



**let's
test**
TOOLKIT

unicef 
for every child

Together, we can keep
our communities healthy.

'Let's Test' Toolkit Strategy

**Evidence-based advocacy and demand-generation communication
to increase testing in LMICs**

Document Date: 19 March 2023

Prepared By: 17 Triggers

Josselyn Neukom

Imara Roychowdhury

Sharleen Hollick

Lillian Diaz

For: UNICEF Global

Advocacy for Diagnostics in LMICs

Contents

Background & Introduction	3
Toolkit Strategy Goal & Objectives	5
Formative Research Objectives & Methodology	6
Formative Research Findings	7
Archetype of a Health Policymaker	8
Various Archetypes of Community Members	10
Archetype of an Advocacy Champion	13
Key Factors Related to Testing Access	14
Key Factors Related to Demand for Testing	19
Pre-testing Findings	24
Creative Direction	24
Strategic Directions	25
Let's Test Toolkit	27
Prioritizing local factors & messages	27
Messaging guidance	27
Policymaker Tools	29
Community Tools	31
How to use the toolkit	33

Background & Introduction

Access to, demand for and use of testing for numerous public health priorities is far below levels needed for optimal health outcomes, particularly in low and middle-income countries (LMICs.)

Of the nearly 5.7 billion COVID-19 tests conducted globally, only 20% were in LMICs, where half of the world's population lives.¹ Whereas mass testing was common earlier in the epidemic, as of early 2023, testing rates have fallen and/or remain below the global ACT-A target (of 1 test/1,000 population/day²) in many LMICs.

Insufficient levels of testing for infectious diseases such as HIV, tuberculosis and malaria is also of grave concern as this threatens disease elimination, health system strengthening and antimicrobial resistance (AMR) agendas.

Testing data is essential to inform health policy and program decisions, particularly in the context of multiple public health priorities and limited resources. Without reliable, regular testing data, Ministries of Health are flying blind as they respond to pandemics and manage multiple infectious and non-communicable health priorities. Widespread testing is needed to detect disease outbreaks, facilitate treatment and guide resource allocation.³

Diagnosis before treatment for all illnesses is essential for patient health and to protect the efficacy of treatment regimens. Limited access to quality, affordable testing at community levels puts additional strain on under-resourced health systems.⁴

Despite the value of testing for COVID-19 and other communicable as well as non-communicable illnesses, resource-constrained LMICs often focus on procuring and delivering treatment and vaccines.⁵

While ensuring sufficient prevention and treatment tools is also critical, improved access to and use of testing is needed to target other resources for best possible health outcomes. Underdiagnosis leads to delayed or incorrect treatment, which causes serious problems at individual, community and health system levels.

¹ WHO, ACT-A. 2022. ACT-A Communications Toolkit. [Available here](#). Accessed May 12, 2022.

² Global COVID-19 Access Tracker. 2022. Testing. [Available here](#). Accessed May 17, 2022.

³ European Centre for Disease Prevention and Control. 2021. Testing strategies for SARS-CoV-2. [Available here](#). Accessed May 11, 2022.

⁴ Johns, S., van Elstrand, S.L. 2020. LMICs will face 'extreme strain' on health systems despite younger populations. [Available here](#). Accessed May 11, 2022.

⁵ World Health Organization Africa. 2022. African countries scale back on COVID-19 measures. [Available here](#). Accessed May 12, 2022.

To address inequities in testing access and use, in 2022 UNICEF commissioned the development of the *Testing Advocacy & Communications Toolkit*. Using an iterative, evidence-based creative design process led by 17 Triggers, the toolkit was developed with input from policymakers, global health stakeholders and community members across multiple LMICs.

The resulting toolkit is designed to facilitate evidence-based advocacy at both national and community levels to increase testing in multiple LMIC contexts. This document describes the evidence base, theoretical framework and process used to design the *Let's Test Advocacy and Communications Toolkit* as well as how the *Toolkit* is designed to be used.

Global Health Community Calls for Increased Testing

The Access to COVID-19 Tools Accelerator (ACT-A) partnership was launched in April 2020 with a focus on accelerating the development, production, and equitable access to COVID-19 testing, treatment, and vaccines.

Within the diagnostics pillar of ACT-A, UNICEF and the Clinton Health Access Initiative (CHAI) led the Advocacy, Communications and Community Engagement (ACCE) task force to develop and disseminate information to increase widespread, decentralized access to COVID-19 testing in low-and-middle-income Countries (LMICs).

These efforts are consistent with World Health Organization (WHO) testing policy guidelines as well as the 2023 World Health Assembly's "Strengthening Diagnostic Capacity" resolution recognizing diagnostics as a key component of primary care.⁶ The "Lancet Commission on Diagnostics" also summarizes the cumulative evidence supporting the need for increased access to testing globally.

⁶ World Health Organization. 2022. Country & Technical Guidance - Coronavirus disease (COVID-19). [Available here](#). Accessed May 9, 2022.

Toolkit Strategy Goal & Objectives

The ultimate goal of the *Toolkit* is to increase testing for COVID-19 and other common illnesses in LMICs.

In order to achieve this goal, the toolkit contains advocacy and communication assets designed to address three objectives related to increasing access to and demand for testing for COVID-19 and other common illnesses:

1. Policymakers ensure that every *public* health facility has COVID-19 testing capabilities;
2. Policymakers ensure community level access to COVID-19 testing; and
3. Communities seek testing when they experience COVID-19 symptoms.

By focusing on three objectives, the Toolkit is designed to empower advocacy champions in LMICs to use evidence-based advocacy and communication tools to address barriers to testing access, demand and use in a specific LMIC.

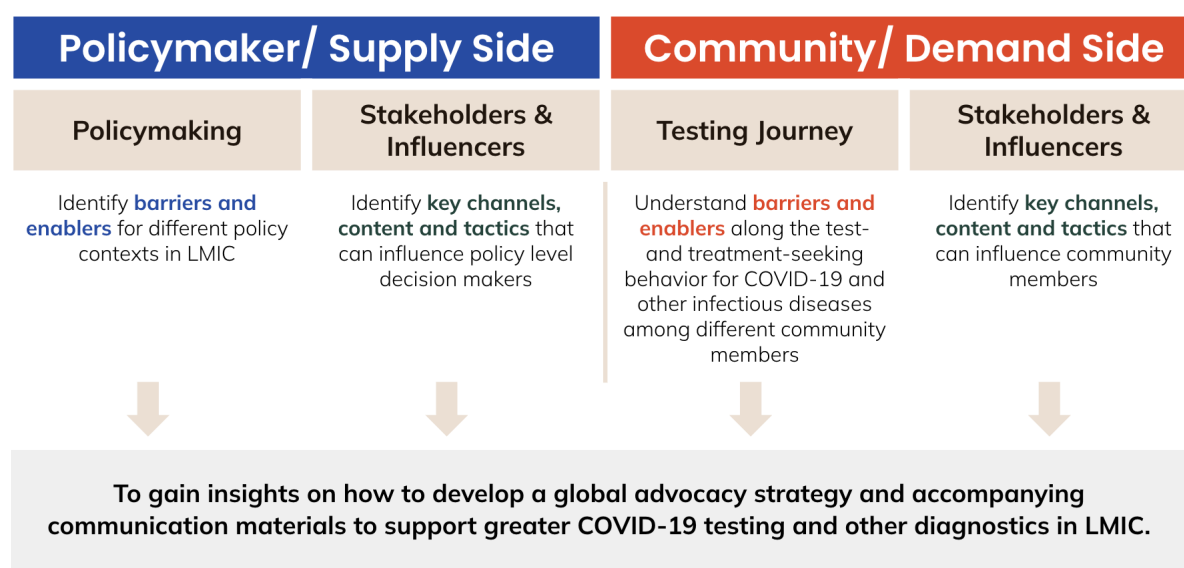
The assumption underlying the Toolkit is that using the right test at the right time for the right reason is not feasible unless both supply and demand-side barriers are addressed. Accordingly, the *Toolkit* includes advocacy tools for use by advocacy champions engaging with policymakers as well as civil society organizations and other implementing partners engaging with communities.

All aspects of the *Toolkit* –including access, format, style and content of individual tools – have been designed using pragmatic insights collected during formative and testing research conducted with *Toolkit* users and representatives of the targeted policymaker and community members.

Formative Research Objectives & Methodology

To inform the *Testing Advocacy Strategy* and *Toolkit* contents, qualitative research was conducted with policymakers, implementing partners and community representatives in five countries during 2022.

The formative research objectives included:



Research comprised interviews with 22 key global experts as well as key informant interviews and focus group discussions with respondents from Uganda, Rwanda, Cambodia, Mozambique, and Democratic Republic of Congo.

Across five countries, researchers spoke with 65 policymakers and civil society organization (CSO) representatives and 345 community members representing a variety of genders, ages and geographies.

Interviews with policymakers and CSO representatives in Rwanda were included to understand success factors and learnings from this aspirational “bright spot” LMIC context.

Formative Research Findings

Formative research findings were analyzed to understand needs and preferences of the

- i) target audience for testing advocacy (health policymakers in LMICs) and communication assets (community members in LMICs);
- ii) intended users of the *Toolkit* i.e. civil society organizations and other Advocacy Champions.

The following archetype summaries describe the demographic and psycho-graphic profile for both the toolkit audience and the toolkit users.

Research findings were analyzed against the “Elephant Rider Path” behavior change framework to identify key factors associated with increased support for testing (policymakers) and increased use of testing (community members). The archetype insights were also used to inform the format, style and tone of the advocacy and communication assets included in the *Toolkit*.

Archetype of a Health Policymaker



Dr. Silvia

BACKGROUND

50+ years old, trained as a medical doctor, living/working in the capital city. Middle-upper income with national and international exposure. MoH worker for many years, with connections throughout the government. More scientifically than politically motivated, but has political clout.

PREFERRED COMMUNICATION

Prefers formal communication through written documents versus online communication or social media. In-person meetings are also key. Relationships are important and facilitate communication.

INFLUENCERS

Most influenced by WHO and bilateral and multilateral funders. Can be influenced by the national media. Strong desire to be respected by national and international health stakeholders. Can be motivated by community needs, when expressed by local or global influencers.

DIAGNOSTIC RESPONSIBILITIES

Shared responsibility for COVID-19 diagnostic policy and program decisions with other technical and political leaders, often through a Task Force forum. Other diagnostic decisions may be driven by vertical programs before approval by the MOH leaders. Varying levels of connection and communication with regulatory authorities who approve all rapid diagnostics. Guide the national AMR strategy and related decisions.

TESTING ATTITUDE

Currently prioritizes vaccination over testing investment for COVID-19. More focused on ensuring access to quality treatment for other common illnesses given higher perceived budget and logistical challenges associated with securing treatment, as well as the perception that 'if we don't have treatment, why invest in testing?' Prioritizes public facility-based testing for COVID-19 and other illnesses as private sector and community-based testing is viewed as tougher to oversee and ensure quality as well as reporting requirements are met

DAY IN THE LIFE

National policymakers' time and attention is in very high demand. They are required for many official meetings to give their technical input non a variety of health areas. They have limited ability to plan their schedule as last minute urgent meetings are common. They travel regularly, both within the country and internationally. They enjoy international trips as learning experiences as well as opportunities for exposure and financial benefits.

Policymakers are respected in their communities and by their families for the role they plan in stewarding health, and face criticism when stewardship efforts are not viewed as effective.

They faced heightened pressures –at work and at home– during the pandemic, as public dialogue about the way the country was managing the pandemic was common.

RELATIONSHIP WITH OTHER LEADERS

Dr. Sylvia works within the context of a complex government system involving multiple Ministries and departments and varying power dynamics.

In some cases, she faces challenges securing support from other divisions within the Government, depending on level, area of expertise, and agency. Ministers of Health may or may not have influence over regulatory authorities who oversee registration of new diagnostics.

In many contexts, health area specific diagnostic policy and program decisions are led by vertical programs (ie HIV, TB, malaria, etc.), and Ministry leaders often defer to specific program experts for these decisions.

Ministries of Health, Planning and Finance are not always aligned, or even communicating, when planning or responding to pandemics and other health priorities.

Various Archetypes of Community Members



Emma - 21 F (DRC)

DEMOGRAPHICS

She lives with her husband and has a young baby in a room they rent in the city. She came to the city to find work.

INCOME RESOURCES

She works at a hairdresser, and she helps out doing odd jobs to try to make some extra money on the side. She usually makes around \$50 a month.

INFLUENCERS

She spends a lot of time online, listening to music, going on Facebook, Instagram and TikTok and talking to friends on WhatsApp. She trusts her husband and her parents.

COVID-19 IMPACTS

She believes that Covid is not a disease that affects young people, but she is worried about the wellbeing of her older family members.

HEALTH SEEKING BEHAVIOR

She self-treats using medication from the local pharmacy. If she is very sick she'll pay to go to the private clinic.

TESTING ATTITUDE

Getting a positive test is not worth it. If she gets a negative test, she might have to be vaccinated. A positive means she will have to buy expensive medication. She has a falsified vaccination card so that she can travel without testing.



Abaho John - 39 M (Uganda)

DEMOGRAPHIC

Abaho John lives with his wife and 4 children in a two roomed house. He has a secondary school education.

INCOME RESOURCES

He runs a small retail shop in the neighborhood. His monthly income averages around \$263 and he is the family's sole provider.

INFLUENCERS

He watches TV and listens to the radio to get the latest updates. He has a smartphone and accesses some of his information from the internet and uses apps like facebook. When it comes to health related topics, he will speak to a HCW at the local HCF who he trusts.

COVID-19 IMPACTS

Lockdown affected his income as he had to close the retail shop. He followed SOPs to prevent spread of Covid-19 but is unvaccinated.

HEALTH SEEKING BEHAVIOR

He uses local herbs to prevent symptoms like cough and flu. If these symptoms persist, he goes to a health facility to get additional treatment.

TESTING ATTITUDE

He fears the stigma that is attached to testing and has heard that it can negatively impact his manhood. He would only get tested if he has severe symptoms that persist. He believes a test for Covid-19 will be painful.



Yey Nang - 58 F (Cambodia)

DEMOGRAPHIC

Yey Nang lives with her son, his wife and her 4 grandchildren. She has a low level of literacy.

INCOME RESOURCES

She no longer works and spends her days looking after her grandchildren. She relies on the income of her son who is the sole breadwinner for the family.

INFLUENCERS

She listens to the radio everyday for the buddhist sermon. She knows all the members of her community and they share information. She attends community events and trusts the village chief. She goes for check ups at the local HCF and trusts the health workers.

COVID-19 IMPACTS

Yey Nang knows that she is the most at risk member of the family. She is fully vaccinated and this makes her feel less worried about getting sick.

HEALTH SEEKING BEHAVIOR

She does not want to fall sick as it comes with a lot of negative consequences. She protects her health using traditional Chinese medicine. If she does fall sick, she will go to the local HCF.

TESTING ATTITUDE

Yey Nang does not know that self testing is an option. She has heard that some people have been tested for Covid at the HCF when returning from the city to visit their relatives. She thinks this is the responsible thing to do so that her family and her community stay safe.

Archetype of an Advocacy Champion

BACKGROUND

Works for civil society organization (CSO) in an LMIC, Sara lives in the capital city—unless working at subnational level. She travels frequently to monitor community-level programming and build partnerships. Although not medically trained, Sara has substantial health and other social sector experience and expertise. She is knowledgeable about the national health system but has less political capital compared to health policy makers.

INFLUENCERS

Works closely with public health stakeholders including MOH, bi-lateral and multinational funders (e.g. USAID, Global Fund, DfID, etc.), as well as WHO and other UN agencies.

RELATIONSHIPS WITH POLICYMAKERS

Relationships are built through historical connections (attended the same University, and/or through extended contact). Relationships with policymakers are valuable and require a lot of time to build and maintain.

Little face time with policymakers - meetings are earned through personal connections or through MOH, WHO or donor-organized, formal meetings such as Technical Working Group meetings.

COMMUNICATION WITH POLICYMAKERS

Formal meetings require substantial preparation and technical inputs (can be challenging for Advocacy Champions to prepare).

Often part of email and/or SMS group communication channels with policymakers and other health sector stakeholders. These channels are sometimes used to share formal updates, publications, and reports relevant to the group.

Key Factors Related to Testing Access

The following factors were identified by policymakers and partners working with policymakers as influencing testing access in LMICs.

Formative research findings related to testing access are summarized here against the ERP behavioral framework. Using a behavioral science lens, the formative findings are analyzed relative to knowledge, beliefs, feelings as well as environmental factors with potential to influence testing access.

What do policymakers KNOW OR BELIEVE that influences supply of testing?	What do policymakers FEEL that influences supply of testing?	What is in policymakers' ENVIRONMENT that influences supply of testing?
<p>FACTOR: Low understanding of the value proposition of diagnostics</p>		
<p>Low knowledge of the benefits of testing</p>		
<p>FACTOR: Limited understanding of the link between testing access and national priorities</p>		
<p>Low understanding of link between diagnostics and UHC and other national targets “Why should we advocate for testing when COVID-19 rates are low? And while 60% of Cambodians are having NCDs?”</p>	<p>Feel UHC is important “As a country, we need to come up with a strategy for fair allocation of resources to all health facilities and hospitals.</p>	<p>Believe that COVID-19 testing should be integrated into routine health services. “COVID-19 testing should be a priority, it is not yet part of the essential care package but it should be made a priority for all. At the moment, it's not clear.”</p>

What do policymakers KNOW OR BELIEVE that influences supply of testing?	What do policymakers FEEL that influences supply of testing?	What is in policymakers' ENVIRONMENT that influences supply of testing?
<p>Belief that COVID-19 is over and disbelief that testing is no longer necessary "COVID-19 is no longer a problem because of the actions that have been developed, allied to the behavioral factors that we have been instilling in people, we have strong public health measures such as vaccination that is now reaching groups that we couldn't reach before, such as teenagers, this contributes to the reduction of mortality."</p>	<p>Feel more worried about other competing health priorities "Now, priorities have shifted to Ebola, but still conducting testing on a limited sample brought to the lab. The categorisation of COVID-19 has been relaxed from a serious biosafety issue."</p>	
<p>FACTOR: Belief that communities are not interested in or not capable of (self) testing</p>		
<p>Belief that communities are no longer worried about COVID-19 "Even through lots of effort towards sensitization, there is very little demand for testing as communities do not see COVID-19 as a threat (risk). People care more about cancer than COVID-19."</p>		<p>Believe that if malaria testing can be decentralized so can COVID-19 testing. "Like malaria, people used to treat presumptively but now VHTs can test for malaria and conduct diagnostics and offer correct treatment to reduce misuse of AM use."</p>
<p>FACTOR: Belief that PCR (lab-based) testing is the gold standard, and testing & diagnostic access should be kept at higher level facilities*</p>		
<p>Perceive that laboratory testing is best-in-class and underemphasis on improving access to point-of-care rapid antigen testing as a result "If people at our factory are tested positive with a rapid test, we will take that person to the public hospital for a PCR test".</p>	<p>Mistrust rapid tests as a way to diagnose COVID-19.</p>	
<p>FACTOR: Skepticism about feasibility of testing at lower levels of the health system</p>		

What do policymakers KNOW OR BELIEVE that influences supply of testing?	What do policymakers FEEL that influences supply of testing?	What is in policymakers' ENVIRONMENT that influences supply of testing?
<p>Belief that health workers can't handle additional responsibility; Belief that communities are not able to self-test. "The Village health teams and mobile lab staff should have been integrated into the public service and remained on standby. I think lack of government commitment and funds has prevented this from happening."</p>		<p>Frontline staff are overworked and underappreciated as a powerful resource. "At the level of the Ministry of Health up to the operational level, the management of COVID-19 cases is not well controlled, there is no veracity, there are people who are working who paid only once a year ago."</p>
<p>FACTOR: Belief that testing is less important now that COVID-19 vaccine coverage is rising and mortality is falling</p>		
<p>Believe that a vaccinated population does not require COVID-19 testing. "Currently, we have less concern because we can control it and because we have vaccines."</p>		
<p>FACTOR: Skepticism around private sector engagement</p>		
	<p>Feel skeptical about private sector actors from manufacturers to private health providers and pharmacists: "The current policy doesn't allow retail pharmacies to test COVID-19 while we have capabilities, reach more people in the community, therefore the government should start looking into this idea of partnering with pharmacies as a channel to increase testing"</p>	
<p>FACTOR: Belief that more COVID-19 testing could lead to negative consequences for the country</p>		

What do policymakers **KNOW OR BELIEVE** that influences supply of testing?

What do policymakers **FEEL** that influences supply of testing?

What is in policymakers' **ENVIRONMENT** that influences supply of testing?

Feel concerned that more testing will increase the likelihood of strict lockdowns with harsh economic consequences "If we look at public health, I think it is really impacted by COVID-19. Also, people's psychology is affected too. Students could not access proper education. It affects the economy of the people, people fall into debt."

FACTOR: Limited ability to subsidize testing costs due to multiple public health priorities and limited donor support & domestic budget support

Insufficient resources due to global health prioritization on vaccination and limited domestic budget support (vs multiple competing priorities) "The COVID-19 vaccination campaign has been a success in the country because Mozambicans embrace vaccination campaigns. They are aware of health-related issues."

Focus on providing free testing or testing that is perceived to be affordable makes it accessible for all "The access is mainly for those who can afford it. But it should be made available to the community also at a free cost because we need it yet it is hard for us to access it freely all the time"

Policy context enables price caps to ensure affordability. "The test kits need to be cheap. \$1 for 1 test kits is not a problem for people in PP, but in rural areas, they cannot afford \$1 for a test."

What do policymakers **KNOW OR BELIEVE**
that influences supply of testing?

What do policymakers **FEEL**
that influences supply of testing?

What is in policymakers' **ENVIRONMENT**
that influences supply of testing?

FACTOR: Limited transparency over national regulatory pathways & disconnect between national health policymakers and regulatory authorities

Lack of transparent, efficient regulatory pathway delays registration of quality assured tests

The analysis highlights how barriers can be grouped together to form factors that overarchingly affect the supply of diagnostics from a policymaker's angle. These factors span knowledge, motivation, and environment, even within the individual factor. The factors are broad, and have been pulled from global research so they are not all applicable to every context.

Key Factors Related to Demand for Testing

The following factors were identified by community members as influencing demand for testing in LMICs. Formative research findings related to testing demand are summarized here against the ERP behavioral framework. Using a behavioral science lens, the formative findings are analyzed relative to knowledge, beliefs, feelings as well as environmental factors with potential to influence informed demand for testing.

What do communities KNOW OR BELIEVE that influences demand for tests?	What do communities FEEL that influences demand for tests?	What is in community ENVIRONMENT that influences demand for tests?
FACTOR: Low understanding of the value proposition of diagnostics		
Belief that COVID-19 is not a serious problem unless they have seen or experienced the consequences first-hand <i>"It is cruel because people could die quickly within just a week. I said it was cruel because I have a relative who died of COVID-19."</i>	Feel there is no benefit to testing. Concerned about post-testing (isolation, treatment, etc.)	
Low knowledge of how tests work and the different types of tests available. <i>"Villagers tend to go to health center for testing because in many cases, they do not know how to use the (rapid self-use) test kit and the tests from health centers are free."</i>	Feel "COVID-19 fatigue" ie tired of talking and thinking about COVID-19, particularly given low perceived severity. <i>"Actually if you randomly ask people if they fear COVID, they will tell you no. So people have moved on passed COVID-19 and are now concerned other things. "</i>	

What do communities KNOW OR BELIEVE that influences demand for tests?	What do communities FEEL that influences demand for tests?	What is in community ENVIRONMENT that influences demand for tests?
	<p>Motivating factors to tests include (perceived) protection for more vulnerable family or community members particularly the elderly.</p> <p><i>"If young people get COVID-19, they might recover fast, but for older adults, they might take longer to recover and some might die"</i></p>	

FACTOR: Myths & Misperceptions around Testing

<p>Belief that individuals can tell when they have COVID-19 by their symptoms.</p> <p><i>"If I could eat and taste food, it is normal flu and could not be COVID-19. If I can eat food and taste it while having fever, it is not necessary to do the test."</i></p>	<p>Feel that testing is not needed outside of cases where it is required/mandatory.</p> <p><i>"Others think people testing for COVID-19 is for only people who are going to travel given that it's a requirement."</i></p>
<p>Skepticism about whether COVID-19 exists and is serious. Concern that testing is used to promote vaccination.</p> <p><i>"Does COVID-19 even exist? Aren't these tests and vaccines deadly? Didn't white men invent this disease to exterminate Africans?"</i></p>	<p>Feel worried about pain during testing.</p> <p><i>"I don't like testing because when they stick that thing into my nose, it hurts."</i></p>
	<p>Feel skeptical about COVID-19 testing accuracy and reliability.</p>
	<p>Feel skeptical about the severity of COVID-19.</p> <p><i>"If COVID-19 exists, why even after months we don't have someone who tested for COVID-19 and died in our community"</i></p>

What do communities KNOW OR BELIEVE that influences demand for tests?	What do communities FEEL that influences demand for tests?	What is in community ENVIRONMENT that influences demand for tests?
	<p>Feel scared of the social stigma that accompanies a positive test result. <i>"Now, there is less discrimination in the village. Though I am still afraid that if I test positive, there will be some people who are scared to buy groceries at my store."</i></p> <p>Feel more worried about other competing day-to-day priorities and that testing might lead to more harsh lockdowns and economic strain. <i>"We did not have a lot of people coming to get tested because they did not want to contribute to the number of positive tests and get lockdown again"</i></p>	

FACTOR: Structural Problems Associated with Testing

<p>Belief that testing offered by the public health system is not reliable or trustworthy. <i>"Health professionals first take care of their relatives but if you have money for bribe, you can get treatment immediately as well. You can arrive at hospital earlier and be assisted after those who arrived later."</i></p>	<p>Feel that COVID-19 is not as serious as other health threats, because testing (for COVID-19 compared to rapid diagnostics available for other health issues) is not as easily accessed. <i>"People have access to HIV and malaria tests more easily because more readily available and at a cheaper cost in private hospitals."</i></p>	<p>Supply shortages and irregularities limit availability of testing at facility & community levels.</p>
--	---	--

What do communities KNOW OR BELIEVE that influences demand for tests?	What do communities FEEL that influences demand for tests?	What is in community ENVIRONMENT that influences demand for tests?
<p>Self-treatment is easy and perceived as saving time and money. It is the go-to response when a person feels unwell.</p> <p><i>"Because all the tests and examinations at the hospital are expensive, I prefer to start with self-medication and if that doesn't work, that's when I can go to the hospital"</i></p>	<p>Feel that testing is being promoted for political or financial gain vs serving a legitimate health need.</p> <p><i>"Some people think that COVID-19 is a political issue and that does not exist. They refuse to be tested as they think it's a money-making business."</i></p>	<p>Limited access to facility-based testing outside of urban areas <i>"Tests are not available for everyone, if they are available you can not reach them due to the distance between the hospital and the house, if you are lucky and your house is close to the hospital, then the queues are long and you have to spend a full day waiting for one test"</i></p>
		<p>Going to a health facility has a high cost (missed work, transport fees, costs at facility, and costs of medication & testing).</p> <p><i>"I would like to take tests but at no cost due lack of financial means, it forces us not to do tests"</i></p>
		<p>High cost of testing, compared to (perceived) limited benefits. <i>"The test is very expensive, so you have to forego a lot of things before you can decide to test."</i></p>
		<p>Public health communication campaigns have focused on promoting vaccination and prevention behaviors vs testing <i>"Most people remember the 3 dos and 3 don'ts because this message came from the Prime Minister"</i></p>

What do communities **KNOW OR BELIEVE**
that influences demand for tests?

What do communities **FEEL**
that influences demand for tests?

What is in community **ENVIRONMENT**
that influences demand for tests?

Local community voices and frontline staff are not well utilized and are not delivering accurate, unified messaging around testing.

“The absence of information discouraged people to get vaccinated and tested. People from here usually do not watch TV shows, there was no door-to-door campaign to mobilize people for testing and vaccination, however for malaria pulverization campaigns they go door to door, so why didn’t they do the same for COVID-19. There was not health staff that walked community to community to get people tested.”

In summary, the analysis of formative research among community members identified three main factors associated with demand for testing: a) communities do not understand why they should seek testing; b) there are pervasive myths and misconceptions related to testing as well as COVID-19; c) a number of access barriers were identified.

Using the research, two main communication objectives emerged for the *Toolkit* to address:

1. Clarify the value proposition of testing by emphasizing the benefits of testing; and
2. Address myths and misperceptions including perceptions that:
 - a. Testing hurts
 - b. (Rapid) testing results are not accurate
 - c. Testing leads to stigmatization
 - d. No need to test, because I can tell if I have COVID-19 (or because I don’t travel, or because I have been vaccinated, or because I am young etc.
 - e. Getting a negative test result is a waste of time and money

Pre-testing Findings

Using two workshops with Advocacy Champions as well as digital A/B testing through Facebook, we tested toolkit access, tool format and visual style as well as mock-up advocacy and communication asset content (including graphic design and messaging.)

The pre-testing findings were used to guide final Toolkit development and informed the following decisions:

Creative Direction

“Let’s Test” Toolkit name & direction was selected based on feedback related to Toolkit name and tagline options tested.

Visual Style

A combination of photographic and graphic visual styles was selected based on options tested and with a view toward facilitating easy adaptation and use by Advocacy Champions in different contexts.

Toolkit Accessibility

A decision was made to plan Toolkit access through online PDF & google Drive based on testing feedback.

Policymaker Assets & Messaging

Participants validated the proposed assets and offered recommendations on formats. Messages were either validated as appropriate to move forward with or recommendations were made to improve messages for optimal comprehension and resonance.

Community Assets

Digital testing demonstrated that there were no red flags identified with draft community-facing content, therefore assets were finalized with minor modifications.

Strategic Directions

In addition to highlighting the key factors relevant to increasing access to, demand for, and use of testing, the formative research and pretesting of mock-up *Toolkit* assets generated insights relevant to access, style and formatting of the *Toolkit* assets.

In light of the multiple factors identified through formative research and the diversity of LMIC contexts included in the research, the *Toolkit* must be designed to enable users to identify factors and assets most relevant in a given context. They can do this using the messaging matrix and a variety of easily adaptable global advocacy and communication assets.

Given the formative findings related to needs and preferences of policymakers and civil society organizations and other possible *Toolkit* users (Advocacy Champions), there is a need for advocacy assets that are suitable for use with policymakers who have a very short amount of time to discuss any individual policy issue. In addition, given the findings that Advocacy Champions are typically passionate about testing but may lack technical expertise needed to meet policymakers' expectation for scientific and highly technical discussions prior to considering a change in policy or programming.

Formative research highlighted the need to help Advocacy Champions save time and resources by providing advocacy and communication tools in a variety of formats that can be applied to a range of channels including email, mobile, social media, as well as offline, in-person.

As the formative research was conducted in 5 countries with a focus on COVID-19 testing barriers and enablers, the *Toolkit* is designed to empower Advocacy Champions globally to adapt the advocacy and/or communication assets for a specific testing behavior and community context.

The *Toolkit* assets will be accessed through a central website together with guidance to facilitate easy access and widespread use.

Strategic Recommendation

A *Toolkit* built around key factors identified through research to address both policymaker and community-level barriers to testing access, demand and use in various LMIC contexts.

The Toolkit will be designed to be easy to use, informative, and adaptable.

Policymaker-facing assets will be suitable for use in short conversations (i.e. assets that can be used to guide brief interpersonal or targeted online discussions) as well as more in-depth technical discussions (i.e. comprehensive presentation with links to evidence and global recommendations).

Community-facing assets will use simple language and visuals that have potential to resonate across multiple contexts, to emphasize the benefits of testing and address myths.

Community facing assets must also include in-person communication tools, as opposed to a digital-only approach. In addition, given the finding—across countries—that desire to protect others was a motivation to test—the benefits of testing will be positioned as a way to collectively take-care of vulnerable community and family members.

Let's Test Toolkit

The **Let's Test Toolkit** builds on a sense of togetherness and a genuine concern for the well-being of a greater community, the Toolkit name is also a call to action for policymakers and community members alike.

Toolkit can be found with this link: [here](#).

Advocacy & Communication Tools/*Assets* can be found with this link: [here](#).

Prioritizing local factors & messages

Consistent with the strategic recommendations informed by formative research, the Toolkit includes a summary of communication objectives and illustrative messages for each of the factors prioritized by policymakers and community members involved in the research.

The messaging matrix tool in the Toolkit is designed to help users identify communication objectives and illustrative messaging relevant to a specific LMIC local context. By using the messaging matrix to prioritize advocacy and communication objectives, Toolkit users can make informed decisions about which Toolkit assets to use and how to modify for optimal results in their setting.

To view communication objectives and illustrative messaging by factor—analyzed using the ERP behavioral framework-- please access the messaging matrix: [here](#)

Messaging guidance

Based on learnings from the formative and pre-testing research, the following messaging guidance has been developed to ensure that advocacy and communication materials used are clear and persuasive.

Overarching Guidance:

Simple: Keep headlines and content as simple as possible. Include specific references to WHO guidance and other scientifically validated evidence when advocating with policymakers. Avoid using jargon with community-facing assets.

Messages should be **adapted** according to a specific type of testing, a specific target audience and formats/channels that are appropriate for communication objectives for this context . Certain assets will have shorter, punchier message headlines (eg. digital posts) while others will give the supporting details and facts (e.g. powerpoint deck designed for use in Technical Working Group meetings).

Policymaker Messages:

Proven: When using specific statistics, facts, or details - try to provide a trustworthy citation (journal article, WHO, CDC, etc.). Advocacy Champions seek specific references to boost confidence and prepare for highly technical discussions with policymakers.

Professional but friendly **tone** for policymaker assets.

Community Messages

Friendly and clear tone on the community side.

Always emphasize facts before busting myths.

Policymaker Tools

Consistent with strategic recommendations identified through formative and pretesting research, the tools for use with policymakers to be useful for short conversations, digital interactions, and longer, technical discussions. Tool formats were selected to allow advocacy champions to approach policy makers using a variety of different channels and land their key advocacy message in under 2 minutes.

Video

A 2-minute animated *hero video* brings the value of testing to life for policymakers by unpacking the problem and showing how testing can inform better policy and national health program decisions.

This video can be used on digital media, but also in short meetings, shared through messaging platforms, or as part of a Technical Working Group meeting or another meeting.

Digital Content

To allow for quick interactions with a large number of target audience members, various digital assets are produced. These are designed to be easily refined and translated before use in a given context. Digital assets will include *static posts*, *gifs*, and *short videos* that address specific factors identified during the formative research.

Static posts with brief messages and explanations are designed to help policymakers understand the benefits of increasing support for testing access. There will also be panels, which are 3-4 static posts that go together to offer a more detailed explanation of a certain factor.

Simple *gifs* are eye-catching and stand out from other content. Messages linked to the Gifs will be short but the animated visuals will help to bring the messages to life. Gifs will be used for messages that need more storytelling.

Short, 30-second *videos* will be used to give more engaging explanations of key messages related to testing. They can frame solutions in more detail and give longer explanations, especially when content is a bit more technical.

These digital assets can be used on social media platforms as well as digital channels such as email and chat groups in messaging apps. Different formats will be used depending on

variables such as internet connectivity and the extent to which the target audience can be reached and communication objectives can be achieved through digital channels.

Conversation Starter Tool

Many of the opportunities for advocacy start off with a casual conversation that happens over a cup of coffee or at the end of another work engagement. These chats might be quick and informal but are ideal for landing ideas and reframing problems that are top of mind for policymakers. This set is designed for easy use at these face-to-face interactions. Key advocacy messages and reference materials are organized by factor and message, and are brought to life in a simple, visual way. Conversation starter cards will be developed as *digital conversation starter PDFs* that can be easily called up on a phone or printed based on the preference of the user.

Modular Powerpoint Deck

Advocacy champions may be passionate about diagnostics but may not always have the time to develop highly technical and well-designed, powerpoint decks to use for longer meetings. The toolkit will include a comprehensive *advocacy slidedeck* for partners planning and conducting more formal advocacy discussions. The deck will be organized in a modular format, so that partners can pull and adapt the most locally relevant sections for impactful advocacy for each specific meeting or discussion with policymakers in their context.

Community Tools

Consistent with strategic recommendations informed by formative and pretesting research, the tools for use with communities need to emphasize the benefits of testing and address common myths that limit informed demand. Toolkit users are encouraged to adapt tools using locally-relevant myths and insights. In addition, all myth-busting tools are designed to emphasize truths, to avoid the possible risk that discussing myths increases misinformation and confusion at community level.

The community-facing tools are designed for use in both digital and offline channels, considering varying connectivity and the offline nature of some components of community outreach in LMICs.

Hero Video

A 2-minute animated *video* brings the value of testing to life for community members by highlighting the benefits of testing with a specific focus on protecting more vulnerable family and community members. This video is designed to be used on digital platforms, but can also be used in community meetings, events, and other interpersonal activities.

Digital Posts

A selection of testing value proposition and myths-busting messaging will be developed into digital posts that can be used to emphasize the value of testing, bust myths, and increase informed demand for testing. This will include:

Static posts with brief messages and explanations help communities clearly understand the call to action to test.

Simple *gifs* are designed to stand out from other content. Short messages will be brought to life with the help of animated visuals.

Digital quiz will include a script and simple graphics to enable community members to engage in a reflective, interactive activity that allows them to check their knowledge of the testing facts.

All community-facing digital assets can be used on social media platforms as well as digital channels.

Interpersonal Communication Tools: “What if” - Stories/ Roleplay, Decision Making Game, Posters.

These tools will be developed around “What if” stories which lay out scenarios to highlight the benefits of testing (and consequences of not testing) using stories, conversation, and role-plays. Three tools will be created:

“What if...” story flipbook designed to help a group discussion facilitator guide role play activities. Exercises will end with a group discussion to promote correct testing behaviors.

A *decision-making game* that explores different scenarios based on the choices made by the players, ultimately demonstrating the positive benefits of testing.

Poster designs will bring key messages to life using bold, visual *posters* that can be printed and placed in various community settings.

Interpersonal Communication Tools: “Myths” - Myth Busting Quiz, Posters

These tools will all cover myths and misconceptions that were uncovered during the research around testing - especially focused on COVID-19. These tools will gamify the myths, to offer IPC Agents additional strategies to discuss testing.

The digital quiz can be turned into an *in person myth busting quiz*, where participants are given voting panels based on prevalent myths in the context, and correct answers are revealed and discussed along the way.

Key messages brought to life in bold, visual *posters* that can be printed out by ACs for use in public areas.

How to use the toolkit

The Toolkit will be accessible as a PDF document. It will include an explanation of the Toolkit purpose, contents and how-to guide. Toolkit users will easily be able to open the advocacy toolkit and quickly understand what the contents of the kit are, and how to use them. The toolkit will include reminders and practical tips to encourage local adaptation based on a specific test and context.

Guide on How to Use the Toolkit

Guidance on how to use the *Toolkit* will be designed to ensure that *Toolkit* users understand the intended target audience(s), desired behaviors (health policymakers increase testing access and communities increase informed demand). Users will also receive clear information about the key factors identified through research analyzed through the ERP behavioral framework, and how to use the messaging matrix to select communication objectives and messaging most relevant for their specific context.

Toolkit users will be encouraged to conduct additional research to inform and pretest locally-relevant tools using sample research and testing guides. They will also be encouraged to adapt and implement changes using the sample creative brief. The following supporting tools will be included:

- Research Guide Template (used to inform the global *Toolkit*)
- Testing Guide Template (used to test global Assets)
- Creative Brief Template (used to guide creative design of global Assets)

To inform planning to implement advocacy and/or communication campaigns to increase access to and demand for testing, the Toolkit will include a sample Implementation Plan. This will be designed to help Toolkit users think about how to use a mixture of tools/formats and channels over a 12-month period to optimally influence testing access and demand.

Monitoring Guide

The advocacy toolkit will include monitoring and learning guidance including:

- Tips for assessing the extent to which advocacy campaigns contribute to measurable changes in access to, demand for, and use of COVID-19 testing and/or other diagnostics.
- Tips for assessing advocacy campaign exposure and engagement results through offline and digital channels.