Somalia National TB Control Program
Advocacy Communication and Social Mobilization Strategy

Building TB Partnerships Toward a Future Secure from TB

2010 - 2015
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## ABBREVIATIONS

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<tbody>
<tr>
<td>ACSM</td>
<td>Advocacy Communication and Social Mobilization</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CDR</td>
<td>Case Detection Rate</td>
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<td>CRIS</td>
<td>Communication Resource Information System</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GFATM</td>
<td>Global Fund for AIDS TB and Malaria</td>
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<td>IDI</td>
<td>In-Depth Interviews</td>
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<td>IDP</td>
<td>Internally Displaced People</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IPC</td>
<td>Interpersonal Communication</td>
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<td>ISO</td>
<td>International Standards Organization</td>
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<td>KAP</td>
<td>Knowledge Attitudes and Practices</td>
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<tr>
<td>MDR-TB</td>
<td>Multidrug-Resistant TB</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MO</td>
<td>Medical Officer</td>
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<td>NGO</td>
<td>Non Government Organisation</td>
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<td>NTP</td>
<td>National Tuberculosis Control Program</td>
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<td>PLWHA</td>
<td>People living with HIV and AIDS</td>
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<td>PPM</td>
<td>Public Private Mix</td>
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<td>PPP</td>
<td>Public Private Partnerships</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>TA</td>
<td>Technical Assistance/Technical Advisor</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>TSR</td>
<td>Treatment Success Rate</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>XDR-TB</td>
<td>Extensively Drug-Resistant Tuberculosis</td>
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FOREWORD

The challenges of managing large-scale health problems such as TB in a conflict and post conflict environment such as that experienced in Somalia/Somaliland are broad and complex. In the decades since the conflicts commenced there has been a deterioration in health infrastructure, services and human resources which is now being actively addressed.

A significant achievement is the development of this Advocacy, Communication and Social Mobilization (ACSM) Strategy for the NTP designed to provide strategic direction and activities as the TB program fully evolves. This strategy acknowledges the new emerging challenges that we face in Somalia/Somaliland from 2010-2015 on the road to peace and reconstruction.

The ACSM strategy attempts to operationalize a number of programs and activities that may have been used in the past as well as some that are new to the Somali context. It also encourages new ideas and ways of working with broader partnerships amongst donors, international and national NGOs, public and private sector TB stakeholders. It is hoped that by utilising these approaches that a more inclusive, participatory planning, development, implementation and evaluation process for the TB ACSM component can institutionalized with time and appropriate technical support. If achieved, the approach will be able to demonstrate measurable behavioural health change in relation to TB prevention treatment and care.

We now invite all TB stakeholders to review and circulate this strategy and provide input and advice on the Strategy to NTP. Following comments on the ACSM strategy document, a final strategy will be developed and endorsed by the Ministry. Once circulated ACSM stakeholders will be required to meet regularly to identify TB program challenges and develop programs and action plans in readiness for more integrated ACSM approaches to follow in the annual lead-up to World TB Day. We look forward to working with all our public and private sector partners in the future implementation of the Somalia/Somaliland NTP - ACSM Strategy and related activities.

Minister of Health (or other lead official)
ACKNOWLEDGEMENTS

Advocacy Communication and Social Mobilisation (ACSM) has been identified by the World Health Organisation as a critical component in TB control. For this reason the NTP has developed an ACSM strategy for Somalia/Somaliland with support from the Global Fund against AIDS, TB and Malaria (GFATM R7 TB Grant).

This ACSM Strategy document was developed following a rapid assessment of all zones in Somalia and consultation conducted with key informants from a number of program partners. As well as providing a spectrum of views from TB stakeholders, literature has also been sourced on awareness knowledge and attitudes toward TB by at risk target audiences from TB patient surveys conducted in clinics around Somalia/Somaliland.

A number of partners working in the area of TB control have provided input to the development of this final strategy. At the risk of not mentioning all participants, let me acknowledge the support of Dr. Sindani Iraneus of the World Health Organisation – Somalia Office, Dr Vianney Rusagara and Ms Rumbidzai Pairamanzi from World Vision, who have worked with the National TB Control Program to support the consultation process, Mohammed M Muhammed – Deputy Country Director of Muslim Aid and his colleagues, Abdirashid Hussain, Mohamed Munim Mohed, Sundus Abdi, Bashir Suleiman, Ms Silixigardi Anna Maria – COOPI, H. Osman – Mercy Corps USA, Giampiero Baldassarri – CCM Italy, and Amultumbu Maurice – Merlin International NGO.

I would also like to acknowledge my colleagues who provided comment on the draft strategy including Dr. - NTP Manager Somaliland, Dr -NTP Manager Puntland and Dr NTP Manager Central South Zone.

Finally, let me thank these TB stakeholders for assisting the consultant: Mr Tahir Turk from Communication Partners International, who facilitated the Workshop and compiled the draft strategy document. All participants have contributed significantly to ensure the timely development of this Strategy. Other TB stakeholders are now invited to review and circulate the final strategy and subsequent workplans developed. We look forward to working with all of our partners in the future implementation of the NTP ACSM Strategy 2009-2014.

NTP Manager from each Zone to sign
Or CCM Manager
EXECUTIVE SUMMARY

TB is a public health emergency in Somalia with the country ranking 6th out of the 22 high TB burden countries. The estimated incidence is high at 224 per 100,000 population. With increasing HIV/AIDS prevalence, the long-standing emergency situation and natural disasters such as drought and a tsunami has negatively affected TB epidemiology.

Given the ongoing instability and conflict in the country, the challenges of reducing the rate of TB infection in Somalia/Somaliland will be significant and complex. The main constraint to successful TB control is the insecurity which hampers reconstruction, service delivery, continuity, regular supervision, access to and utilization of services. A number of other challenges arise including the number of internally displaced people and nomadic populations, limited human and financial resources, current low technical capacity for ACSM, and a systematic plan for ACSM programming. The NTP ACSM Strategy 2009-2014 has been developed to address these and other program challenges.

A cornerstone of the strategy is the recognition that the program can only achieve success through the establishment of an expanded range of partnerships, given the resource constrained settings. A more integrated, systematic planning approach should also be institutionalised with key stakeholder involvement in the planning, implementation and evaluation of program activities.

In order to achieve these ends, NTP Somalia/Somaliland will need to expand its current networks of support, as well as engaging ACSM public and private partnerships to involve all key organizations. Given the low ACSM capacity, technical support will be required to build competencies in core program delivery areas.

Given the need to address priority issues in the short-term, a range of specific activities and ACSM channels have been identified including; more intensive efforts toward raising TB knowledge and awareness and reducing stigma, building capacity through training and technical transfer, and more comprehensive monitoring and evaluation of ACSM activities to measure the behavioural impact of interventions. Operating principles and a strategic planning framework to guide a sustainable ACSM program within conflict and insecure settings is also proposed.

1 WHO Global TB Report 2007
1. INTRODUCTION

Globally there were an estimated 9.2 million new cases of TB in 2006, including 4.1 million (44%) of new smear-positive cases and 0.7 million (8%) of HIV-positive cases. Up to 5000 people die everyday from TB with more than 2 million deaths annually. A total of 5.1 million new cases (out of the estimated 9.2 million new cases) were notified for 2006 among the 202 countries and territories, of which 2.5 million (50%) were new smear-positive cases. The African, South-East Asia and Western Pacific regions accounted for 83% of total case notifications.²

In Somalia TB is a public health emergency with the country ranking 6th out of the 22 high TB burden countries in the region. The estimated incidence is high at 224 per 100,000 population. With increasing HIV/AIDS prevalence, the long-standing emergency situation and natural disasters such as drought and a tsunami has negatively affected TB epidemiology.

Somalia’s TB control program has generally yielded good results, in spite of the difficult environment and the complex humanitarian emergency situation in which it operates. The majority of control activities have been implemented by dedicated local health workers supported by several NGOs under the coordination and technical assistance from WHO in collaboration with Somali authorities. For the past decade, the fundamental elements of the program (provision of high quality drugs, basic training on DOTS, regular monitoring and supervision, surveillance) have continued to operate in spite of the numerous challenges.

Advocacy Communication and Social Mobilisation (ACSM) has been identified by WHO as a critical component in TB control. However, the latest WHO report identifies that ACSM is still a new area for many countries, and much more guidance and technical support are necessary.³ However, a number of gaps have been identified within the ACSM component by program reviewers and TB stakeholders which to date, may not have been adequately addressed.

A successful bid provided funding from Global Fund for AIDS TB and Malaria (GFATM) Rd 3 (commenced Aug 2004) and laid the groundwork for TB care with a greater focus on infrastructure and training of health workers and laboratory staff. Funding for another successful

³ WHO (2005)
bid for GFATM Rd 7 (commenced October 2008) provided for a limited range of ACSM and other component activities up to 2013 with ACSM objectives of empowering people with TB and communities and engaging all care providers through PPM.

However, one of the main ACSM gaps identified in the program is the lack of a cohesive ACSM strategy to engage all program partners. Although an IEC (information Education and Communication) Strategy was developed in 2006, it was never endorsed or adopted by NTP stakeholders.\(^4\) This ACSM strategy has been developed to address the emerging challenges for the TB program in Somalia/Somaliland. The approaches and activities outlined in this strategy form the basis of the GFATM TB Rd 9 ACSM component proposal to address the ACSM program gaps and ongoing challenges. Endorsement and adoption of the strategy by Zonal Administrations was achieved in April 2009.

2. ADVOCACY COMMUNICATION AND SOCIAL MOBILIZATION

The World Health Organisation views each component of Advocacy, Communication and Social Mobilization as follows;

- **Advocacy** - Advocacy is a dynamic process that includes activities designed to place TB high on the political and development agenda, foster political will, and increase and sustain financial and other resources.

- **Communication** - Exchange of information about TB between patients/families/providers and communities. A two-way participatory process of dialogue. Using interpersonal skills aimed at changing behaviour, shifting social norms & removing barriers to behaviour change.

- **Social Mobilization** - Mobilizing a force of different groups in civil society for joint action to fight stigma & eliminate TB as a public health threat. Not isolated but collective efforts for sustainable behaviour/social change and the development of a more supportive attitude to patient care.\(^5\)

ACSM approaches have evolved to incorporate a comprehensive range of audience-focused processes in which insights from dialogue with stakeholders & research findings inform decisions about the best ways to affect behaviour change. Some of the approaches include identification of problems and populations at most risk, defining of program objectives, identifying an overall strategic approach, articulating key messages, selecting ACSM tools and channels, and developing a management and monitoring system. Common features of successful social marketing campaigns gleaned from the health communication literature indicate that the most successful programs are:


\(^5\) Adapted from WHO (2007) Stop TB Partnership.
• Strategic, Collaborative & Participatory.
• Targeted and Audience Focused.
• Behaviour Centered.
• Multi-level & Integrated – with interpersonal communication (IPC) supported by media resources.
• Monitored and Evaluated with research informing decision making.

2.1 Recommendations from ACSM Reviews
A number of recommendations for the ACSM component emanated from a recent country review conducted in all zones.\(^6\)
• Design and implement strategic workplans for ASCM activities.
• Proposed approaches could include piloting of programs rather than rolling out of ACSM activities in all areas.
• Activities in the workplans should be scaled up progressively to learn what works or not, and apply lessons in other targeted areas.
• Steer a paradigm shift in the Stop TB strategy with greater community outreach - involve the community
• Seek new target groups within the community and identify their role and possible involvement - ex-patients, faith leaders, women's/youth groups, the media, elders, traditional healers.
• Educate the community through training and awareness raising.
• Empower the community by using local resources – Creation of DOTs Committees to oversee the daily administration of drugs to patients.
• Establish a common baseline on case detection - evaluation of ASCM activities in a number of districts and accounting for the specificities of each district when implementing workplans.

3. SITUATION ANALYSIS
The following information was gleaned from desk research and discussions with Somalia/Somaliland TB stakeholders.

3.1 Country Data
Somalia is located on the horn of Africa with a total surface area 637.7 thousand sq. km. The topography is characterized by arid desert areas, inhospitable mountain regions and a coastal fringe. The country is now devided into 3 major zones Somaliland in the North West, Puntland in the North East and South Central Zones occupying the southern regions.

The country is comprised of a former British protectorate and an Italian colony. Somalia was created in 1960 when the two territories merged. Since then its development has been slow. Somalia has been without an effective central government since President Siad Barre was overthrown in 1991.

Years of fighting between rival warlords and the results of famine and disease have led to the deaths of up to one million people. Relations with neighbours have been soured by territorial claims on Somali-inhabited areas of Ethiopia, Kenya and Djibouti.\(^7\)

### 3.2 Health Indicators

The estimated total population of Somalia is almost 8.2 million, with 1.4 million children under the age of 4 years.\(^8\) The total life expectancy at birth is 47.7 years.\(^9\) The under-5 mortality rate is 145 per 1000 children with a low per capita total health expenditure of approximately US$8. HIV prevalence is relatively low at 0.5. Human resource capacity in the health sector is low with about 310 Physicians and 1,490 nursing and midwifery personnel.

TB prevalence, all forms is 24,757 with TB incidence, all forms at 18,444. TB mortality numbered 3,488 with TB incidence, of smear-positive cases at 8,270.\(^10\) Somalia’s Case Detection Rate (CDR) has improved in recent years, reaching over 60% in 2005 with some zonal and regional variations. Treatment Success Rate (TSR) during the same period was over 90%, failure rate of 0.9%, death rate 2% and defaulter rate of 4%.\(^11\) DOTS coverage has been at 100% since 2001.\(^12\)

### 3.3 Communications Environment

Somalia has a strong oral culture in the often tight-knit communities as a result of the long periods of conflict and the general suspicion of outsiders. The oral culture is especially strong amongst Nomadic populations and other rural populations who have relatively little contact with the outside world. The major languages spoken are; Somali, Arabic, Italian and English.

Available data and stakeholder feedback on media sources in Somalia/Somaliland indicate an expanding network of national and regional media agencies with television and radio stations

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which reach many communities across the country. In many cases, given the levels of insecurity and violence, people stay indoors where electronic media such as a radio or TV are often their only source of information from the outside world.

Although there is good media coverage in Somalia, the quality of electronic media programming and propaganda was sometimes seen as questionable by some stakeholders. The relative lack of other entertainment means that people are generally attached to their FM radios in Mogadishu and elsewhere. Radio stations proliferate including Panafrique, Shabelle, BBC Somali.com, Radio Hargeisa and Radio Horyaal (Somaliland) Radio Free Somali, Radio Gaalkacyo, Radio Garowe, Radio Golis, Radio Laascaanood, Radio Xoriyo, Somali Radio (USA), Voice of America Somali, Radio Midnimo and SBS FM (Bosaso Puntland).

Space TV also has broad coverage with, ETN (Puntland) TV and HCC (Home Cable TV) in Somaliland with the Eastern Television Network (ETN) in Bosaso, Puntland, Somalia being the largest in the country. Internet users are still relatively low with only 1 in 100 people accessing the internet.\textsuperscript{13}

Newspapers are an effective medium amongst opinion leaders with coverage rapidly dropping off in rural areas. The main newspapers and internet news sites are Haatu, Somali Herald site is primarily in English and includes many Somali media links, Somali Tribune primarily in Somali, and Somaliwide, primarily in Somali.

\textbf{3.4 Knowledge Attitudes and Practices}

Information on the behavioural determinants of awareness, knowledge, attitudes and perceptions toward TB prevention, treatment and care are pre-requisites for the implementation of any effective ACSM strategy. To date there have been 2 knowledge, attitude and practice (KAP) surveys conducted in Somalia/Somaliland with health care workers and patients and at-risk populations in 2 Districts in Somalia/Somaliland.\textsuperscript{14}

However, KAP data is rudimentary with only three knowledge indicators incorporated in the survey. Anecdotal feedback from some stakeholders indicated good awareness of TB in a number of communities, however, more evidence based monitoring programs are required to truly gauge TB KAP in a range of population segments.

\textsuperscript{13} Tuberculosis Knowledge Survey in Somalia among patients (2002-2007)
4. ACSM PROGRAM ACHIEVEMENTS

“I think the community knows more about TB than HIV.”

TB Stakeholder

The following achievements for NTP were identified from the literature and stakeholder feedback:

- Training workshops in 3 zones: training clinical staff and private sector practitioners in interpersonal communication on TB.
- Community events included training of volunteers in role plays and group songs.
- Three, small scale community campaigns conducted including use of singers and printing and distribution of 250 posters – Total campaigns and training budget $162,000.\(^\text{15}\)
- Already some community participation in TB care with treatment partners in the form of a significant others; the ‘Damin’ system guarantor ensures that the patient completes according to a contractual agreement.
- The Use of Cured TB patients as advocates was identified as a component of Rd 7 as well as development of appropriate media communication tools and engagement of civil society and decision makers in passing on messages.

5. ACSM PROGRAM CHALLENGES

“The perception in the community is that anything that is public is poor quality.”

TB Stakeholder

As well as a number of achievements the following challenges have been identified:

- Current ACSM programming approach lacking any strategic thinking.
- Insecure environments in some areas with sporadic fighting causing fear and resistance of public movements.
- Geographic isolation of some communities with IDPs and nomadic populations difficult to reach.
- Community DOTS is challenging to implement due to low capacity of potential DOTS providers.
- Vertical program does not provide treatment centres within existing clinics.
- Insufficient KAP data (knowledge, attitudes and practices) from which to clearly identify target groups needs and wants.

6. ACSM STRATEGIC FRAMEWORK

“The history of the program is that it is vertical, but we have to change; we have to think and talk about this.”

TB Stakeholder

\(^{15}\) Behavioral change communication - community outreach: TB Patients’ association GFATM Rd 7.
Although much has been achieved as a result of GFATM and other donor funding for ACSM in Somalia/Somaliland, the opportunities which arises with future funding rounds is for the development of more strategic, evidence based approaches to ACSM. If adopted by stakeholders, this will move the ACSM component away from ad-hoc responses, towards more integrated, multi-level, intensive, programmatic approaches to encourage broader participation and involvement by stakeholders and ownership by communities.

6.1 ACSM Strategy – 10 Elements for Success

If a more strategic integrated planning model can be institutionalised for the ACSM program, ‘measurable behavioural impact’ can be achieved as the result of a comprehensive range of interventions conducted at population health levels. Some of the elements to achieve programming success include the following:

1. **Phased Approach** – Acknowledging that behaviour change will take time to achieve, especially where target groups have poor risk and self-efficacy perceptions.

2. **Coordinated Strategy Management** – Acknowledging the importance of effective campaign management to identify priorities for the planning, development, implementation and evaluation process. This can be best achieved through the existing TB Coordinating Team, which already has representation by a number of key stakeholders and could be expanded to provide additional technical support (see Figure 1).

3. **Strategic Planning Approach** – Acknowledging the need to develop proactive planning approaches rather than operating out of crisis management paradigms, and the need to break down a complex range of procedures into manageable stages that provide involvement, participation and ownership of all stakeholders.

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**Figure 1. ACSM STEERING COMMITTEE MANAGEMENT STRUCTURE AND COMPOSITION**

- **SOMALIA/SOMALILAND NTP**
- **Health Sector Committee**

  Membership needed here?

- **Tb Coordination Team (TBCT) - ACSM Implementing Group**

  Zonal NTPs, Chair of Health Sector Committee, WHO, World Vision, CCM – Italy monitoring and supervisory group, and other partners

- **Clinical Services S/holders**
- **PPM Health Sector S/holders**
- **Patient Groups – Cured and Treated Patient S/holders**
- **Faith Based S/holders**
4. **Multilevel, Integrated Programming** – Acknowledging the importance of a range of programming approaches with large and diverse population segments, and the need for all stakeholders to work together in the resource limited settings to achieve campaign impact (see Figure 2).

5. **Intensive Targeted Interventions** – Acknowledging the need to set the programme agenda with intensive campaign periods of 6-8 weeks to specific target populations due to limited financial resources, potential message fatigue and low ranking of health issues by many message receivers.

**Figure 2. SETTING THE PROGRAM AGENDA THROUGH MULTI-LEVEL PROGRAMMING**

6. Develop creative, simple messages based upon target group motivations, and the underlying determinants of behaviour to ensure that messages touch the head as well as the heart.

7. **Ensuring Optimum Reach and Frequency of Messages** - Highlights the importance of repeated message exposure, through interpersonal and media communication channels to optimise message reach, frequency, recall and retention.

8. **Adapting Programming to The Security Situation** – Acknowledging the importance of being aware of security situation before conducting community based programming or altering programming approaches to the needs of the security environment.

9. **Evidence Based Programming** – Is a reminder to utilise monitoring and evaluation at all stages of the planning, development and implementation cycle with campaign ‘intelligence’ informing planning decisions for the next stage of programme activity.

10. **Developing Programming Core Competencies** – Highlighting the specialised and technical nature of ACSM programming and the need to build technical capacity and core competencies if long term, sustainability is to be achieved (see Figure 3).

**Figure 3. CORE COMPETENCY AREAS FOR ACSM PROGRAM DEVELOPMENT**
Also required is the need to develop public-private partnerships in ACSM with advertising, public relations and market research partners with specialised technical competencies in core areas of ACSM programming. Where these are not currently available in Somalia, they can be sourced from neighbouring countries with the intention of instilling technical transfer of these programming competencies to Somali counterparts over the course of the strategy.

6.2 Strategic Planning Cycle

“The small pockets of activities have improved. It has put the (ACSM) program on the runway, and now we just need to have lift-off.”

TB Stakeholder

It has been acknowledged that for the successful development and implementation of the ACSM strategy at all levels, a coordinated, participatory approach is required with stakeholder feedback at every stage of the ACSM program evolution. A staged planning model is proposed to assist in planning for each phase of the program in line with GFATM funding cycles.

Each year of funding will be one Phase of the ACSM strategic planning cycle. For GFATM Round 9, Four phases of ACSM programming are proposed with the initial year utilised for the establishment of management committees, expansion of community based program partners and contracting of private sector partners. A diagrammatic illustration of the approach is as follows (Figure 4):

Figure 3. STRATEGIC ACSM PLANNING CYCLE
It is proposed that the ACSM strategy will operate continuously within the 4-Stage Planning Cycle with the following range of activities:

**Stage 1 - Planning**

- Conduct participatory stakeholder consultations with donors, government, civil society and the private sector.
- Conduct formative research with target groups and rapid assessments to identify risk settings for a comprehensive, localized, situational analysis.
- Utilise ACSM Technical sub-Committee, National and Zonal ACSM staff for coordination of ACSM campaign planning, development, implementation and review.
- Out-source services as required to NGOs and private sector for Training, Capacity Building, Community Based Advocacy, Media Production and Dissemination, and Monitoring and Evaluation.
- Develop ACSM Planning Documents – Creative Communication and Market Research Briefs for approval by ACSM Technical sub-Committee members and partner agencies, and seek consensus on the way forward.
- Produce inclusive, participatory National and Zonal implementation work-plans that include delegated agencies, timing/phasing considerations, Technical sub-Committee inputs, approval points and adequate budget.

**Stage 2 - Development**

- Conduct relevant training programs and capacity building to ensure effective community based ACSM program delivery.
- Develop communication messages and creative concepts for activities and materials.
• Conduct ACSM pre-testing and report results and recommendations to ACSM Technical sub-Committee members and partner agencies.
• Amend and produce final resources and activities in accord with ACSM sub-Committee, recommendations.

**Stage 3 - Implementation**

• Disseminate resources through National, Zonal, NGO and civil society community networks.
• Mobilize National, Zonal and Community level operatives for concentrated program activities.
• Execute supporting multi-media umbrella, media advocacy and integrated range of community-based activities to support Campaign Phase objectives.

**Stage 4 - Monitoring Evaluation and Review**

• Develop Market Research Brief for tendering of Qualitative (focus group) and Quantitative (pre and post intervention) research and integrate within Monitoring and Evaluation Framework.
• Measure behavioural determinants through KAP including indicators for knowledge, attitudes and perceptions, behavioural intentions, actual behaviours, maintenance and advocacy for of behaviour.
• Establish input and output indicators (internal measures of capacity, skill, program penetration, and resource distribution.)
• Establish impact and outcome indicators (audience-based measures of individual behaviour change and population-based measures relating to prevalence, service demand, referral, treatment uptake and adherence.)
• Conduct operational research to generate data for problem-solving and decision making;
• Advocate the successes of each Phase of the ACSM program impact and elicit stakeholder feedback at National, Zonal and Community levels, and integrate comments into future planning cycles (Phases) of the strategy.
6.3 Audience Segmentation

“In Somali communities they consider older people as more credible sources of information.”

TB Program Stakeholder

ACSM messages will only be effective if they speak directly to the needs of particular audience segments with similar attributes and concerns. For these reasons it is important to consider different target populations at different phases of the program. Early campaign phases should include opinion leaders and key community influencers who operate in community social networks. It is now acknowledged that the initial support, advocacy and mobilisation afforded by these influential groups will be critical to success of the program in future implementation phases.

As well as the successful engagement of key influencers in early phases of the program, targeted interventions as well as a more general roll-out of program messages and activities is proposed to a number of other audience segments in different phases of the strategy.

6.4 Adapting Programming to the Security Situation

Security of field staff should never be compromised when planning ACSM activities in insecure settings. For these reasons a planning approach similar to conducting military missions should be adopted when contemplating any outdoor activities or travelling to Districts to conduct advocacy work. The UN provide security reports which can be sourced by health agencies on a weekly basis (See Figure 5. ACSM Programming - Security Matrix). These reports should form the basis for any ACSM planning activities. Additionally an ACSM Programming Security Matrix and Management System has been developed for consideration of health staff considering conducting community activities.16

**Figure 5. ACSM PROGRAMMING - SECURITY MATRIX**

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<th>SECURITY LEVEL</th>
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<td>Yellow = 2</td>
<td>Orange = 3</td>
<td>Red = 4</td>
</tr>
<tr>
<td>Travel Expected Duration and Distance</td>
<td>Less than 30 mins or Less than 50Kms</td>
<td>30 mins -1 Hour or Less than 100Kms</td>
<td>1-2 Hours or Less than 200Kms</td>
<td>More than 2 hours or More than 200 Kms</td>
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<tr>
<td>ACSM Program Type</td>
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<td>Indoor Meeting with group of less</td>
<td>Indoor Activity with group of</td>
<td>Outdoor Activity</td>
<td></td>
</tr>
</tbody>
</table>

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16 Adapted from UNAMI Security Incident Report.
7. ACSM PROGRAM TARGET GROUPS

The following are a range of potential target populations for different phases of the strategy:

7.1 Influencing Groups

“When the Sheikh says something, then they will listen.”

TB Stakeholder

- Donors and International NGOs.
- Senior Public Servants, District and Local level administrators.
- Journalists and the Media.
- Local Leaders, Village Heads and Religious Leaders.
- Head Teachers, School Health and other Academic staff at Primary and Secondary Schools and Colleges.
- Traditional Leaders and Traditional Healers.
- Successfully treated TB Patients and their Families
- Business Leaders, Celebrities, Musicians, Sporting Heroes and other Role Models.

7.2 Primary Audience Segments

- TB patients, their families and communities with a history of high TB incidence in geographic hotspots.
- Females and Males in lower-socio-economic categories including: slum dwellers, tribal populations, nomadic and migratory populations, fishermen, prisoners in jails and correctional facilities and other marginalized groups.
- MDR and XDR-TB cases.

7.3 Secondary Audience Segments

- General Population - females and males 16 years and above, in urban, rural and remote rural areas.
8. ACSM STRATEGY OBJECTIVES
The following objectives are proposed for the ACSM strategy:

8.1 TB Strategy Objectives
The overarching objectives for the five year program for 2010-2015, are as follows:

- To mobilize resources for NTP and especially for ACSM implementation.
- To build TB ACSM partnerships with international and national and Zonal partners in the public and private sector.
- To support high quality community DOTS expansion and enhancement.
- To address through ACSM TB/HIV, MDR-TB and other challenges.
- To support ACSM technical transfer and health systems strengthening.
- To engage all health care providers in TB prevention and control IPC.
- To empower communities and people with TB.
- To enable ACSM monitoring and evaluation to measure ACSM program impact.

8.2 Audience-Based Objectives
A number of audience based objectives are proposed during various phases of the ACSM strategy including the following:

- *Increase awareness and knowledge* – ever having heard of TB and correct knowledge – signs and symptoms of TB - modes of transmission and means of prevention, need for early health seeking behaviour, location of DOT providers (public/private and community), duration of treatment, cost of treatment, treatment efficacy and adherence.
- *Change attitudes and perceptions* – stigmatizing attitudes toward TB patients, personal risk perceptions, self-efficacy perceptions toward early health seeking behaviour, treatment adherence and treatment efficacy.
- *Increase behavioural intentions* - toward early detection, early health seeking behaviour, treatment adherence and patient support.
- *Increase behaviour change and maintenance* - incidence of at-risk patients attending clinics for screening, incidence of treatment adherence, and successfully treated patients advocating for DOTS.

8.3 Service Delivery Objectives
The following objectives will ensure that health service delivery systems and agencies operating on the supply side respond proactively to program beneficiary needs.

- Increase ACSM capacity of TB service and DOTS providers to meet client expectations, advocate for early health seeking and treatment, appropriate early referrals, correct diagnosis, contact tracing and treatment adherence.
8.4 Community Based Objectives

The following objectives for delivery of the ACSM strategy through community sources are proposed as follows:

- Strengthen partnerships with donors, NGOs, and other civil society organisations, involve and mobilise communities and in particular, marginalised and vulnerable populations for TB prevention, treatment and care programs.
- Enable key influencers - community leaders, religious leaders, health workers, journalists and teachers to confidently answer frequently asked questions on TB.
- Develop user-friendly IEC aids to support the training of community key influencers.
- Create opportunities for dialogue on TB prevention, treatment and care through resource support and advocacy initiatives - between health providers and communities, between communities and community leaders, between family members, neighbours and youth.
- Set the program agenda; strengthen the areas of sensitisation, social communication networks, health promotion, social marketing and community mobilization.
- Utilise a range of ACSM channels and places for dialogue.
- Protect the interests of the multisectoral, national TB and HIV prevention, treatment and care programs by reinforcing the need for collaborative, integrated efforts at a National, Zonal and District levels.

9. MESSAGE DEVELOPMENT

There is behaviour of spitting which is prevalent. People really do this a lot. This could be a behaviour we could modify.

TB Stakeholder

The process of developing effective messages to cut-through the communication clutter will be a key to the success of this ACSM strategy. Messages must be based on well-developed audience research and reflect the cultural, spiritual, socio-economic and gender determinants impacting on behaviour change. The principal challenge is to identify a single key message point that will motivate the audience to think or act differently and to follow through on the call to action. Messages for each campaign must be single-minded, uniformly applied, pervasive, delivered in an engaging way, and sustained over time in order to achieve the desired result.
Although there is a degree of audience-based research on TB currently available in Somalia/Somaliland, a continuous process of formative research and message pre-testing via qualitative and quantitative techniques needs to be institutionalized to adequately inform the message development process. This can be supported by conducting population-based, quantitative KAP surveys exploring TB-related awareness, knowledge, attitudes, practices and behaviour prior to and following campaign Phases. As well as establishing a baseline for the ACSM strategy, these combined monitoring and evaluation (M&E) approaches, will ensure high quality, pre-tested messages and materials will be developed, which are responsive to audience needs.

Private sector partner agencies will need to be selected to assist with the message development and materials production process. The Creative Communication Brief is an important strategic planning tool for collaborating with communication specialists on message and materials issues. The creative brief is completed by the client and articulates the relevant background information on the health problem, the objectives of the ACSM strategy, what we know about the audience, potential channels for reaching the audience, opportunities and challenges in the communication environment, and specific psychographic profiles that need to be addressed. Most importantly, the creative communication brief should state the main messages and key benefits as to why the audience should act on the messages being delivered, as well as addressing the stages of behaviour change within the timing of the intervention.

9.1 Potential Message Themes

“Providing a unified message for the whole country would be good.”

TB Stakeholder

The literature shows that TB messages to promote understanding of the symptoms of TB and treatment efficacy, can have a significant impact on TB prevalence. Experience from other countries also shows that as the ACSM strategy evolves, and more specific data is assimilated on the mitigating factors supporting this health problem, ACSM programme priorities may change. Given the focus on lower-socio economic groupings and the need to promote early help seeking behaviour to these groups who are often marginalized and less efficacious, the focus should be on reducing stigma and building confidence to seek screening and treatment as soon as possible. Some potential message themes to be considered for the ACSM Campaigns follow.

9.1.1 Messages to Reduce Stigma

- **Building TB Brand Equity** - to improve perceptions of TB generally in the community, in order to make early detection and disclosure more acceptable in the community through the creation of a range of tangible and intangible benefits to health services user groups.
• Creating Transformational Appeals – to stimulate interest, build personal risk perceptions, graphically display treatment efficacy and subsequent reduction in debilitation thereby, reducing general community resistance and increasing community dialogue on TB.

9.1.2 Messages to encourage early Health Seeking Behaviour and Treatment Adherence

• Promoting the benefits of early help seeking behaviour - following cough for more than 3 weeks as well as treatment efficacy – cost and cure if help is sought early.
• Promoting the Improved and Expanded Service Delivery Network - through traditional service providers (public and private clinics) and non-traditional service providers (Community DOT and Fixed DOT providers).
• Providing Complementary Messaging – linking early detection, screening and treatment to reduction in debilitation of patient, infection of other family and community members.

9.1.3 Messages to Build TB Knowledge and Change Attitudes

• TB is a significant problem in Somalia/Somaliland.
• A complete cure from TB is available if you seek help early.
• If you have a cough for more than 3 weeks go to your local health centre.
• A simple saliva test will identify if you have TB. Costly X-Rays are not required to detect TB.
• If you do have TB you will need to take treatment through oral medicine for a 6 month period.
• The TB treatment is available free of charge at all TB Centres and from Community DOT providers.
• If you go to a private health practitioner you may need to pay for the medicines.
• The quality of the free public sector medicines is as good and usually better than those provided through the private sector.
• A DOT provider within your community can assist you to make sure the medicine is taken every day.
• If you do not stick to the treatment for the full period, your body can build up resistance to the medicine, making it more difficult for you to be cured.
• Early detection, screening and treatment can prevent long term disability or death from TB, as well as prevent spreading the infection to other family and community members.

10. ILLUSTRATIVE ACTIVITIES

“NTP maintain that the oral tradition is very important. Information travels much faster in Somalia from person to person. One thing happens in one area and it travels quickly.”

TB Stakeholder

10.1 Community Level Activities

Somalia’s topography and traditions have ensured the cultural integrity of its regions. The culture is steeped in oral tradition, with the large rural sector, in particular, dependant on
vernacular, dialogue-oriented, communication approaches. Therefore, key to the success in stemming the tide of TB in Somalia/Somaliland is to build the momentum for change at District, and community levels.

Interpersonal, dialogue based approaches in conjunction with efficient service delivery, can be the most successful approaches to encourage health seeking behavior change, particularly where literacy is low or community distrust of outsiders may be high. In order to achieve these ends in the 3 year term of this strategy, the following activities are recommended.

10.1.1 Capacity Building
There is a need to strengthen the capacity of a number of public and private sector partners to achieve a greater understanding of strategic ACSM approaches and the principles of behaviour change. Technical assistance and training is required to properly plan, develop, implement and evaluate the ACSM strategy at a number of levels. Financial resources will be required to support the programs technical assistance function to ensure that program partners are properly trained in ACSM processes in order to build institutional capacity over the duration of the strategy.

Capacity building and technical transfer should be an integral part to build the ACSMs program core competency areas. This can be elicited with support from technical advisors available through INGOs, as well as private sector partners within Somalia and in neighbouring countries who have currently not contributed significantly to the ACSM strategy.

ACSM private sector communication and research partners should be engaged to conduct a number of the highly technical areas of the program such as development of media materials, and methodologies for monitoring and evaluation of a number of aspects of the program. An essential component of these partnerships is engagement of local counterparts so that technical transfer can be assured and skills developed within Somalia to carry on the work following the term of the strategy. This approach to capacity building and institutional strengthening will assist NTPs in the efficient disbursement of ACSM funds to achieve greater program impact.

ACSM Activities to support Capacity Building
• Support the establishment of an ACSM Technical Committee as part of the TBCT and build technical capacity through engagement of public and private sector partners with relevant technical skills for ACSM.
• Provide additional specialized TA to support the TBCT and other program stakeholders to further build ACSM capacity through strategic planning processes.
• Capacity building in some cases may include establishment of infrastructure and equipment including human resources, computing hardware/software and audio-visual equipment.

• Once capacity is established at Zonal levels, expand the capacity building process with NGO partner support at District levels.

10.1.2 Training

“Disease has been removed from a moral or hygiene issue and now is seen as any other disease, and the strongest factor is the people who have been cured.”

TB Stakeholder

Somalia/Somaliland has an existing human resource network of health and auxiliary workers, community DOT providers and health personnel in all regions. However the workforce is often provided with too little training in TB communication, in relation to other health program priorities, and no refresher training. Although training is sometimes maligned as a process of never-ending workshops with few meaningful outcomes, training can be a useful tool to instill understanding of ACSM processes, what has been to date, a clinical focus to the program.

Training activities to support the ACSM strategy development, implementation and evaluation process, can build institutional capacity and a degree of sustainability with stakeholders involved in community-based DOTS provision and health promotion. Continuous feedback and ongoing technical support will be required to enable the process of skills development and the effective utilization of skills which focus on IPC approaches. Another aspect of the training could incorporate specific agreed upon activities with NGOs and other stakeholders involved in training to ensure integration and participation in all state level ACSM campaigns.

ACSM training’s desired outcomes could include the development of a range of local level activities, events and materials with workplans and activities agreed upon by NGO management, prior to the training. An aspect of the training should ensure that learning is translated into realistic and achievable interventions in-line with agreed upon deliverables, with monitoring and evaluation being an integral component of activities.

Front-line health workers should be provided with a broader training platform which includes building IPC skills, confidence and leadership development. It is also important to instill a greater understanding of the importance of IPC with MOs and other clinical staff as a necessary component of their clinical service delivery.

ACSM Activities to support Training

• Identify ACSM training needs within NGOs, and provide training support to ensure coordinated, integrated, District and Zonal and National ACSM priorities and planning
approaches - problem identification, audience segmentation, behavioural objectives, achievable interventions and performance monitoring.

- Support field-staff – health workers, DOT providers and auxiliary staff in ACSM training. Also train TB clinical service providers to instil a culture of ‘customer focus,’ enhanced service delivery and effective inter-personal communication skills.
- Conduct ACSM training workshops at Zonal levels, over a one month period in the lead-up to the World TB Day campaign and involve media journalists and local NGOs in ACSM trainings.
- Review existing training programmes and training capacity and conduct training of trainers (ToT) to leverage and expand activities.

8.1.3 Peer Education

“The Damin system makes sure that an influential relative is taking care of the patient.”

TB Stakeholder

TB is often more prevalent in settings such as IDP camps, tribal and remote rural areas which contain the most economically disadvantaged and marginalized population groups. These population segments represent some of the most difficult to reach populations due to their infrequent attendance to media communication channels and access to other forms of communication.

For these reasons successfully treated TB patients who live in these communities can often be the most effective channels of communication with their peers. Lessons learned from peer education programs have shown that the approach can reduce stigma, increase understanding, ownership and involvement toward important health problems. Peer-led communication activities ensure that messages disseminated are more credible, and more likely to be heard and acted upon by other peers.

As well as cured patients, peer educators could also include village heads, village doctors, school teachers, worksite representatives, and other opinion leaders who are in an excellent position to discuss TB within their constituencies. Peers could be trained and given appropriate resource materials to equip them with the information they need in order to act as effective advocates for the ACSM strategy.

The participatory process of dialogue within targeted vulnerable and marginalized communities, coupled with moderation by peer leaders can be a powerful behaviour change tool. In order for these programmes to be successful, venues for peer led interventions will need to be identified, and moderators trained and supported with appropriate ACSM aids.
ACSM activities to support Peer Education

- Identify NGOs, and other civil society organisations to work with cured patients and local leaders to establish cured patient support groups in all areas.
- Provide training to cured patients in order to scale-up peer to peer (PTP) training programs in particular, with IDPs, slum dwellers, fishermen, transient and nomadic populations, and other vulnerable groups.
- Encourage peers to also become DOTS providers in their communities and utilise successfully trialed ‘Damin’ pledge system to ensure patient treatment adherence.
- Build capacity and support for peer education by including incentives within training formats, successful treatment outcomes and IEC resource materials support.

10.1. 4 Advocacy

Advocacy is an important and integral aspect of the community sensitization process that has been underutilised in Somalia/Somaliland. Advocacy can include events, and advocacy conducted by role models and other community leaders. These efforts should continue to add-value to the ACSM process through more purposive advocacy approaches through community social structure channels as well as media advocacy approaches.

Advocacy training is an important component in the process in order to provide skills, key TB messages and question and answer sheets to build opinion leader’s confidence in discussing TB within their communities. Opinion leaders could include; local politician’s local leaders, religious leaders, journalists, business leaders, celebrities, sporting identities, musicians, artists and traditional healers. Following training, incentives such as IEC materials and merchandise could be provided to empower advocates to promote TB control within their constituencies. The process can also be a key feature in any efforts to raise community awareness of TB risk and prevention approaches and reduce community stigma.

ACSM activities to support Advocacy

- Identify potential advocates and conduct ACSM training workshops in all Zones, and provide IEC materials and other incentives for advocacy work.
- Provide media training skills for advocates to conduct media advocacy – radio talkback, TV panel discussions and newspaper stories.
- Support NGO partners to identify and use the trained community leaders, role models and opinion leaders when planning their ACSM programs, and integrate advocacy as a key element of community events.
- Support advocacy through the identification and training of media sector partners, to regularly disseminate proactive, structured media releases, incorporating accurate program information including relevant research findings on TB and other points of interest.
10.1.5 Community Theatre and Enter-Educate Events

“When we give big messages we invite the circus people.”

TB Stakeholder

Community approaches adopted by NTP are an appropriate mix of traditional and contemporary media. These enter-educate events are designed to first entertain the public through engaging activities such as acrobatics, circus troupes, singers, musicians and community drama. In this way educational messages on TB can be imparted incorporating emotional and powerful themes through dramatic executions. Community theatre can break through language and cultural barriers and is an extremely useful communication tool.

Enter-educate events do such as community theatre not require literary skills or clever speaking to be effective. Theatre communicates with the whole community - its appeals to community emotions, passions and prejudices. It is an entertaining way of sharing information. Both adults and children learn their best when they are entertained and interested.

It is a form of play acting in the open, before the general public. It can portray real life situations of patients which usually involve conflicts and emotions. It is a medium to expose injustice towards TB patients (especially women) in the social system and stimulates the audience to think hard about practical solutions. It communicates important messages, ideas and attitudes in a manner that easily captures people’s attention. Some elements of humour, tragedy and intrigue can be induced to sustain interest in the audience during the performance. Through out enacting, participation from the audience should be encouraged.

More recent developments in Music, Dance and Drama (MDD) use sport and physical activities in the form of cooperative games linked to health messages to further expand this interactive and entertaining media form. These activities make use of idiomatic expressions, which may vary from one ethnic community to another and are the basis for ACSM within and across generational and community leadership structures.

The integration of messages on TB into street theatre requires a degree of coordination to establish quality assured messages and programs, and integration of activities, as well as the active involvement of participants in the development and implementation process.

An important aspect of this creative media form is to establish a link with the audience and encourage participation through scenarios which enable community and individual problem solving, and exploration of pre-existing attitudes and beliefs. However, caution should always be excercised when conducting these events in public settings where insecurity is high.
ACSM Activities to support Community Theatre and Enter-Educate Events

- Integrate and expand on enter-educate opportunities and promotional events with NGO partners and integrate activities within the wider ACSM framework of coordinated activities.
- Support the development of a coordinated MDD and sporting events to engage communities which may have been traumatized by conflict and insecurity.
- Providing TA and infrastructure support to lead proponents including transport, audio-visual equipment and merchandise for distribution.
- Add value to community theatre by producing televised dramas and soap operas from community productions for television transmission, radio plays, CDs and audio cassettes for community distribution.
- Support the professional development of popular musicians and role models in the arts who can promote TB prevention and care by developing songs on TB, thus making them advocates for the program.

10.2 Zonal and National Level Activities

At a Zonal level, media has the undeniable power to inject changes into the society. Mass media are important components, as well as indicators, to support the development process and may be particularly relevant in conflict settings where people do not travel far from home. They are a means of increasing awareness and knowledge, sensitizing, carrying development messages, and channeling reactions between audiences and health workers.

In NTP however, it is a challenge to present TB information in a manner that will be credible, understandable and acceptable, as well as ensuring that the information flow remains efficient. One major challenge is the large and scattered populations in remote areas where out-reach becomes difficult.

An effective approach is communication through various media and the integration of strategic communication. Strategic communication is a powerful tool that strives for behaviour change and not for just information dissemination, education, or awareness-raising. In order to effect behaviour change, it is necessary to identify the root causes of non-compliance, its manifestations and the most effective communication channels for delivering messages to support population health approaches. The idea is to build consensus by raising public understanding and generating informed dialogue among stakeholders. Well-conceived, professionally implemented, strategic media communication campaigns are of particular need in the future.
10.2.1 Radio

“Pick-up with radio is very big. There are local, regional and FM stations.”

TB Stakeholder

Stakeholder feedback and available data indicates that radio has the widest reach among the mass media in Somalia/Somaliland despite the greater impact of television in urban areas. FM radio stations are well listened to by many Somali’s who crave information from the outside world. Radio is also an important medium with illiterate groups who depend on oral based communication for their health information.

However, more interesting health and social programming may create further interest in radio listening if well planned and executed. While the urban audiences are shifting to television and other media, there is still a need to strengthen radio reach to more inaccessible rural populations in remote rural and border areas with the BBC currently fulfilling this role.

**ACSM activities to support Radio**

- Provide public service announcements and paid media schedules featuring key influencers and opinion leaders on radio, and provide radio talk-back opportunities on important TB issues.
- Establish linkages with existing popular radio soap opera productions for the provision of themes and storylines to support TB messaging to set the ACSM program agendas and support community based IPC.
- Fund the translation of community theatre and other MDD approaches into radio treatments.
- Provide training to radio journalists on advocacy approaches in support of TB prevention treatment and care.

10.2.2 Television

Television ownership and coverage, especially in urban areas has been steadily expanding in Somalia/Somaliland. Television is now an emerging medium in the region in both urban and peri-urban areas with inexpensive Chinese television sets coming onto the market and high interest in the visual impact and novelty of television by most population groups. The other aspect of television is the high impact available due to graphic imagery with rural population segments who have yet to become immersed in this medium.

Viewers have a choice of several entertainment channels, sports, news and other variety shows. The limited but rapidly expanding satellite broadcasts in Somalia/Somaliland will surely increase viewing options and alter viewing patterns even further.
**ACSM activities to support Television**

- Provide public service announcements and paid media schedules featuring key influencers opinion leaders and successfully treated patients.
- Translate community theatre and other MDD approaches for television broadcast.
- Provide training to television journalists on advocacy approaches in support of TB prevention.
- Conduct televised activities such as TV panel discussions using advocates – business, religious and local leaders, to raise TB risk perceptions, referral options, reduce TB stigma and promote early health seeking behaviour.
- Provide television current affairs and news opportunities on important TB issues.
- Develop campaign (generic) brand and campaign specific positioning (slogan) to provide a cohesive, integrated range of ACSM messages through National, Zonal and District media and community based resourcing.

**10.2.3 Newspapers**

News-print media can provide ACSM opportunities through ‘long copy,’ informational approaches and topical news stories generated through media advocacy activities. Although access to daily newspapers in rural areas drops-off rapidly, as does the reading culture, the more remote the area, print is an important medium for opinion leaders with readership far exceeding circulation.

There are a number of low-cost Zonal newspapers in Somalia/Somaliland with the main Zonal newspapers of Haatuf, Somali Herald, Somali Tribune, Somaliwide being influential, with a host of other local level newspapers. A number of other International newspapers and magazines round-out the market for print news. The daily newspaper’s editorial policies although sometimes questioned by readers provide lively debate, and the medium’s primary audience segments are policy makers and the educated elite. Opportunities arise through working closely with journalists, to generate more positive, purposive coverage for NTP.

**ACSM activities to support Print Media**

- Support the focus of Zonal news-print media TB stories to political leaders and key influencers – health workers, head teachers, local and religious leaders, to influence TB advocacy behaviour within social structure channels.
- Support NGOs through capacity building and training to develop greater interest and involvement in print journalism with the development of TB events and other health stories focusing on vulnerable populations, and covered by print media.
- Support NGOs and other partners through media training for the development of media events, launches, media releases and print based-stories to set the TB program agenda with influential groups and support community based IPC programs.
10.2.4 Outdoor Media

Outdoor media can provide ACSM campaign impact, memorability and longevity, and is accessible to large numbers of people in rural and urban areas. There are some opportunities for targeted approaches to billboards in higher risk areas such as IDP camps, slums and tribal communities although messaging needs to be pictographic and the billboards or wall-brands need to be located in secure areas. There is somewhat limited experience with outdoor media through stand-alone signage, painted on roadside barrier walls, and vehicle stickers.

A potentially cost effective and relatively untapped outdoor media opportunity is the bus and taxi services with public transport vehicles ferrying numbers of people around the country, daily. Buses and taxis provide moving TB billboards on high-traffic routes, as well as providing ‘captive audience’ reminders, through TB messages placed inside of the vehicles. Wall branding on high profile buildings and retail shopping areas can also extend the life of the message and reduce infrastructure costs of building billboard frames or contracting for their use. Given the fact that mobility is a characteristic of a number of vulnerable population groups, outdoor media should be fully explored as a potentially important means of message dissemination.

**ACSM activities to support Outdoor Media**

- Work with the Transport companies and public sector and worksites, to identify potential, free, outdoor sites (hospitals, clinics, school-grounds, factory entry points, truck-stops, bus-parks,) to be used exclusively for TB and other public health, social marketing activities, and contract an agency to erect hoardings at the sites.
- Develop high-quality billboard messages and contract an agency to implement a pilot program of vehicle signage for buses and taxis in urban and rural areas.
- Identify potential walls on public and private sector buildings and contract with signage suppliers and owners to paint TB wall brands.
- Integrate wall branding program with clinical signage to provide distinctive TB signage at all public clinics, to assist the public in locating the clinics.
- Develop an M&E program to evaluate the outdoor strategy and make recommendations for possible future scaling up of activities.

10.2.4 Community IEC Materials Development and Delivery

“The program is vertical and passive - the IEC materials are targeting those already infected so maybe we need to create prevention messages.”

TB Stakeholder

A critical feature of any TB prevention efforts is the need to build knowledge and change attitudes and perceptions of vulnerable groups who when faced with continuing conflict, may be paranoid, fatalistic, and lacking in confidence and skills to make effective health decisions. Community-based IEC materials in the form of publications, other print based materials and
merchandise can assist key influencers in supporting behaviour change within these groups and mobilizing the call to action.

However, community materials are often cited by stakeholders as being in short supply. This includes publications to increase knowledge on key modes of TB transmission and prevention, and the need for early health seeking behaviour, treatment adherence and referral options. Other community materials will need to be produced in more user friendly formats to support health service providers to be more aware of the range of issues related to TB prevention, treatment services, and referral options.

As there is currently a poor reading culture and lower literacy in rural areas, more visually based messaging such as flip charts could be scaled-up to overcome these challenges. Publications should be seen as predominantly supporting advocates and other influential groups in their understanding and dissemination of important TB messages to their constituents through IPC approaches.

A key feature of any IEC materials development program is the timely and efficient delivery of materials, when and where they are needed. Therefore an ACSM Communication Resource Information System (CRIS) utilising logistics similar to that employed for TB medical supply distribution should be considered to minimize the current ad-hoc production and dissemination of these resources. A materials distribution database could be developed incorporating public sector distribution in non-traditional outlets, through pharmacies, schools, hospitals, health facilities, community centers and administrative offices in urban and rural networks.

The current medical logistics program could also provide valuable distribution support through existing networks at Zonal and District levels. A demand driven approach should be encouraged following establishment of the IEC materials distribution network. TB stakeholders could be provided with resource order forms to monitor resource dissemination and minimize stockpiling.

**ACSM activities to support Community Materials Production and Distribution**

- Rationalise the existing broad range of resources produced by a number of NGO partners into a core set of quality assured publication materials.
- Design, pre-test, develop and distribute the core range of IEC materials and merchandise to support TB community based IPC approaches.
- Seek support from private sector distributors to disseminate materials to reduce costs and improve delivery times, or integrate materials resourcing with drug supply to service providers.
- Monitor the system to identify current and future NGO, public sector, IEC materials demand in all Zones and Districts.
10.2.5 Quality Assurance

Quality Assurance (QA) is a process of establishing policies and guidelines to ensure that programs and products developed are of the highest standard. This ACSM strategy feature can utilize QA mechanisms for processes such as the International Standards Organization (ISO) standards for World’s best practice, WHO standards for ACSM quality assurance, or development of continuous improvement mechanisms within the strategy to ensure that ACSM programs, products and services are effectively delivered and continuously improved upon. QA processes could include service delivery for the range of TB prevention programs and activities being considered or scaled-up or quality-assured ACSM message and materials pre-testing, prior to materials production and distribution.

Effective monitoring and evaluation to assure the program meets behavioural objectives is an essential component of the ACSM strategy. As such it has not been given enough emphasis to date to ensure that a quality approach to program development is adhered to, and a culture of continuous improvement instilled.

ACSM activities to support Quality Assurance

- Increase ACSM program efforts towards more ‘customer focused’ approaches by service providers and incorporate QA in all ACSM training activities.
- Incorporate customer satisfaction surveys within formative, qualitative and quantitative surveys and report findings to program partners.
- Provide patient charter in all NTP facilities and develop an M&E program to increase the levels of client entry, and assess involvement and satisfaction with health service delivery.
- Incorporate QA policy guidelines into all program activities, events and IEC development to ensure ACSM strategy best practice.

10.2.6 Operationalising the Program

The ACSM strategy will not be effective unless there is ownership and participation by all stakeholders through a practical, achievable planning approach. This will require coordination of workplans and demarcation of responsibilities to avoid duplication and ensure effective utilisation of resources. An integral part of the process will involve effective monitoring and evaluation of the program activities to identify lessons learned.

ACSM activities to support Operationalising the Program

- Develop practical integrated ACSM workplans with all program partners to ensure consistent, evidence based approaches and full utilisation of resources through multilevel programming approaches.
- Provide training, merchandise and IEC materials incentives to staff to build program involvement and participation.
- Following training and capacity building, concentrate majority of ACSM activities around an intensive, programming period in the lead-up to World TB Day.
• Develop annual post intervention KAP surveys to monitor ACSM program impact.

11. MONITORING AND EVALUATION
A monitoring and evaluation (M&E) framework will need to be developed to accurately measure the impact of specific ACSM interventions as this has been identified as a gap in current ACSM planning and development. This can be addressed through the technical support of program private sector research partners. Although 2 small-scale KAP surveys have been conducted in clinical settings, more representative samples of the regional and national populations will have to be established in areas where there is less conflict, and these surveys will need to be institutionalized as an integral part of the ACSM Strategy.

It is anticipated that a number of operational M&E mechanisms will be required for the program including the following:

• **Qualitative research** – for formative elicitation surveys, and message pre-testing. This type of research could take the form of focus group discussions (FGDs) with like minded groups, or one to one, in-depth interviews (IDIs) with program beneficiaries and key informants.

• **Quantitative research** – to provide more rigorous and scientific indicators of ACSM program success and identify the changes in the primary behavioural determinants including; TB Awareness, Knowledge, Attitudes and Perceptions, Behavioural Intentions and Behaviours.

11.1 Performance Indicators
Although the NTP currently have a set of performance targets to measure case detection, referrals, and treatment outcomes, it is now timely to integrate these program indicators with KAP behavioural determinants to provide a more comprehensive picture for long-term program success. A range of Key Performance Indicators (KPIs) should be included as part of the ACSM strategy M&E framework including the following indicators:

11.1.1 Input Indicators
• Establishment of National, Zonal and District ACSM Committees/DOTS Committees.
• Establishment of strategic public/private partnerships for TB ACSM.
• Development of ACSM Strategic Plans, ACSM, Market Research, Communication and Advocacy Briefs.
• National ACSM infrastructure established – human resources, equipment and other supplies.

11.1.2 Output Indicators
• Number of organisations and individuals trained in TB ACSM.
• Number of community activities, events and promotions conducted, and the coverage of these activities.
• Number of main media and IEC materials produced and disseminated – radio, television, news print and outdoor media - public service announcements and publications.

• Number of supporting community resources – signage, audio-visuals, merchandise and other community materials produced and disseminated.

• Number of media advocacy events and articles generated on Radio, TV and in newspapers.

11.1.3 Impact Indicators

• **Awareness** - Increase in general awareness of TB and TB as a priority health issue.

• **Knowledge** - Increase in knowledge of TB symptoms, TB diagnosis, referral, treatment, case detection and cure.

• **Attitudes** – toward TB Stigma, attitudes toward NTP and DOTS health service provision, attitudes toward treatment adherence.

• **Perceptions** - Increase in personal risk perceptions toward TB. Misperceptions of treatment costs, Increase in response and self-efficacy perceptions.

• **Behaviour** - Increase in behavioural intentions toward early health seeking behaviour, case detection, early screening, referral, treatment adherence, utilization of public sector services and community DOT provision, and advocacy in favour of all of the above.

11.1.4 Outcome Indicators

• Increase in TB ACSM organizational capacity and sustained programming.

• Decrease in TB stigma and risk behaviours.

• Decrease in TB morbidity and mortality.

• Decrease in TB prevalence.

• Decrease in health care costs.

• Improvements in quality of life.

It should be noted that the M&E Framework is a continuous process which operates at every stage of the Strategic ACSM Planning Cycle. However, post-intervention survey data should be collected following completion of each phase of the development cycle to provide campaign intelligence and set strategic direction for future ACSM phases, themes and approaches. Specific performance indicators and measures for the KAP surveys could include the following:

• **Campaign prompted and unprompted recall** - of community based and IPC approaches, Community dialogue - social networks, community advocates, peers, etc. Community Events – community theatre, music and dance, workshops. Community media - outdoor signage – billboards, wall branding, transport signage publications materials and merchandise - **Performance measure** - Campaign impact evaluation.

• **Message Assimilation** - reach and frequency of main media materials, to desired target groups - **Performance measure** - media confirmation schedule.
• **Message Salience** - Target group understanding, acceptance and ownership of campaign messages, *Performance measure* - Campaign impact evaluation.

• **KAP** - Recall of campaign call to action and key messages. Changes in knowledge, attitudes, risk and self-efficacy perceptions, behavioural intentions, and behaviours - *Performance measure* - Campaign impact evaluation.

• **Social Acceptability** - Stakeholder and community acceptability of campaign programs and resources - *Performance measure* - stakeholder feedback via consultation process and participatory research.

### 12. CONCLUSION

The success of the ACSM strategy from 2010-2015 will depend largely on the systems put into place to allow programming activities to continue and scale-up in the insecure environment. This will require adequate infrastructure development, as well as greater opportunities for health workers and other program staff to operate, as well as allowing program beneficiaries to safely access services.

This will require the establishment of an effective system to manage the many technical and coordination aspects of the ACSM strategy rollout. If effective management and coordinating mechanisms are not in place, a number of competing forces may surface to undermine the strategy and the potential effectiveness of interventions. Broad representation and best practice in ACSM program management will ensure the optimum delivery of the strategy.

Once stakeholder feedback is incorporated and the draft ACSM strategy is finalized, the ACSM Technical Committee meetings should be integrated within the existing quarterly meetings of the TBCT with additional representation as required from technical advisors and private sector partners. All stakeholders within the health sector will need to work together to operationalise the strategy. This will include identification of core activities for each program partner, development of technical expertise, establishment of funding streams and demarcation of roles and responsibilities for a coordinated roll-out of the program.

Final work-plans should provide detailed budget estimates for all activities along with timelines, responsibility matrix and approval points. Zonal and NGO workplans will need to reflect a unified strategy, messages and branding in order to be successful in the longer term. A range of activities should be piloted and evaluated for potential scaling up in future years. Finally, monitoring and evaluation indicators will need to be identified that are linked to activities of the phased campaigns. This will provide opportunities to measure behavioural impact as a result of an integrated range of interventions at National, Zonal and District levels.
It is hoped that the key elements, guiding principles and illustrative activities outlined in this TB ACSM strategy for Somalia/Somaliland will provide a model from which to build technical and organizational capacity, participation, ownership and involvement by all program partners. The strategy also aims to provide supporting mechanisms from which to undertake the major challenges in building the health system within insecure settings and mobilizing communities for TB control.