

## Information Note: Advocacy and Communication

### Introduction

The Stop TB Strategy<sup>1</sup> emphasizes that advocacy, communication and social mobilization (ACSM) can improve case detection and treatment adherence by combating stigma and discrimination and empowering individuals and communities to mobilize political commitment and resources for TB. ACSM, as an acronym, was formally added to the Stop TB Strategy in 2006 to move beyond simply providing TB information to patients to increasing the involvement of and dialogue with TB-affected communities and other partners. It is important to remember that ACSM includes a set of **cross-cutting activities** that are relevant to all aspects of the Stop TB Strategy. ACSM can support **specific objectives** for interventions for TB, TB/HIV, MDR-TB, Childhood TB, PPM or **other program components** to address the social, cultural, financial, and psychological barriers to successful implementation.

Since the adoption of ACSM as a component, many countries have made progress in developing ACSM strategies, like involving community organizations and TB affected individuals or garnering financial support for ACSM through Global Fund applications. However, over the past few years, the Global Fund TRP has noted that ACSM activities in TB proposals remain weak. One reason is that ACSM has been understood as an independent rather than cross-cutting component, with proposed activities that are not evidence-based and have unclear or no TB-related justification for selection. In addition, the TRP has noted that ACSM proposals lack appropriate indicators to measure ACSM outcomes and activities are often seen as a generic "laundry list" without clear linkages to actual TB control challenges on the ground.

A complexity of developing strong and TB-oriented ACSM activities lies in the fact that it is specific to the country context and involves diverse strategies and approaches. In order to provide clearer guidance for countries, partners, and consultants in preparation for Round 11, ACSM will be discussed by each of its individual components (i.e. advocacy, communication, and social mobilization). This should help countries to develop activities that suit their needs rather than pick from a standard list of activities. This information note will focus on advocacy and communication.

### What are advocacy and communication?

#### **Advocacy:**

At the country-level, advocacy for TB can include a broad set of coordinated activities designed to prioritize TB on the national health agenda, generally accomplished by: a) building political will to increase and sustain financial and other resources for TB, and b) holding authorities accountable to ensure that pledges are fulfilled within an acceptable timeframe.

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<sup>1</sup> <http://www.who.int/tb/strategy/en/>

In country contexts, advocacy efforts seek to ensure that national governments remain strongly committed to implementing national TB control/elimination policies. Advocacy goals at country level should be set by reviewing all objectives under a TB control plan and then determining which would benefit most from advocacy, or which area has the least political support. This would include activities such as stakeholder meetings, review of existing evidence, and situation analysis to identifying policy gaps, resource needs, and key roles of different actors. Advocacy goals should be linked to objectives and desired outcomes.

Increasing political commitment needs inputs from many stakeholders. NTP leaders can influence national leaders by using a mix of advocacy approaches themselves but by also supporting other people to take up TB advocacy such as journalists, researchers, HIV advocates, and celebrities. Although it is slow to achieve, policy change can be measured incrementally and is an important step for lasting change.

### **Communication**

Within countries, and in the context of TB control, communication is principally concerned with informing and creating awareness in the general public or targeted populations about TB, and empowering people to take action. It is concerned with communicating a series of messages about the disease (e.g. “if you have a cough for more than two weeks, seek treatment”, or “TB is curable”), or informing the public about what services exist (for diagnosis and treatment).

Communication is aimed at ultimately changing behaviors such as persuading people with symptoms to seek diagnosis and treatment. Knowledge alone will not be enough to get people to seek treatment, as in every specific context there are a number of different barriers to seeking diagnosis and treatment (for example, access to DOTS centres, stigma in the community, etc). Communication strategies should therefore focus on the specific issue and activities and messaging should be focused on addressing that main barrier to health-seeking behaviour.

### **IMPORTANT TIPS for advocacy and communication planning and proposal preparation**

It is crucial to note that advocacy and communication are **not stand-alone activities**. Taken together with other technical interventions, they can enhance the speed and effectiveness of TB control improvements. Advocacy and communication activities should be designed to support overall progress in TB control and integrated within the national TB control plan. If this is not the case, the advocacy and communication strategy/plan must have objectives that are **directly linked** to TB control priorities and gaps as stated in the national TB strategy.

When writing a proposal, advocacy and communication activities should directly reflect the TB control problems identified and prioritized in the proposal itself and should clearly show how the proposed activities will address those specific challenges. Proposed activities should follow a logical progression from intervention to outcome, as described

in the *attached table on the last page of this note*, using an example of case detection. Generic activities with no clear connection to the identified gaps should be avoided.

## **Advocacy and communication in Global Fund proposals - changes in Round 11**

This information note aims to introduce changes that are being made in WHO's [Stop TB Planning Matrix and Frameworks Tool](#) to address the specific weaknesses in the area of advocacy and communication that have been noted over the years.

The key change for Round 11 is that *Service Delivery Area 5.1: Advocacy, Communication and Social Mobilization (ACSM)* will be removed from the Stop TB Planning Matrix and Framework as a stand-alone SDA. Instead, advocacy and communication activities will be integrated into every other SDA to reinforce the idea that advocacy and communication are not an end in themselves, but should be used as tools to reach a specific purpose in a specific SDA (examples provided in next section). It is encouraged that proposals for Round 11 follow this format. This means that proposals should avoid having a separate SDA on advocacy and communication. Instead relevant advocacy and/or communication objectives, strategies and activities, should be integrated into the other SDAs, such as TB/HIV, MDR-TB, patient support, human rights and high-risk groups, PPM, as determined by the situation analysis.

Furthermore, proposals for Round 11 should also strengthen the justification for chosen advocacy and communication activities. That is, all interventions should be based on quantitative and/or qualitative research to determine which advocacy and/or communication interventions are the most appropriate and likely to be effective for the proposed target population or geographic area. Proposals should always include a budget line for formative research and/or situation analysis, if it has not already been completed.

### **Sample advocacy and communication activities to address each component of Stop TB Strategy**

This section provides a list of sample advocacy and communication activities that are relevant in key SDAs of the Stop TB Strategy. This list is in no way exhaustive – other activities may be proposed depending on the challenges identified.

#### SDA 1.3: Patient Support

- Advocate to national authorities to ensure patient support mechanisms are put in place, well communicated to patients and enforced to prevent defaults and support treatment completion.
- Produce material in local language to inform target population about incentives and eligibility criteria to enhance willingness to access care and increase number of suspects presenting for evaluation.
- Discuss the placement and fulfillment of the patient charter with NTP/health facility staff and ensure placement is accompanied with relevant changes in practice to improve provider-patient relationships and increase treatment success.

### SDA 2.1: Implement collaborative TB/HIV activities

- Meetings with HIV and TB programme leaders to build consensus on integration of TB/HIV activities and targets that will improve access to care.
- Ensure that People Living with HIV/AIDS and TB infected individuals are informed about the availability of TB-HIV services at their local health facility to increase demand for and usage of these services.
- Design and implement media campaigns for TB patients to get tested for HIV and vice versa to improve case detection.
- Organize sensitization workshop on TB/HIV collaborative activities for health activists to act as outreach agents in the community and improve referrals.

### SDA 2.2: MDR-TB

- Advocate with national authorities to ensure that rights of MDR-TB patients are well adhered to by health-care workers, employers, etc. to prevent discrimination.
- Communication to providers through meetings and printed materials on the importance of using standard regimens, quality-assured drugs, and DOT to treat their TB patients for prevention of MDR-TB.
- Communicate, via IEC materials, meetings and other communication channels to inform patients about incentives, enablers to enhance willingness to access services and stay on treatment.
- Health education and communication to patients on importance MDR-TB prevention and of adhering to treatment.

### SDA 2.3.1: High risk groups: Address prisoners, refugees and other high-risk groups and special situations

- Advocate with prison authorities to increase uptake of TB programmes for prisoners to address the needs of a high-risk population.
- Advocacy and communication activities to highlight access and discrimination issues that indigenous populations face to change policy and improve their access to care.
- Targeted communication to inform high-risk groups of TB, as well as on their rights as patients, to improve their use of services and increase case detection in these groups.

### SDA 2.3.3: Childhood TB interventions

- Advocacy activities to place the issue of childhood TB higher on programme agenda and to ensure screening of all children who are household contacts of TB cases.
- Production of IEC materials for target groups: health workers, mother, EPI, community (posters, pamphlets) to increase referrals for evaluation.

### SDA 4.1/4.2: Engage all care providers (Public-Public. and Public-Private-Mix (PPM) approaches; International Standards for TB Care (ISTC).

- Advocacy activities targeted at private providers to join PPM scheme to increase the reach of the national program and number of cases notified.
- Development/printing of guidelines, IEC materials and tools for PPM to create standardized process in line with NTP guidance.

## Indicators for advocacy and communication activities

Coming up with indicators for advocacy and communication activities has also been a weakness in proposals due to the fact that activities have been too generic and not linked to specific TB control challenges.

Advocacy and communication are tools used to reach targets that are supported by a number of interwoven interventions and so setting specific outcome indicators for advocacy and communication are less necessary. Some activities have clear objectives - such as advocacy for resource mobilization (the outcome one would measure would be level of funding before and after the advocacy intervention). However, other activities are much harder and more expensive to measure - such as the impact of mass media campaigns or distribution of IEC materials.

Process indicators for advocacy and communication are essential to monitor progress of implementation. But in terms of outcome and impact, it is advised that focus should be on measuring the **end-result** of what those activities were aimed at supporting, such as additional cases detected or additional cases cured.

ACSM activities should be planned with the help of experienced practitioners or by using existing ACSM resources, as listed below. Support for ACSM planning, implementation and evaluation can be requested from TBTEAM<sup>2</sup> ([tbteam@who.int](mailto:tbteam@who.int)) or by emailing [stoptbacsm@who.int](mailto:stoptbacsm@who.int).

### Resources and links to tools and guidance

References and web links:

Partnership Centre for Resource Mobilization: <http://www.stoptb.org/bi/resmob/index.asp>

Advocacy partnership tool (UK)

ACSM for TB control: a handbook for country programmes:

[http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM\\_Handbook.pdf](http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM_Handbook.pdf)

ACSM for TB control: a guide to developing knowledge, attitude and practice surveys:

[http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM\\_KAP%20GUIDE.pdf](http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM_KAP%20GUIDE.pdf)

Working with the media: how to make your messages on tuberculosis count:

<http://www.stoptb.org/assets/documents/resources/publications/acsm/Working%20with%20the%20Media%20Final%20Web.pdf>

Advocacy, communication and social mobilization: collection of country-level good practices:

[http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM\\_final\\_24%20Nov.pdf](http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM_final_24%20Nov.pdf)

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<sup>2</sup> <http://www.stoptb.org/countries/tbteam/>

Sample analysis framework for developing ACSM interventions. This is an example of how advocacy and communication activities would be planned for the challenge of low case detection.

National TB control objective	Challenge	Barriers (possible contributing factors)	Needed changes	Potential advocacy or communications interventions to address barriers and support changes	Expected results
<p>Example: Reach the target of 70% case detection by 2011.</p>	<p>Case detection is only 55%, below the target of 70%.</p>	<p>1. Lack of sufficient human resources to staff all microscopy centers.</p> <p>2. High level of stigma related to TB and HIV prevents people from seeking services.</p>	<p>1. Additional personnel hired to staff all existing microscopy facilities.</p> <p>2. Reduction of stigma around TB and HIV and behavior change among TB suspects to allow for greater access to services.</p>	<p>1. Advocacy for positions to be filled through presentation of current case detection data to key decision-makers.</p> <p>2. Survey of specific issues related to stigma and implementation of a communications strategy to address those issues.</p>	<p>1. Resources made available and microscopy positions filled by December 2012.</p> <p>2. Ten percent increase in number of suspects reporting to services for evaluation.</p>