recording of data and timely submission of ACSM report in the district reporting format to the state TB cell
	CTD to formulate guidelines for involvement of NGOs/ PPs and share it with states for reference	As per guidelines, STO, State IEC Officer, and RNTCP Medical/Public Health Consultant should identify weak areas and look for appropriate NGOs/PPs for support at the state level	DTO, RNTCP Medical/Public Health Consultant, State IEC Officer, and District PPM Coordinator should identify weak areas and look for appropriate NGOs/PPs for support at the district level

Activities	National	State	District
Information and messages to patients	Development of material on: • Signs and symptoms and complications of TB for early reporting to health facility and early detection • Adverse/side effects of anti-TB drugs • Importance of regular and complete treatment	Dissemination of information within the state on: • Signs and symptoms and complications of TB for early reporting to health facility and early detection • Adverse/side effects of anti-TB drugs • Importance of regular and complete treatment	Dissemination of information within the district on: • Signs and symptoms and complications of TB for early reporting to health facility and early detection • Adverse/side effects of anti-TB drugs • Importance of regular and complete treatment
Social Mobilization Activities			
Partners, community, and civil society organizations (CSOs)	CTD and ACSM, PPM Consultant should formulate guidelines to mobilize and appropriately utilize the resources available with partners, community, and CSOs	STO, State IEC Officer, and RNTCP Medical/ Public Health Consultant should identify and mobilize partners, community, and CSOs to support RNTCP at the state level	DTO, RNTCP Medical/ Public Health Consultant, State IEC Officer, and PPM Coordinator should identify and mobilize partners, community, and CSOs to support RNTCP at the district level
Non-health corporate sector	CTD to develop some guidelines to mobilize non-health corporate sector	STO, State IEC Officer, and RNTCP Medical/ Public Health Consultant should identify available corporate sectors in the state and mobilize them to support RNTCP as a social cause	DTO, RNTCP Medical/ Public Health Consultant, State IEC Officer, and PPM Coordinator should identify available corporate sectors in the district and mobilize them to support RNTCP as a social cause
Patients		Cured patients from within the community should be mobilized to work as DOTS providers and do further advocacy, thereby reducing stigma	Cured patients from within the community should be mobilized to work as DOTS providers and do further advocacy, thereby reducing stigma

ACSM for Urban TB control

ACSM activities	National	State	District
Advocacy Activities			
To increase administrative and political commitment on issues of TB and MDR-TB in urban areas	Advocacy with National Urban Health Mission (NUHM) and associated ministries(urban planning, housing and urban poverty, school education) for prioritization on TB issues in urban areas	Advocacy activities (meetings, workshops) with departments at the state level	Advocacy meeting with local ward councilors Advocacy with business entities for workplace interventions
To mobilize support from other stakeholders on TB issues in urban areas	Media advocacy and sensitization activities Advocacy with private sector for workplace interventions on TB	Advocacy meetings with private sector bodies, associations, media	Advocacy meetings with pharmacist association, local private provider association, nursing homes
Communication Activities			
To increase level of awareness among urban communities on TB, its treatment, support, care, and available services	Mass media campaigns on TB issues	State-level campaigns on urban TB issues	Communication campaign in slums, workplace interventions
To increase awareness among all care providers about availability of TB diagnosis, need of TB notification, standardized treatment, and quality TB care	Development of communication materials on standard treatment, TB notification, etc.	Sensitization workshop/ conference/ meeting with key private partners	Partnership meetings with all care providers(doctors, hospitals, chemists)
To increase knowledge and skills of health workers on interpersonal communication/ counseling	Develop urban-specific IPC and counseling training module for health workers (TB and MDR-TB) Development of job aides for IPC	Refresher training of health workers on IPC and counseling Translation of IPC job aids in local language, if required	Refresher training of health workers on IPC and counseling
To encourage treatment adherence and support treatment completion among all TB patients	Revision of NGO/PP schemes to make it more rewarding for partners	Meeting with NGOs and partners for support in high-risk areas, especially for vulnerable populations	Meeting with CBOs, peer educators, urban social health activists (USHAs), Mahila Arogya Samitee (MAS) on treatment support groups
To create awareness on prevention and control of infection in urban setting	Community infection control training module Infection Control message development	Training and sensitization of key officials from health care facilities on infection control guidelines	Short training of health workers on community infection control

ACSM activities	National	State	District
Social Mobilization Activities			
To strengthen and empower local communities/ groups in urban communities to participate actively in TB control efforts		Working with CSOs/ partnerships for support to local communities	Formation of peer educator group (cured TB patients) Linking with urban health insurance model
To strengthen partnership with other care providers in urban areas		Advocacy meeting with urban departments for social support to TB patients	Linking with urban development schemes for support (nutrition, housing employment) Partnering with local NGOs

Special populations

Enhanced outreach by RNTCP to poor and disadvantaged populations belonging to SC/ST and economically backward districts is critical to ensure universal access. Focusing on at-risk and clinically, socially, and occupationally vulnerable populations can increase coverage. More resources will be required to finance scale-up of innovative approaches to engage the private sector with development of more flexible strategies. TB is a 'notifiable' disease and mechanisms are needed to ensure that all TB cases treated in other sectors are notified to RNTCP.

ACSM for TB-HIV Co-infection

Advocacy	Communication	Social Mobilization
Individual Patient Level		
• Advocacy to TB patient for undergoing HIV testing. • Simultaneous regular Treatment of both the disease is essential • Adherence to preventive health behavior.	Create Awareness on • Symptoms of Tuberculosis • Need for HIV testing among TB patients and vice versa • Mode of transmission of HIV/AIDS • Availability of free diagnosis and treatment services for Tuberculosis and HIV • Side effects of TB treatment and Anti-Retroviral therapy. • HIV positive patient is 10 times more vulnerable to get TB infection. • TB disease accelerates the progression of AIDS.	• Cured TB patients or patients on treatment can act as motivator to other patients, become a DOT provider and propagate the preventive health behavior in the community. • Cured TB patients can form their own SHG/NGO to work for combating stigma, rehabilitation of the co-infected patients.
Community Level		
• **Advocacy with PRI members to support TB patients in the community, and reduce stigma.**	Create knowledge and awareness on • Symptoms of Tuberculosis • Need for HIV testing among TB patients and vice versa • Mode of transmission of HIV/AIDS • Availability of free diagnosis for Tuberculosis and HIV • Side effects of TB treatment and Anti-Retroviral therapy. • Incomplete and irregular treatment leads to fatal conditions both in HIV and TB infection. • Do not stigmatize TB, HIV &TB-HIV co-infected patients. • TB can be cured with DOTS treatment even among HIV patients. • Anti-Retro Viral Therapy for HIV can help increase longevity among People Living with HIV AIDS (PLHIV)	• Sensitized Local NGOs to come forward and fight for rights of CO-infected patients. • Sensitized Self Help Groups (SHGs) come forward for nutritional support and vocational training for TB HIV Co-infected Patients. • Members of SHG can be also be Community DOT Providers

Advocacy	Communication	Social Mobilization
Provider Level		
• Advocacy with National state and district level bodies/ agencies/ association of health care providers both public and private on. (examples) - Standard of TB care in India - Notification of TB cases - TB patients must be screened for HIV test. - HIV patients must be referred for detection of TB. - Air Borne Infection control measures - Bio medical waste management guidelines for disposing samples of HIV patients. - Proper counselling of TB Patients undergoing HIV test. - Maintain line list of TB Patients referred for HIV testing and HIV patients referred to TB investigation-cross referrals	• Sensitize providers to Diagnose and Treat TB-HIV Co-infection patients as per National Standards of TB care in India, and National guidelines on TB and HIV. • Sensitize providers to handle Adverse Drug reactions/ Drug side effects/ Drug Toxicity • Knowledge about the Programme	• Sensitized provider could mobilize to support TB-HIV Co-infected patients and provide nutritional/ vocational support. • Sensitized provider can be DOT Provider under RNTCP. • Sensitized provider can delegate the issue of stigma associated with co-infected patients at various meetings.

ACSM activities for Programmatic Management of Drug Resistant TB

Advocacy	Communication	Social Mobilization
Individual Patient Level		
	Create awareness among patients and family member through counseling on; • What is drug resistance TB what causes drug resistance and how to know if the patient has drug resistant TB? • Free diagnostic test of drug resistance and the duration of test results. • Reimbursement of transportation cost when patient goes for testing • Where to go for free diagnosis and treatment of Drug Resistant TB? • Duration of treatment and detailed information about drug side effects. • What to do when there are side effects (minor and major side effects). • Importance to take medicines regularly and complete the treatment. • Importance of sputum examination at the end of treatment. • Taking infection control measures to prevent infection to family member	• Cured DRTB patients can act as motivator and propagate preventive health behavior in the community. • Cured DRTB patients can act as DOT providers. • Cured DRTB patients can form their own SHG/NGO to work for combating stigma related to TB &DRTB Patients.
Community Level		
• Advocacy with Panchayti Raj Members, local political leaders, SHGs to provide Nutrition support, and rehabilitation to patient and families of TB/MDR TB patients • Sensitization of community to reduce stigma on MDR TB patients	Create awareness among patient families and community; • TB and drug resistance TB can be cured with proper treatment. • Free diagnostic test of drug resistance and the duration of test results. • Provide community support to TB patients with Nutrition support. • Do not discriminate/ stigmatize failure of DOTS patient . • Motivate them for free diagnostic and treatment available under RNTCP. • It needs regular and complete treatment for about 24 months.	• Sensitized SHGs come forward for Nutritional, vocational & rehabilitation support to DRTB Patients. • Members of SHG can be Community DOT Providers

Advocacy	Communication	Social Mobilization
Provider Level		
• Advocacy with providers, association, NGOs/hospitals, registered bodies etc. on - Diagnosis and treatment as per STCI. - Notification of DRTB cases in Nikshay - Counseling patients for Adherence-complete and regular treatment. - Advocacy for Air Borne Infection Control (AIC) measures for TB Patients in waiting arena and wards.	Create knowledge on • What is Standard of TB care in India • Who are the DR TB suspect • Availability of free Lab Diagnosis for DR TB. • Availability of free Treatment for DR TB. • Availability of DR TB center for initial Hospitalization. • Common side effect and their management. • Uninterrupted Drug supply for DRTB patients. • Isolation ward for admission of DR TB patients • Infection control measures	• Sensitized Local NGOs to sign MoU with local health authorities for any assistance to DRTB patients –Nutritional supplements • Appreciation of Providers with maximum number of cured DRTB patients by local authorities.

Reaching the Unreached,
FIND, TREAT, CURE TB, SAVE LIVES

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