Kingdom of Cambodia

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Ministry of Health

NATIONAL ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION STRATEGY FOR TB RESPONSE IN CAMBODIA

2023-2025

USAID
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ACKNOWLEDGEMENT

The National Advocacy, Communication and Social Mobilization Strategy for TB Response in Cambodia (ACSM) has been developed based on the national strategic plan to end TB in Cambodia 2021-2030 creates greater political and social commitment and supports behavioral change in order to ensure access to treatment and care for all. The ACSM offers a clear context, priorities, and strategies as well as guidance for CENAT, implementing partners, SBC practitioners, and health experts.

My heartfelt gratitude goes to Ministry of Health, Officials of CENAT and implementing partners for providing invaluable support, feedbacks and encouragement for preparing good perspectives and encouragement for preparing and finalising this strategy.

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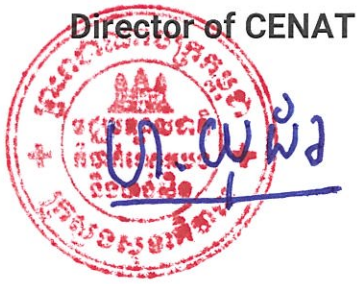
Director of CENAT



Dr. Huot Chan Yuda

Executive Summary

Tuberculosis is a curable and preventable disease. Under the strong leadership of the National Center for Tuberculosis and Leprosy Control (CENAT), Cambodia's National Tuberculosis Program (NTP) has made significant progress towards achieving the goals established in the National Strategic Plan to End Tuberculosis in Cambodia, 2021-2030 (NSP) which included reducing TB incidence by 80% and TB mortality by 90% by 2030 as compared to 2015. Cambodia has achieved MDG-TB four years before the target date. More than half a million TB patients were treated and cured, and 400,000 deaths have been averted since 2000. The estimated TB incidence in Cambodia has significantly declined from 575 in 2000 to 423 in 2011, to 302 in 2018, and to 274 in 2021.

Despite these impressive accomplishments of the NTP, the TB response still faces enormous challenges. First, the NTP is confronted with a significant financing gap, which is projected to increase to meet current and future NSP targets. Second, more than one third of the estimated cases in the country go missing or unreported. For example, an estimated 49,000 people were infected with TB in 2018, but only 16,000 (33%) were detected. Third, stigma continues to be a major barrier to access to TB services, diagnosis, and treatment, and more than 50% of people with TB in Cambodia reported self-stigma (stigmatizing themselves), or perceived community stigma. Last, there is scarcity of data on knowledge, attitudes, and practices on TB in Cambodia. Social and behavior change materials and interventions are not widely known or available at national, subnational, and community levels.

Advocacy, communication, and social mobilization (ACSM) are three distinct sets of activities, all of which have the shared goal of bringing about behavior change. Advocacy primarily works with public leaders or decision-makers; communication generally targets individuals or subpopulations in the public; and social mobilization aims to secure support from the broad public and specific communities. The difference between the three categories is often blurred, and interventions under one area may influence beneficially or facilitate processes in the other areas.

An ACSM strategy is acknowledged as an essential strategic component of TB response. It creates greater political and social commitment and supports behavioral change in order to ensure access to treatment and care for all, particularly poor, vulnerable and hard-to reach populations.

This ACSM strategy will greatly contribute to the successful implementation of the NSP 2021-2030. It focuses on establishing the path for the delivery of ACSM to address four important TB response challenges: 1) mobilizing political commitment and resources for TB, 2) improving case detection and treatment adherence, 3) combating stigma, 4) empowering people affected by TB and their communities and improving TB care seeking behaviors.

Abbreviation and acronyms

ACSM	Advocacy, Communication and Social Mobilization
AIDS	Acquired Immunodeficiency Syndrome
CCWC	Commune Council for Women and Children
C-DOTS	Community- Directly Observed Treatment Short Course Strategy
CENAT	The National Center for TB and Leprosy Control
CSO	Civil Society Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HC	Health Centre
HCMC	Health Centre Management Committee
HIV	Human Immunodeficiency Virus
ICC	Inter-Agency Coordination Committee
IEC	Information, Education and Communication
IMC-TB	Inter-Ministerial Committee for TB
MDG	Millennium Development Goal
MDR -TB	Multi Drug Resistance Tuberculosis
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NCHP	National Centre for Health Promotion
NSP	National Strategic Plan
NTP	The National Tuberculosis Program
OD	Operational District
PSI-PHB	Population Service International-Promoting Healthy Behaviors
RGC	Royal Government of Cambodia
RH	Referral Hospital
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goal
STD	Sexually Transmitted Disease
TB	Tuberculosis
USAID	United States Agency for International Development
VHSG	Village Health Support Group
WHO	World Health Organization

1. ACSM Strategy Objectives

This ACSM strategy will serve as a three-year guide for CENAT to lead the tuberculosis (TB) epidemic response in Cambodia and reduce morbidity and mortality from TB. The strategy maps out a clear path to address the social and behavioral drivers of TB infection, morbidity, and mortality, with explicit attention to advocacy, communication, and social mobilization interventions. The strategy draws from global evidence in effective social and behavior change programs, and builds upon the existing TB coordination and resource structures led by the Royal Government of Cambodia through The National Center for TB and Leprosy Control (CENAT).

An ACSM strategy will contribute to the successful implementation of National Strategic Plan for Ending TB 2021-2030. The strategy aims to contribute to reducing TB-related morbidity and mortality in Cambodia, through the following objectives:

- Establish priority behaviors, audiences, and proven interventions to lead delivery of the ACSM component of CENAT's National TB program;
- Guide funders, implementing partners, civil society, and private sector actors to deliver support to national TB efforts in an evidence-based and coordinated fashion;
- Invigorate and grow national and subnational coordinating mechanisms for social and behavior change for TB; and
- Ensure efficient, evidence-based, and harmonized TB response at all levels of society.

2. Global TB Landscape: Commitments, Strategy, and Targets

Tuberculosis (TB) is a communicable disease that is one of the leading causes of ill health and death worldwide. Until the COVID-19 pandemic, TB was the leading cause of death from a single infectious disease, ranking above HIV/AIDS (WHO 2021). TB is caused by the bacillus *Mycobacterium tuberculosis,* which is spread when people who are sick with TB expel bacteria into the air, for example by coughing. It mainly affects the lungs (pulmonary TB) but can affect other sites of the human body. About 25% of the world's population have been infected with TB. Most people (~90%) who develop the disease are adults, with more cases among men than women.

TB is curable and preventable. About 85% of people living with TB can be successfully treated with a six-month drug regimen (ibid). When a person develops active TB, the symptoms may be mild for many months. This can lead to delays in seeking care, and results in transmission of the bacteria to others. People with active TB can infect 10-15 other people through close contact over the course of a year (WHO 2022). About one-quarter of the world's population carries latent TB, which means people have been infected by TB bacteria but have not yet become ill with the disease and cannot transmit the disease. People with latent TB have a 5-10% lifetime risk of falling ill with TB (WHO 2022). However, persons with compromised immune systems, such as people living with HIV, malnutrition, diabetes, or people who use tobacco have a much higher risk of becoming ill.

In 2014 and 2015, all WHO member states and the United Nations (UN) committed to ending the TB epidemic, through their adaptation of WHO's End TB and the UN Sustainable Development Goals (SDGs) (WHO 2021). The strategy and SGDs included milestones and targets for significant reductions in the TB incidence rate, the absolute number of TB deaths, and costs by TB patients and their families. Cambodia's Ministry of Health and the National Tuberculosis and Leprosy Centre (CENAT) has adopted them for the National Tuberculosis Program (NTP) and the National Strategic Plan (NSP) for Ending Tuberculosis in Cambodia 2021-2030. The Information below summarizes the NSP to End TB, which frames and guides this ACSM strategy.

Table 1: The NST to End TB at a Glance

Vision	**A World Free of TB (zero deaths, disease and suffering due to TB)**			
Goal	**End the Global Epidemic**			
Indicators	**Milestones**		**Targets**	
	2020	2025	2030	2035
Percentage reduction in the absolute number of TB deaths (compared with 2015 baseline)	35%	75%	90%	95%
Percentage reduction in the TB incidence rate (compared with 2015 baseline)	20%	50%	80%	90%
Percentage of TB-affected households facing catastrophic costs due to TB (level in 2015 unknown)	0%	0%	0%	0%

Source: WHO 2021

WHO End TB Strategy Principles

1. Government stewardship and accountability, with monitoring and evaluation
2. Strong coalition with civil society organizations and communities
3. Protection and promotion of human rights, ethics, and equity
4. Adaptation of the strategy and targets at country level, with global collaboration

Pillars and Components

1. **Integrated, patient-centered care and prevention**
   - Early diagnosis of TB including drug-susceptibility testing, and systematic screening of contacts and high-risk groups
   - Treatment of all people with TB including drug-resistant TB, and patient support
   - Collaborative TB/HIV activities, and management of comorbidities
   - Preventive treatment of persons at high risk, and vaccination against TB

2. **Bold policies and supportive systems**
   - Political commitment with adequate resources for TB and prevention
   - Engagement of communities, civil society organizations, and public and private care providers
   - Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control
   - Social protection, poverty alleviation and actions on other health determinants of TB

3. **Intensified research and innovation**
   - Discovery, development, and rapid uptake of new tools, interventions, and strategies
   - Research to optimize implementation and impact, and promote innovation

Table 2: Global TB targets set in the SDGs, the End TB Strategy and the political declaration of the UN high-level meeting on TB, for the period up to the SDG deadline of 2030

SDG Target 3.3	By 2030, end the epidemics of AIDS, TB, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases, and other communicable disease
WHO End TB Strategy	80% reduction in the TB incidence rate (new and relapse case per 100,000 population per year) by 2030, compared with 2015, 2020 milestone: 20% reduction: 2025 milestone: 50% reduction milestone
	90% reduction in the annual number of TB deaths by 2030, compared with 2015, 2020 milestone: 35% reduction: 2025 milestone: 75% reduction
	No households affected by TB catastrophic cost by 2020
UN high-level meeting on TB, 2018	40 million people treated for TB from 2018 to 2022, including: • 35.5 million children • 1.5 million people with drug-resistant TB, including 115,000 children
	At least 30 million people provided with TB preventive treatment from 2018 to 2022, including: • 6 million people live with HIV • 4 million children aged under 5 years and 20 million people in other age groups, who are household contacts of people affected by TB

(Source: WHO 2021)

3. TB Context, Strategies and Financing

Health Context

Tuberculosis is a curable and preventable disease. Cambodia recently improved its TB incidence rate and was removed from the list of 30 countries with the world's highest TB burden countries; however, it remains as a TB watchlist country (WHO, Global Tuberculosis Report 2021[1]). Based on WHO's Global TB Report in 2021, Cambodia had a TB incidence of 274 per 100,000 population and an estimated 46,000 people were infected with TB. However, an estimated one third of cases in the country still go undetected or unreported.

The coverage of TB services has been extended nationwide, covering 100% of all Referral Hospitals (RHs) and Health Centre (HCs). One of the key components of the NTP was Community DOTS (C-DOTS) which has been expanded from 506 HCs in 2008 to 644 HCs in 2018, and again expanded in 2021 to cover 1,147 HCs in 89 Operational districts (ODs). Beginning in 2021, the management of comorbidity of TB/HIV is now implemented in all ODs, compared to only 57 ODs in 2008. Childhood TB management has been implemented in all ODs. In addition, the NTP has 11 multidrug resistant TB (MDR-TB) treatment sites as of 2021.

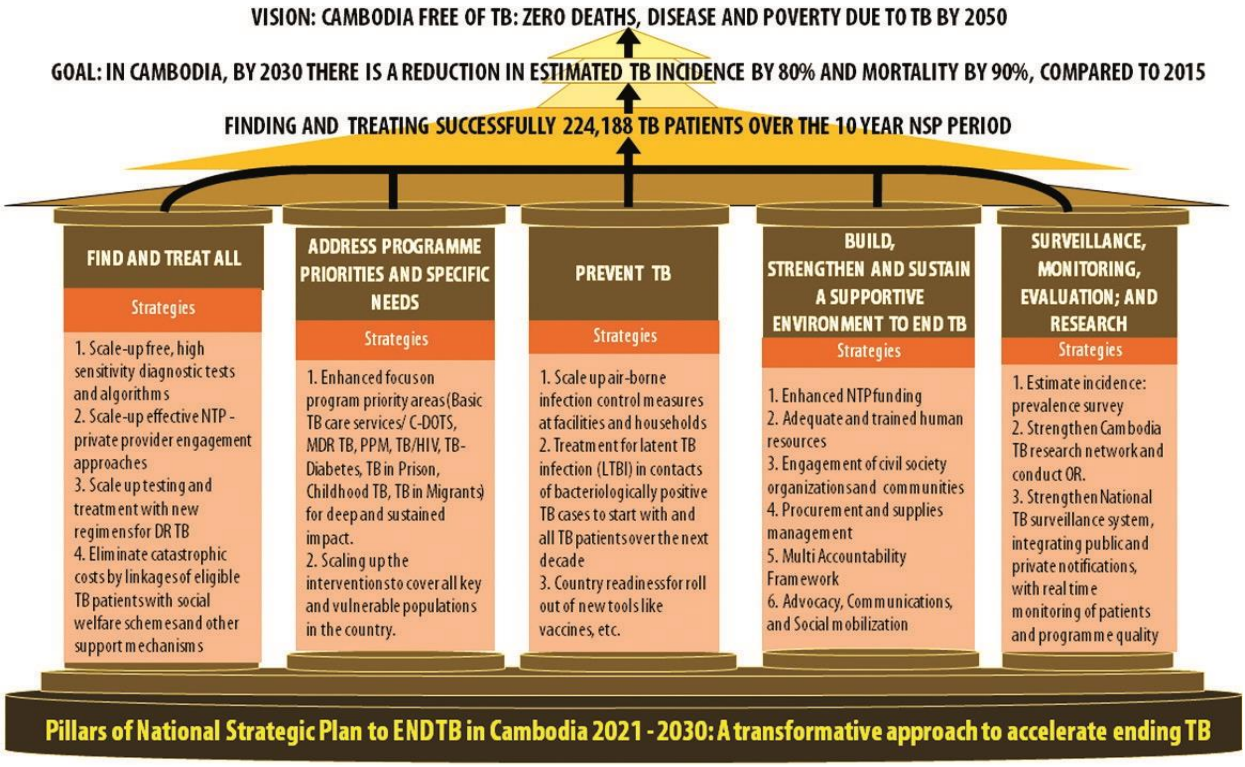
TB Eradication Progress to Date

More than half a million TB patients were treated and cured, and 400,000 deaths have been averted since 2000. The estimated TB incidence in Cambodia has significantly declined from 575 in 2000 to 423 in 2011, to 302 in 2018, and to 274 in 2021. The country has achieved a decline in prevalence of smear positive TB over a nine-year period of 2002-2011. The treatment success rate remains very high at 94% for drug sensitive and 71% for multidrug-resistant tuberculosis, which is one of the best in the world (CENAT 2021b). Under the strong leadership of the Royal Government of Cambodia and the Ministry of Health--coupled with intersectoral partnerships with health partners, NGOs, CSOs and community members—CENAT through its National Tuberculosis Program has made significant progress towards achieving the goals established in the National Strategic Plan for Ending Tuberculosis in Cambodia, 2021-2030: reduce TB incidence by 80% and TB mortality by 90% by 2030 as compared to 2015. Cambodia has achieved its MDG-TB goal four years before the target date.

National Strategic Plan to End TB in Cambodia by 2030

The Ministry of Health of Cambodia has given high priority to TB response with the support from the Royal Government of Cambodia (RGC) led by the Prime Minister, Samdech Akka Moha Sena Padei Techo Hun Sen, as the Honorable Chairman of the National Anti-Tuberculosis Committee. Under the robust leadership and commitment of the RGC, the Ministry of Health and multilateral partnerships with international and national organizations and non-government organizations, the NTP developed the National Strategic Plan to End TB in Cambodia 2021-2030 with the goal to accelerate the reduction of TB incidence by 80% and the mortality by 90% by 2030, compared to 2015.

1 https://www.who.int/publications/digital/global-tuberculosis-report-2021/tb-disease-burden/incidence



(Source CENAT 2021a)

While advocacy, communication, and social mobilization are specifically mentioned under *Build, strengthen and sustain a supportive environment to end TB* (strategy 6), ACSM approaches are required to address the following strategies:

- Efforts to improve testing and treatment seeking, acceptance, and literacy efforts related to *Find and Treat All* pillar;
- Approaches to tailor demand- and supply-side efforts to address the specific needs, barriers and motivators of priority populations through *Address Programme Priorities and Specific Needs* pillar
- *Prevent TB* pillar will require development of high quality communication and social mobilization approaches to prevent airborne infection and ensure people living with latent TB are tested, treated, and adhere to their full course of treatment.
- Increase in NTP funding for TB, particularly for social and behavior change, will ensure that both demand- and supply-side factors are addressed to eradicate TB in Cambodia, as well as *build, strengthen and sustain a supportive environment to end TB.*
- Routine monitoring and research about intermediate factors that drive TB related behaviors (and incidence) are required within *surveillance, monitoring, and evaluation* pillar. Measures to track TB provider behavior related to case notification, support for treatment adherence, and CDOTS are required for successful achievement of the national strategy.

The following table summarizes impact and outcome indicators that will measure success of TB eradication efforts as outlined in the national strategic plan for TB (2021-2030).

Figure 1: Impact and Outcome Indicators of NSP 2021-2030

	BASELINE	MILESTONE		TARGET	
IMPACT INDICATORS	**2015**	**2020**	**2021**	**2025**	**2030**
1. To reduce estimated TB Incidence rate (per 100,000) BS 2018=302	367	261	232	90%	90%
2. To reduce estimated mortality due to TB (per 100,000)	21	16	12	9	3
3. To achieve no catastrophic cost for affected families due to TB (no baseline available)		80%	90%	>95%	>95%
Outcome indicators	**2015**	**2020**	**2021**	**2025**	**2030**
1. Total TB patient notification	35,638	32,400	32,500	30,000	15,500
2. Number of childhood TB cases notified	6,885	5,830	5,670	5,400	TBD in 2025
3. MDR/RR TB patients notified	75	145	165	170	TBD in 2025
4. Treatment success rate among notified DSTB[2]	93%	>90	>90	> 90	>90
5. Treatment success rate among notified RR/MDR TB[3]		>75	>75	>75	>75
6. Proportion of identified/eligible individuals for TB preventive treatment (TPT) / LTBI[4] - initiated on LTBI treatment *(New indicator)*		11716 (2019)	15000	8500	TBD
7. TPT completion rate *(new indicator)*	N/A	85%	>85%	>85%	>85%
8. Treatment coverage	58% (2018)	80%	90%	90%	90%
9. Percentage of HC with C-DOTS		81%	85%	>90%	>90%
10. Number of RH with comprehensive TB services		30	60	75	>90

(Source: CENAT, 2021a)

The National Tuberculosis Program Structures and Systems

National Level

CENAT provides leadership and managerial responsibility for the NTP. CENAT is responsible for developing policies and plans, training, supervision, monitoring and evaluating the NTP, procuring drugs, and coordinating partners supporting the NTP. CENAT has one national public hospital, which functions as the national TB reference laboratory as well as the referral TB hospital and leprosy in-patient services with a total of 130 beds.

[2] Drug Sensitive TB

[3] Rif Resistant / Multi Drug Resistant TB

[4] Latent TB Infection

Provincial level

Every province has a provincial TB medical supervisor, and a provincial TB laboratory supervisor, appointed by the provincial health department. They are responsible for all TB services in the province, especially planning, training, coordinating and regular supervision of the ODs, TB microscope center and HC.

Operational district level

Every OD has an OD TB supervisor who is responsible for all TB services in the district and to manage the TB registry, plan, train, coordinate and supervise HCs every month. They work with the clinical teams of RHs in provision of services to TB patients.

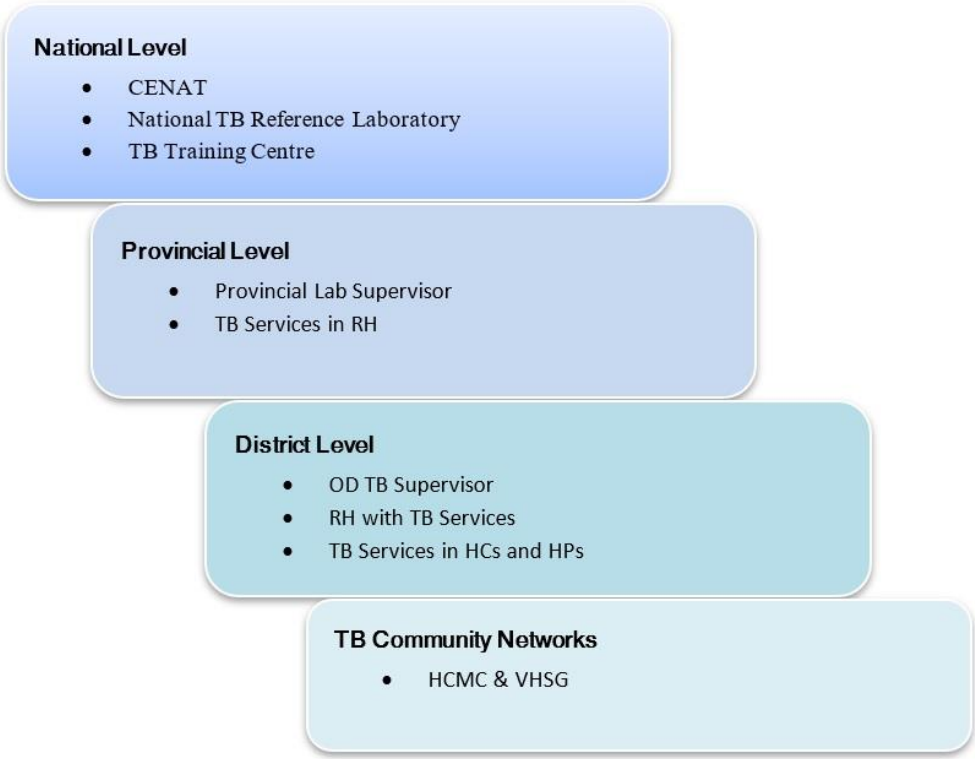
Health center level

Every HC has one or two HC workers designated for TB services, on top of the heavy and busy workload. Designated health workers provide basic TB services such as DOTS, provision of TB drugs, TB health education and outreach, and referring people with suspected TB to RH for diagnosis.

Networks with the community

Community-based TB activities or Community DOTS (C-DOTS) are often run in coordination with other health interventions such as maternal and child health, malaria, and HIV/AIDS. This is in line with the Community Participation Policy for Health, through the Village Health Support Groups (VHSG) and Health Center Management Committees (HCMC). Two VHSG members per village were trained on numerous health problems, including TB. For TB, VHSG are trained to refer presumptive TB cases, collect and transport sputum specimens to RH for diagnostic examination, accompany presumptive TB people to RH for X-ray at RH, conduct TB sensitizing outreach, support TB patients on treatment and collect TB drugs from HC for TB patients in the community. They have routine monthly or bi-monthly meetings with HC health workers and HCMC for planning, or refreshing the basic knowledge and skills on TB and other health problems.

Figure 2: NTP Structure from national to community level (Source: CENAT 2021a)



Challenges to the current structure: The RGC has a strong commitment to end TB by 2030. A National Anti-Tuberculosis Committee was created, but has not actively functioned since its inception. The Inter-Agency Coordination Committee (ICC) was established and presided over by CENAT with participation of Ministry of Health Departments, WHO, CSOs, NGOs and INGOs. ICC served as a technical working group at only the national level, and not at the sub-national level. There is a lack of high-level Inter-Ministerial Committee for TB (IMC-TB), with participation of the numerous ministries such as the Ministry of Health, the Ministry of Economics and Finance, the Ministry of Interior, the Ministry of Education, Youth and Sports, and the Ministry of Women's Affairs. An IMC-TB could serve a critical role in high level advocacy, coordination, policy and decision making. This platform has proved very successful in the HIV/AIDS response in Cambodia.

4. Key Drivers of TB in Cambodia

Structural Drivers of TB

Delays and Access to TB Services: Delayed diagnosis and treatment of TB in Cambodia is substantial. Several factors are associated with delays in TB diagnosis including: seeking care from private health care providers who are not authorized to diagnose and treat TB; self-medication before TB diagnosis; absence of TB symptoms such as cough, bleeding cough, and night sweats; education below primary level; lower knowledge of TB symptoms and transmission; and rural residence. The median time from the onset of symptoms to TB diagnosis among people with TB in Cambodia was 49 days, which it is comparable to recent studies conducted in other high TB-burden countries in Asia (Aimossawi et al. 2019). The study showed that people who sought care from private health care providers and/or self-medicated before TB diagnosis were 23% more likely to experience a longer delay to diagnosis. Many Cambodians prefer to seek first treatment from a private health care provider due to ease of access, drugs supply, and responsiveness; however, since private providers are not able to diagnose and treat TB, patients who first visit private clinics for TB care further delay diagnosis. The private sector plays an important role in provision of TB services particularly for screening and diagnosis, and the public-private partnership is essential in finding and treating missing TB cases in Cambodia. Delays in TB care-seeking of more than 2 months have shown to elevate the risk of household infection; alternately, likelihood of infecting others typically declines rapidly after the onset of treatment. Factors related to delays in care seeking must be addressed in the ACSM intervention.

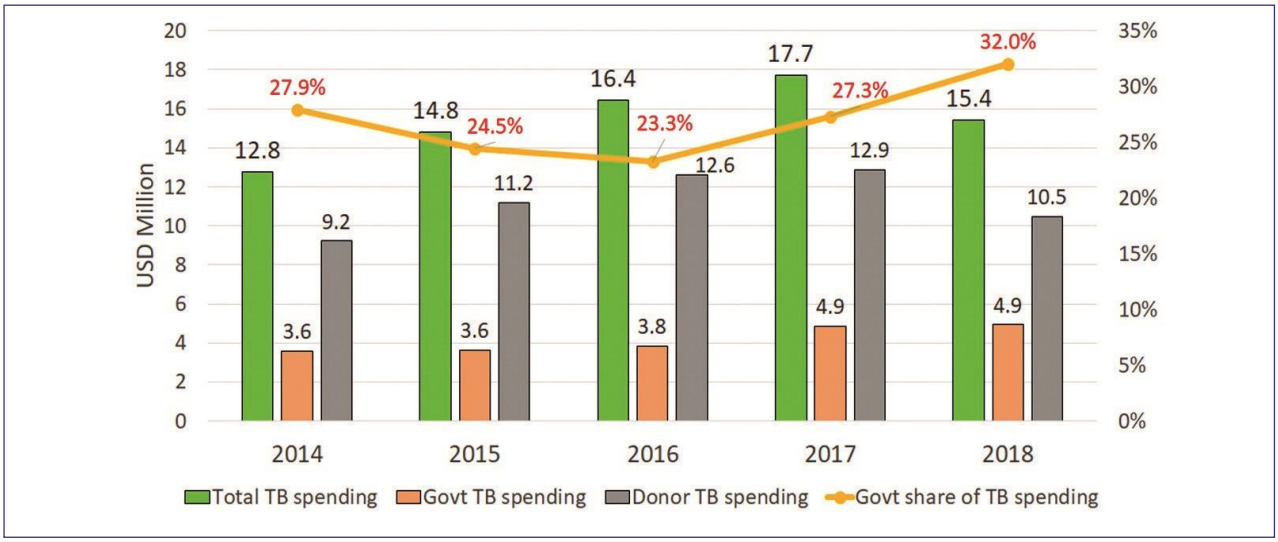
Cost: A critical challenge has been that more than one third of the estimated cases in the country go missing or unreported. Even though TB diagnosis, treatment and medication are free, TB patients suffer from nonmedical expenses such as transport and wage loss. These expenses place additional strain on TB patients and their families, especially for low socio-economic status individuals and households. While there are financial support sources for the poor and the elderly, such as the social equity fund and other social funds run by NGOs, the resources are not widely known to potential beneficiaries. Therefore, efforts should be channeled towards the general population and TB key population to educate and raise awareness. The services, support and resources for TB should be integrated with other services, particularly those serving key populations such as HIV/AIDS and STDs clinics, diabetes clinics, drug rehabilitation and the penitentiary systems. The intervention for TB comorbidity such as HIV/AIDS and diabetes, and TB among children need countrywide scaling up.

Shortage of Government Funding for TB: Over the last NSP period, the RGC's financing of the TB response increased significantly. Commitment to boosting investment in TB is reflected in an increase in the RGC's spending on TB from US$ 3.6 million in 2014 to US$ 4.9 million in 2018, equal to a 36% increase. The RGC's share of overall TB spending in Cambodia also increased; from 28% in 2014 to about 32% in 2018 (Figure 3).5 However, remaining challenges must be addressed to improve the national response. In order to meet current and future NSP targets, the gap in available finances must be addressed. Based on the costing formulated for the NSP for the period 2021-2025, resource needs are estimated to be about USD $177 Million. Funding for TB from the RGC is expected to increase around 4 to 5 percent per year, while resources from donors are expected to remain stable during 2021-2023; beyond this period the situation is uncertain. This will result in a considerable financing gap, especially during the 2024-2025 period, amounting to about 50% gap in the required resources to deliver against the NSP. Continued dependency on external funding

[5] CENAT (2019) Yearly financial reconciliation expenditure reports 2014-2018. CENAT Accounting System.

creates challenges to sustainability. The figure below shows funding trends in total TB spending from 2014-2018, and demonstrates overall increase in CENAT spending by 2018.

Figure 3: The RGC and donor's spending on TB in 2014-2018 (US$ million)



(Source: CENAT 2021a)

Social Drivers of TB

Gender and TB

A study on barriers in access to services and information gaps by gender and key population in Cambodia revealed gender specific struggles and barriers to accessing TB services (Yi et al. 2021). Women juggling multiple commitments and instances of living in a male dominant family/society have affected the ability of women to prioritize their health. For men, living in a patriarchal society also led to them downplaying illnesses and not seeking health care. ACSM intervention--through awareness raising, advocacy, and outreach-- should be implemented to address gender-specific vulnerabilities in improving access to TB care.

Stigma

Stigma is a complex matter involving institutional and societal attitudes and personal experience characterized by adverse social judgement either perceived, anticipated, or experienced by people with TB (Teo et al. 2020). It is one of the major barriers to access to TB services, diagnosis, and treatment globally and in Cambodia. A study by Teo and colleagues on characterizing and measuring TB in the community revealed that more than 50% of people with TB reported perceived stigma by the community and self-stigma, which means they held stigmatizing views toward themselves because of their TB diagnosis. The findings were similar to several high TB-burden countries such as Vietnam and India, which reported TB stigma from 30% to 60%. The study reported significant findings: living in rural areas was associated with higher TB stigma; fear of spreading TB led people with TB to avoid others intentionally; fear of getting TB led people to avoid those they knew or suspected of having TB. The findings were consistent with expressions of stigma that occur with TB and other highly stigmatized illnesses like HIV/AIDS, and included drivers of stigma such as fear of transmission, perceived risk, and associations of TB disease with shame, judgment and ill-perception of others. Countries including Cambodia have committed to reaching 90% of the key and vulnerable populations with TB essential services and ending stigma and all forms of discrimination. Therefore, measuring and addressing TB stigma that prevents people from seeking, accessing, or staying in care must be prioritized. It is also crucial to recognize the role of community involvement in TB care and

support and the potential benefits of community mobilization in stigma reduction. Interventions should be contextualized to the local settings and engagement from diverse population groups ranging from general population, health workers, TB patients and key population of TB such former TB patients, household contacts of people with smear-positive TB, close contacts of people with smear-positive TB, people aged over 55 years of age, people with HIV/AIDS and people with diabetes, prisoners and people who use drugs. The efforts to fight stigma against TB must be addressed in the advocacy, communication, and social mobilization (ACSM) for TB response.

Housing and Stability

Migrants and mobile populations are a priority for CENAT's achievement of the NSP. Migration can lead to loss of health services or other shifts in access, potential for close contact with people infected with TB in poorly ventilated spaces, and loss of access to health information due to changes in language during or after migrating.

Individual and Household Drivers of TB

Knowledge, Attitudes and Practices (KAP) of TB

Limited data are available to properly summarize current knowledge, attitudes, and practices for TB in the diverse provinces of Cambodia. The Promoting Healthy Behaviors Activity (PHB), with support from USAID, conducted formative research that showed high levels of knowledge associated with TB and TB symptoms, but limited understanding of where and how to get TB treatment, fear of treatment side-effects, and concerns of stigma associated with a TB diagnosis. CENAT with support from PHB and its TB partners are currently planning to conduct a KAP survey in 2023 as part of the National TB Prevalence Study, which will provide important insight into TB-related attitude and behaviors, and CENAT should consider funding routine knowledge, attitudes, and practices surveys going forward so programming can be tailored to the needs of priority populations.

Delays in TB Diagnosis: The use of smear microscopy for TB diagnosis was associated with longer time to treatment initiation. Other factors that drive delays in TB testing and diagnosis include: seeking private health care and self-medication before TB diagnosis; lack of perceived risk, threat, and susceptibility; actual or perceived stigma (Teo et al. 2020)

Social Support for TB care seeking: One study found that encouragement from family members, friends and TB survivors were essential in encouraging TB care-seeking (Teo et al. 2020). The study revealed that approaches to improve knowledge on the cause of the disease, route of transmission, curability and symptoms can change people's attitude towards TB. The importance of social support for care seeking was also identified as a key behavioral determinant by PHB's formative research, cited above. Support for people affected by TB has also been found to be effective in reducing TB stigma. Historically, attention and investments in TB have focused on biomedical models of care.

Treatment Adherence: Adherence to TB regimens requires many months of treatment each day. This can be difficult for patients. Drivers that challenge adherence to TB medication include time, cost, forgetting medication, or limited social support for adherence. Focus should be paid to addressing factors that challenge adherence to TB medications among priority populations.

5. Key TB Behavior and Audience Priorities

In order to achieve its 2030 goal to end TB in Cambodia, CENAT must continuously improve TB prevention, screening, diagnosis, and treatment adherence behaviors among priority populations in effective and tailored ways. This

Key TB Behaviors and behavioral drivers to address through ACSM strategy implementation

Case detection behaviors:

- Behavior: People with suspected TB present to health center (public or private) for TB screening and testing
- Behavior: family/neighbors of people with TB symptoms encourage, accompany, or consult with health providers to get people with symptoms typical of TB screened for TB.
- Behavior: TB positive cases return to clinic 1 week after sputum sample to receive results of TB test, TB prescription, and adherence support tools.
- Behavior: providers provide quality, effective counselling to TB patients to understand diagnosis, treatment course, how to navigate side effects, and how to use adherence tracking tools.
    - Drivers of Case Detection Behaviors
    - Individual:
        - Perceived Social support to test/go to facility
        - Belief that getting tested/treated for TB can prevent illness among family members, particularly children/grandchildren
        - Correct knowledge of TB symptoms, including cough for 14 days or more
        - Correct knowledge that TB can be cured
        - First point of care seeking (diagnosis) at TB facility
        - Perceived social support for TB care seeking
    - Influencers (family, neighbors)
        - Confidence among family/neighbors to successfully encourage people with TB symptoms to facility for TB test
        - Belief that TB can be cured
        - Correct knowledge of TB symptoms, including cough for 14 days or more
        - Stigma
    - Providers/facility level
        - Trust in quality health services at public facilities
        - Effective, quality counselling and tools
        - Responsiveness to patient questions, phone calls, and queries
        - Effective counselling to ensure patients deliver good sputum samples for testing
        - Coordination with OD or provincial officers to conduct community outreach or house to house testing in communities where positive cases are identified.

TB Treatment behaviors

- Behavior: TB patients take TB medication daily at the same time
- Behavior: TB patients record daily medication in TB tracking booklet
- Behavior: CDOTS observers observe TB positive patients take medication daily
- Behavior: TB patients present for follow-up appointments at XXX months, and review TB adherence booklets with providers

- Behavior: TB patients call or go to health center for support to manage side effects of TB medication.
    - Drivers of Treatment Behaviors
    - Individual level:
        - Low perceived and actual Time and cost barriers,
        - Reminders/remember to take medication daily at same time,
        - Perceived social/family support for adherence social support for adherence.
    - Influencer level (family, friends):
        - Social support for adherence
    - Providers/facility level:
        - Trust in quality health services at public facilities
        - Effective, quality counselling and tools
        - Responsiveness to patient questions, phone calls, and queries
        - Effective counselling on side effects management, outcome expectations, and lapses in adherence to ensure patients deliver good sputum samples for testing
        - Coordination with OD or provincial officers to follow up cases that lapse in treatment/appointments.

TB Prevention behaviors

- People exposed to TB positive cases (in household or community) receive testing for TB within one month of positive case identification in a community
- People who are TB positive cover mouth with mask, scarf, elbow when coughing.
- People who care for TB patients wear masks or scarves when caring for patients with active TB

Priority Populations

Priority audiences for the national TB ACSM strategy include:

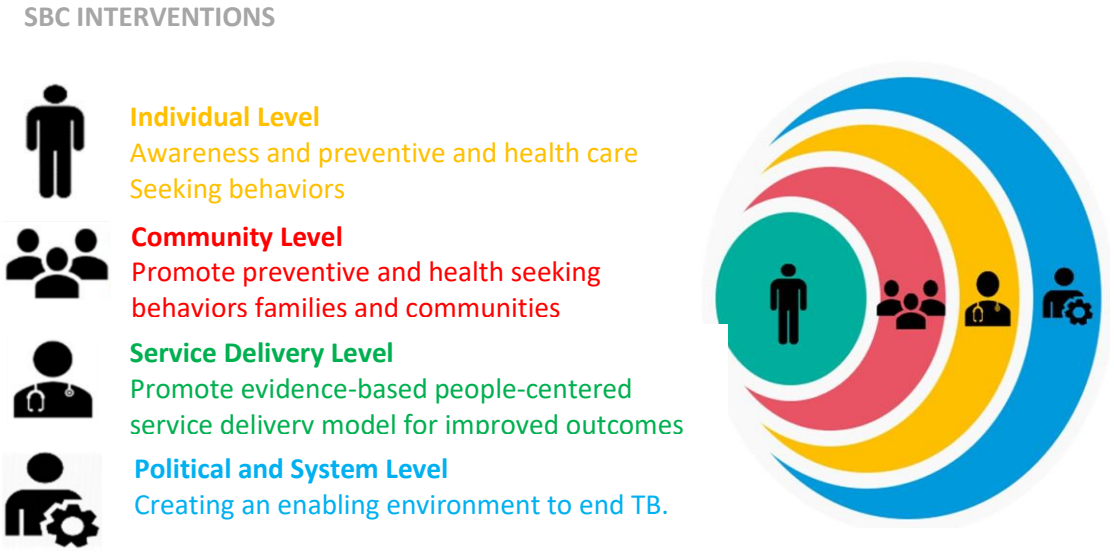
- people living with TB,
- people over 55 years of age,
- people living with HIV,
- people in congregational settings (specifically prisons, factories, and enterprises),
- people who are migrants or mobile populations,
- people who are close contacts of TB positive cases.

Secondary audiences are those that have a strong influence on the outcomes among priority populations:

- Family members/friends of people at higher risk or who have TB
- CDOTS observers
- Providers at primary, secondary, and tertiary health facilities
- Policy makers and funders

6. Social and Behavior Change for TB

In partnership with USAID's Promoting Healthy Behaviors Activity (PHB) led by Population Services International (PSI), the National Centre for Health Promotion (NCHP) of the Ministry of Health produced a Practitioner Guideline for Social and Behavior Change Communication (SBCC)[6] (NCHP 2022). The guideline explicitly identifies models and steps for the development and implementation of SBC interventions for a specific health topic. This guideline highlights the importance of understanding the difference between various approaches for addressing factors that can support or improve the practice of health behaviors among individuals, families, communities, and health workers, as seen in the visual below. Please see the guideline for the most up-to-date description of RGC priorities and practices to address social and behavioral barriers to health.



6.1 Advocacy, Communication, Social Mobilization (ACSM) and TB Response

This ACSM strategy focuses on three distinct practices used within social and behavior change: advocacy, communication, and social mobilization. Each of these approaches is used to address specific factors that influence the practice of health behaviors. One of the major distinctions is their audiences: advocacy primarily works with public leaders or decision-makers; communication generally targets individuals or subpopulations in the public as well as those who influence those audiences; and social mobilization aims to secure support from the broad public and specific communities. The lines between the three categories are often blurred, and interventions under one area may influence beneficially or facilitate processes in the other areas. Broad descriptions of the three terms are provided here to help define and distinguish between categories of ACSM activities for TB response.

[6] NCHP. SBC Practitioner's Guideline 2022. https://library.nchp.gov.kh/detail/sbc-practitioners-guideline-2022

Figure 3: ACSM approach is three interconnected approaches used to support practice of TB behaviors

ACSM activities are a means to end TB, not an end in themselves (WHO 2007). They address key behaviors required to eradicate TB such as:

For individuals: accessing TB care, providing effective sputum samples, initiating treatment, understanding treatment instructions and follow-up, adhering to treatment every day for 6 months, preventing TB transmission to others, and completing treatment. They also might be behaviors for family members to prevent themselves getting TB when someone in their household tests positive for TB.

For family/friends: behaviors related to TB may include social support from community or family members to encourage or accompany people with suspected TB symptoms to facilities, or behaviors of providers to deliver quality, equitable, timely, and effective counseling and care for TB.

ACSM is increasingly being acknowledged as an essential strategic component of TB response. ACSM activities create greater social commitment, and support TB related behaviors which ensure access to treatment and care for all, particularly poor, vulnerable and hard-to reach populations.

Advocacy seeks to secure needed financial resources and change policies, guidelines, or procedures by influencing stakeholders such as politicians and decision-makers. It consists of the organization of information into an assertion to be communicated through various interpersonal and media channels with a view to gaining acceptance and commitment by the political and social leadership. It focuses on influencing policy makers, community leaders, donors and decision-making bodies by a variety of means, for example through conferences, summits, meetings between various levels of government and civil society organizations, news coverage, parliamentary debates and interaction with service providers.

Advocacy can make activities more effective, by gaining the support of people in power, changing the social environment, and increasing the level of resources available. It can be achieved at different levels: local, national, and international. These levels refer to the level where the power or influence lies, rather than where the advocates are working.

Advocacy activities that contribute to TB control objectives might include engaging religious and traditional leaders to advocate with their communities to support TB care seeking and those living with TB; improving knowledge and attitudes among political representatives, reforming legislation or policies, or influencing public discourse through dissemination of media packages and training of journalists in accurate reporting on TB; advocating for policy change so private providers can diagnose TB; as well as direct efforts to advocate for increased allocation of resources in order to deliver the nation's TB response.

Strategic Communication aims to address the individual, household, community, and social factors that influence TB care, treatment, and prevention behaviors. This is done by using formative research, data and evidence; segmenting specific audiences and tailoring approaches and messaging to their priorities; improving interpersonal communication and counselling between people with TB, their families and providers.

Communication activities might include promoting available TB services; developing a multi-channel campaign to address specific key behaviors and the factors that lead to those behaviors, as described above; supporting and encouraging family members to more actively support their loved ones on treatment; or disseminating accurate information and dispelling myths about TB, or educating and encouraging people with TB and their family members to be more actively involved in care and to support community approaches to facilitating treatment completion.

Social mobilization aims to change norms, improve services, expand community support and solve social problems, often by bringing groups together to act at a community level. Social mobilisation can generate demand for services, dialogue, negotiation, and consensus among a range of players that includes decision-makers, the media, NGOs, CSOs, opinion leaders, policy-makers, the private sector, professional associations, client/patient networks and religious groups.

Social mobilization events, community-led health initiatives, community health worker visits, and community participation are all used to improve TB knowledge and information, engage communities in dialogue about TB to normalize and reduce stigma, mobilize people for TB screening and referral testing, communicate and gather community members when community TB testing occurs for active case finding TB awareness, promote health-seeking behavior, inspire dialogue, and heighten community concern, support, and action for TB response.

ACSM spreads across all aspects of TB response and is integral to the successful implementation of NSP 2021-2030.

Current TB Resources and partners

a. *Assuring Quality across TB ACSM interventions in Cambodia*
b. *Coordinating Mechanisms*
    a. *National*
    b. *Provincial*
    c. *Multi Sectoral*
c. *Resource Mobilization*

7. ACSM Strategy for TB Response in Cambodia

When integrated into the national TB response, an ACSM has proven to be an effective approach to TB response in areas of:

- Improving case detection and treatment adherence
- Combating stigma and discrimination
- Empowering people affected by TB
- Improving health seeking behaviors and seeking TB care
- Mobilizing political commitment and resources for TB response

The NTP is committed to developing and implementing a comprehensive integrated long-term ACSM strategy as a core component of TB response. However, an analysis of objective based interventions and activities, and budget summary of the NSP from 2021-2025 showed that ACSM was not a significant focus for funding or intervention in the national TB response.

Led by CENAT and in collaboration with health partners, NGOs, CSOs, the national ACSM strategy integrates specific approaches to target people with TB, TB key population such as people over 55 years of age, people exposed to TB patients, and TB/HIV comorbidity. Promoting public-private and public-public collaboration and mobilizing political commitment and resources for TB prevention and control will cut across all aspects of NTP activities, although concentrated where ACSM approaches have the most to offer. The goal of the ACSM strategy is:

- To contribute to the successful implementation of the National Strategic Plan to End TB in Cambodia, 2021-2030.

7.1 Maximizing Skills and Resources Through Partnership

TB is a multi-sector and multi-level issue and requires support from a variety of organizations to achieve effective TB control, including addressing TB/HIV co-infection. The NTP will bring together key donors and implementing partners and organizations with communication resources and experience to form a collaborative partnership for ACSM activities. This source of expertise will support planning and management of the following ACSM activities at the provincial, district and community levels.

Activities

- Designate of ACSM teams within CENAT/NTP at national, provincial/district levels
- Create management mechanism for partnership to coordinate ACSM support, including budgets
- Identify gaps in ACSM expertise, funding, partners, and other necessary resources
- Assess skills and resources of partnership organizations
    - Identify research organization to provide assistance to conduct assessment, analyze data, design monitoring framework, conduct evaluation
- Conduct mapping of in-country resources, including commercial sector
- Identify stakeholders and determine their interest
- Establish partnership with stakeholders
- Develop a partnership plan including assigning roles and responsibilities
- Produce an implementation plan, including assessment, funding procurement, information systems, management, distribution, monitoring and evaluation, resource allocation, supervision, training
- Launch the ACSM strategy at an event
- Create a monitoring mechanism to:
    - track ACSM activities being implemented by CENAT and all partners
    - monitor outputs and outcomes of ACSM activities

- determine how close activities are to meeting the projected timeline and budget
- ensure staff members are delivering their work functions correctly
- make mid-course corrections

- Conduct evaluation to assess the collective outcomes and impact of all ACSM activities, as coordinated by this strategy

7.2 Identifying and Understanding the Obstacles to TB Response

To inform the design of ACSM activities for TB, the CENAT/NTP will conduct a survey which will fill gaps in existing evidence and support: analysis of the situation, assessment of needs, epidemiological data, and prioritization of behaviors, audiences, and factors to address. This information will identify priority populations to reach with ACSM efforts and the findings will be used to define specific activities. It will also provide baseline data to inform the development of the monitoring and evaluation (M&E) framework and define M&E activities. Critical to ACSM, formative research should always include strong examination of the range of factors that address the practice of TB behaviors, as detailed in sections above.

Activities

- Design and conduct Knowledge, Attitudes and Practices (KAP) survey, to segment target populations, identify key behaviors to be addressed with ACSM, and identify the factors most likely to change those behaviors for target audiences.
- Conduct needs assessment and situation analysis to identify the constraining and enabling factors and relate to NTP goals
- Collect, analyze and use epidemiological data to further inform constraining and enabling factors
- Design activities at all levels that address constraints and strengthen enabling factors such as those listed in sections above. Deliver these through advocacy, communication, and social mobilization
- Use assessment findings in:
  - **Advocacy**
    - Integrate KAP and statistics to advocate politicians, key decision-makers and funders
    - Engage political leaders and encourage them to draw attention to combating TB-related stigma in their public addresses
    - Prioritize funding for specific types of interventions or key populations, based on findings from formative research

  - **Communication**
    - Create specific messages to inform the public about TB and the benefits of completing treatment, accessing to and seeking care
    - Design interpersonal communication and counselling training for health workers
    - Develop educational materials and messages to encourage family members of people with TB to take an active role in care and support treatment completion

  - **Social mobilization**
    - Raise awareness of TB prevention, recognition and treatment by ensuring that program staff provide input to community events that are well-attended by people at high risk of TB
    - Generate community dialogue during village or community meetings to discuss factors affecting TB diagnosis and care
    - Employ the media channels that the KAP survey has identified as the most accessible and preferred by target groups

7.3 Delivering ACSM

Based on survey and assessment findings, the ACSM team led by CENAT will develop an implementation plan, including distribution, funding procurement, information systems, management, monitoring and evaluation, resource allocation, supervision, and training for nationwide activities. It will also provide support for provincial level ACSM teams to develop their own action plans, indicators and measurements of achievement to address specific issues at each level based on the local profile.

Mobilizing Political Commitment and Resources
Mobilizing political commitment and resources for TB is an important objective of the ACSM strategy. To assure quality, CENAT will ensure that all planned ACSM interventions are based in evidence (will be effective) and are linked with the goal and objectives of the NSP 2021-2030.

ACSM approaches

- Formulate TB Interministerial Committee with participation of MoH the MoI, MEF, MoSVY, MoP, MOWA, and the private sector
- Review TOR and expand membership of the existing national TB platform (ICC) called sub-technical Working for TB Control, with more participation of CSOs and representatives of TB patients and the community
- Absorb national policy makers and political leaders about the health and economic benefits of TB control
- Engage local and community level authorities to encourage them to contribute to TB control efforts
- Collect support of international and national partners

Activities

- Seminars and briefing meetings with national, provincial, and local leaders
- Print information (letters, fact sheets) and distribute to policy makers and political leaders
- Events around the World TB Day and other occasions
- Social media (Facebook), printed media and mass media

Maintain a high cure rate and implement Community DOTS nationwide
Maintaining a high cure rate is critical to achieving the strategy. High cure rate means those who are on TB treatment adhere to their drug regimens every day for six months or more in order to be cured of TB.

ACSM approaches

- Interpersonal communication and counselling training for health workers
- Delivery of DOTS through key community members (requires training and communication materials for VHSG, C-DOTS watchers, CCWC)
- Social media (Facebook), mass media including radio and television
- Development and distribution of materials to facilities improve provider counseling around TB testing and treatment adherence
- Coordination of all partners through use of shared audiences, key messages, and harmonized workplan

Activities to deliver these approaches

- Conduct a workplanning meeting with all ACSM implementers and funders to develop a shared ACSM workplan of activities, geographies, populations and key behaviors covered.
- Meet with the ACSM working group quarterly and review progress against workplan, share successes, review monitoring data and direct focus of interventions (province/district, population, channel, etc)
- Identify audience segments and develop audience profiles. These should guide all implementer and research focus and prioritization of audiences. This should also support coordination to ensure all priority populations are being reached adequately with tailored approaches.
- Develop a key message guide with ACSM working group. Use the key behaviors and factors listed in sections above to guide communication objective and key message development. This should guide all communication, advocacy, and social mobilization messaging for all key behaviors, factors, and audiences.
- Review all TB communication materials in use currently. Identify materials that can be scaled up (printed or used without any changes), or those that can be adapted from other contexts because they address the same factors detailed in sections above.
- Engage people who have been cured of TB as advocates. They might advocate to local leadership for continued support to TB ACSM programs or encourage people currently affected by TB to complete treatment. They might also serve as the expert perspective in a community radio or social media discussion promoting that TB can be cured, or advocating for family support to those with TB.

7.4 Achieve and maintain a high case detection rate

Achieving a high case detection rate requires using data and evidence to direct case detection efforts while ensuring efficient use of funding and staff resources. Maintaining a high case detection rate means that systems and processes are established to ensure continued use of data to focus/adapt case detection priorities over time.

ACSM approaches

- Raise public awareness about TB causes, susceptibility, severity, treatment and where to seek care
- Reduce stigma against people with TB and correct misconceptions about TB disease
- Help health workers, VHSG, CCWC, communities and individuals identify TB suspects
- Encourage TB suspects and individuals with presumptive symptoms of TB to seek care from appropriate sources
- Target hard-to-reach populations (prisoners, migrants) with information on TB symptoms and other factors detailed in sections above, as well as promote availability of TB diagnostic services or bring those services directly to key populations

Activities

- Use formative research to develop tailored materials to address factors that drive TB behaviors among specific priority populations (depending on their needs). Materials must be tested to ensure they do not inadvertently increase stigma
- Pre-test materials with priority audiences prior to printing and scaling
- Deliver multi-channel campaigns focused on specific audiences, behaviors, and factors through Social media (Facebook), mass media including radio and television
- Distribution of print materials at community meetings or events
- Interpersonal communication and community mobilisation activities

7.5 Best Practices in Developing ACSM Concepts, Messages and Materials

Consistent and accurate messages about TB makes ACSM strategies effective – the health care provider, the community mobiliser and the radio announcer or social media influencer should all give the same key information to target audiences, reinforcing the main points. As noted in activities above, the ACSM team will collaborate with key partners with experience in strategic communication techniques to develop: audience segments with profiles, key behaviors and the factors that address them, communication objectives, and key messages for each audience segment. A creative brief should then be developed to give to implementers at all levels so anyone addressing TB behaviors in Cambodia is using the same harmonized messaging. It is likely that the style and emphasis of the messages will differ for each target group but the key points will remain the same throughout the messages.

Targeting messages appropriately

- Use the assessment findings to develop messages for vulnerable individuals who may not seek diagnosis or treatment services because they are afraid of being stigmatized by their communities
- Messages must be relevant to the target audience, appropriate to the general level of knowledge of TB among the target group, and should directly address the desired action or change
- Accurate and clear messages should be based on scientific accuracy, particularly those related to TB/HIV co-infection or MDR-TB where recommended treatment regimens, as well as access to treatment, frequently change
- Messages should be simple and should not contain medical or scientific terms
- Choose an appropriate writing style, vocabulary, typography, layout, graphics and color for the target group

Messengers of information

- Use the assessment findings to identify who the audience trusts to deliver the particular message
- Messengers can be individuals or organizations. The most effective messengers may be members of local social networks, community leaders or local health staff

Logos, slogans and other graphic representations

These can help unite different ACSM activities, help establish program recognition and trust, and graphics and messages should reinforce each other, following the overarching ACSM strategy.

- Use assessment findings to understand the cultural norms associated with the images to be portrayed
- Use ideas that reflect local customs and ways of talking to describe and identify TB
- Pre-test messages, concepts and images, analyze results, and revise accordingly before production of materials

Development and production of materials

- Review existing materials to identify those that address the same factors you prioritized from your evidence that will most likely improve TB behaviors
- Determine whether new materials are necessary
- Modify or develop new materials

Types of materials to support ACSM activities

- Meetings with policy makers (e.g. meetings with law makers to advocate for increased TB funding)

    - Fact sheets
    - Presentations, other visual aids such as slides, photos, posters
    - Letters
    - Briefs that summarise data or assessment findings
- Outreach to media (e.g. to promote World TB Day, awareness campaign)
    - Press releases
    - Public service announcements, live-read scripts/announcements
    - Summaries of key findings, articles
- Public awareness activities (e.g. increase awareness/reduce misconceptions about TB, reduce stigma)
    - Informational booklets, leaflets/flyers, posters
    - Radio and television spots (live-read scripts or produced public service advertisements)
    - Community theatre (drama, comedy)
- Peer education and training (e.g. for health care workers and communities to identify TB cases, provide the proper care/treatment)
    - Training modules
    - Fact sheets
    - Flip charts/flannel boards
    - Instructional posters/wall paintings/job aids
    - Videotapes
- Presentations at seminars or other gatherings (e.g., with decision makers or health care professionals)
    - Presentation slides or other visual aids such as photos
    - Displays (including posters, photographs, real objects, models)

7.6 Monitoring and evaluation of ACSM activities

Development of a monitoring and evaluation (M&E) framework for ACSM activities should be based on the overall goal of this ACSM strategy, as well as the objectives and activities that are detailed here. The ACSM team led by CENAT must develop a few key indicators to track expected outputs and outcomes of this strategy. These can be used to measure progress in delivering against the strategy and contributing to eradicating TB. These outputs and outcomes should be tracked by selected indicators linked to the ACSM activities that are expected to give the desired results. The M&E framework will guide the development and implementation of reporting mechanisms and the routine analysis that will be used to track progress, collect feedback on the interventions and, identify any problems early on so that corrective action can be taken. The ACSM planning and implementation process is circular. Feedback might indicate program areas or ACSM interventions that should be changed, expanded or phased out.

Conduct short-term and long-term monitoring and tracking

- Develop M&E framework for ACSM strategy implementation
    - What is the overall goal of the strategy?
    - What are the specific objectives linked to the goal?
    - What activities will be implemented to reach the goal and objectives?
    - What outputs and outcomes does the NTP expect to see as a result of implementing the activities?
    - What indicators will be used to track progress in the short and long term? Who will report on the indicators, how often will they report on them, and what sources of data will be available to support routine monitoring?

- Collect and analyze indicators through routine reporting mechanisms in order to address the following questions:
    - Are ACSM activities on track?
    - How close are they to meeting projected timeline and budget?
    - Do staff members understand and perform their roles correctly?
- Possible data sources of information for tracking ACSM components:
        - inventory of materials
        - distribution list
        - activity reports
        - television and radio logs
        - social media tracking and data
        - staff surveys or focus groups
        - partner feedback
        - timeline and budget assessments
        - news and information searches
        - health information system
        - attitude or household surveys

Respond to feedback and make mid-course corrections

- Review, analyze and discuss monitoring data regularly
    - Involve key decision-makers, stakeholders and TB advocates in helping to analyze and use feedback
    - Use day-to-day (process) monitoring of ACSM activities and operations to identify problems or opportunities for ACSM interventions during implementation
    - Use cumulative research to make future ACSM program decisions part of a process, not an end

Possible process, output and outcome indicators to monitor progress towards objectives

- Number of people participated in activities
- Number and type of materials disseminated
- Number of materials given to each of the partners and number disseminated by partners
- Number of people reached or engaging in social media-related communications
- Number and level of staff trained in ACSM related topics
- Quality of training in ACSM and performance of roles
- Upcoming events, legislation or policies that might affect the program or ACSM activities
- Number of messages sent to law-makers or other decision-makers
- Number of advocacy related meetings held
- Number of articles published in newspapers, magazines or other publications
- Activities carried out on budget and according to the expected timeline
- Number of work plans followed
- Number of partnership meetings and type of decisions made
- Trend in the knowledge, attitudes, or behaviors among key audience groups
- Collect case studies of successes and for lesson learning

An outcome evaluation measures how well the ACSM strategy has met its goal and objectives and what should be changed to improve future ACSM activities.

Conduct an outcome evaluation (with assistance from external research organisation)

- Determine what information the evaluation must provide
    - Must link to ACSM strategy goal and objectives
    - Include questions from partners and donors

- Data
    - Define the data to collect
    - Decide on data collection methods
    - Develop and pre-test data collection instruments
    - Collect data
    - Process data
    - Analyze data to answer the evaluation questions
- Write an evaluation report
- Disseminate the evaluation report

Possible sources of information

- repeated surveys (baseline and follow-up)
- stories, drawings, photos of important milestones or events
- in-depth interviews with participants and observers
- group discussions
- review of reports and documents

Possible outcome indicators to evaluate achievement against objectives

1. **To mobilize resources and strengthen political commitment for TB, including a multi-sector approach**

- Increasing capacity and technical assistance for ACSM
    - Country has an evidence-based, sufficiently resourced ACSM Strategic Plan
    - % districts/provinces with TB ACSM plans based on recent formative research
    - % national health budget devoted to TB ACSM (5-15%)
    - % districts/provinces with designated ACSM staff with appropriate qualifications
    - Multi-sectoral involvement exists at the national level for TB control

2. **To increase civil society engagement in TB control and elimination, including C-DOTS**

- Improving case detection and treatment adherence
    - % of population who know that going to a DOTS facility is the best way to diagnose TB
- Combating stigma and discrimination
    - % of population expressing accepting attitudes towards TB suspects, patients and survivors
    - Most Significant Change Stories (qualitative)
- Empowering people and communities affected by TB
    - Number of TB patients or survivors trained to become educators, monitors, advocates, and DOTS watchers
    - Most Significant Change Stories (qualitative)
    - Comparative increase in level of knowledge of TB among general population:
        - transmission, vulnerability, prevention
        - diagnosis, treatment, cure
        - stigma
        - TB and HIV
    - Correlation between exposure to program messages and knowledge, attitudes and practices related to TB among specific target groups
    - Establishment of community networks, linkages between community and local health services institutionalized

3. **To strengthen health care provider capacity to effectively communicate about TB control and promote DOTS**
    - Improving case detection and treatment adherence
        - % of districts that have active pro-poor incentive schemes for TB patients on DOTS
    - Health seeking behavior
        - Public health facility attendance
        - How often people generally seek health care at a clinic or hospital
        - Who a person would talk to about TB if they were diagnosed
        - What a person would do if they thought they had symptoms of TB
    - Sources of information on TB
        - sources from which people currently receive health information
        - sources trusted the most
        - perceptions of effectiveness of TB treatment
        - perceptions of the side effects or other problems related to TB treatment

4. **To establish and maintain an evidence base to support, plan, monitor, and evaluate ACSM activities**

    - Baseline and follow up surveys
    - Regular documentation and dissemination
    - Monitoring and evaluation mechanism for ACSM integrated into NTP system

References

1. Aimossawi HJ, Longacre C, Pillay Y and KaK N (2019). A Social and Behavioral Change Communication Framework for Addressing Delays to Appropriate TB Care and Treatment. J Lung Heath Dis (2019) 3(4):1-7
2. CENAT (2021a). National Strategic Plan To End Tuberculosis in Cambodia 2021-2030. Ministry of Health. Cambodia
3. CENAT (2021b). Annual Report 2021. Ministry of Health. Cambodia
4. Teo AKJ, Tan RKJ, Smyth C, Soltan V, Eng S et al (2020). Charactering and Measuring Tuberculosis Stigma in the Community: A Mixed-Methods Study in Cambodia. Open Forum Infectious Disease (2020):1-9
5. Teo AKJ, Ork C, Eng S, Sok N, Tuot S et al (2020). Determinants of Delayed Diagnosis and Treatment of Tuberculosis in Cambodia: A Mixed-Methods Study. Infectious Diseases of Poverty (2020) 9: (49):1-12
6. The National Centre for Health Promotion, the Ministry of Health. (2022). Guideline for Social Behavior Change.
7. WHO (2022). WHO Country Report on TB. (https://www.who.int/westernpacific/health-topics/tuberculosis)
8. WHO (2021). Global Tuberculosis Report. (https://www.who.int/publications/i/items/9789240037021)
9. WHO (2007). Advocacy, communication and social mobilization (ACSM) for tuberculosis control (http://www.who.int/publications/i/item/9789241596183)
10. Yi S, Teo AKJ, Sok S, Tout S, Tieng S et al (2021). Barriers in Access to Services and Information Gaps by Genders and Key Populations in the National Tuberculosis Program in Cambodia. Global Public Health (2021):1-14