ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION TO FIGHT TB

ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION TO FIGHT TB

A 10 YEAR FRAMEWORK FOR ACTION

ACSM
SUB GROUP
AT COUNTRY LEVEL

World Health Organization

Stop TB Partnership

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Acknowledgements

This strategic framework was compiled by James Deane and Will Parks. It builds on the work and contributions of many people and is in part a collation from many existing strategic documents and workplans. These have been credited wherever possible. Particular thanks are due to the following individuals: Thad Pennas of the Stop TB Secretariat, who has collated and supported this process with great efficiency as well as producing or editing many documents from which this work is based; Michael Luhan and the many other colleagues from other working groups of the Stop TB Partnership, who gave their time and insights into this exercise; and Silvio Waisbord, who has provided an exceptional amount of analysis underpinning the workplan. It has benefited substantially from the review and input of the Stop TB Partnership Advocacy, Communication and Social Mobilization Subgroup at Country Level, and was approved at a meeting of that group in Mexico City in September 2005.

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Joanne Carter, Chair, Advocacy, Communication and Social Moblization Working Subgroup (2005-2006)
Thierry Cailler, Graphic Designer, issues.ch

Preface

The value of advocacy, communication and social mobilization (ACSM) is becoming increasingly valued in TB control strategies. It is to the credit of the Stop TB Partnership that a new ACSM working group was set up in 2005 to inject greater strategic coherence and urgency to this work. I am honoured to be elected as both the vice-chair of this group and the first Vice-Chair of the ACSM Subgroup at Country Level.

There is an increasing wealth of experience and evidence, including from my country Mexico, demonstrating the value of ACSM in mobilizing political support and leadership for TB control strategies at all levels; in empowering people affected by TB; in improving case detection and boosting treatment adherence; and in tackling stigma.

This document sets out a 10-year strategic framework for ACSM activities and is a key supporting document to the Stop TB Partnership's *Global Plan to Stop TB 2006–2015*. This plan demonstrates a step change in both ambition and innovation in tackling TB, and I believe that the ACSM strategies set out in this framework will play a critical role in supporting the achievement of the Stop TB Partnership objectives.

Vice-Minister of Health
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Vice-Chair of the Advocacy, Communication and Social Mobilization Subgroup at Country Level

Executive summary

A significant scaling up of advocacy, communication and social mobilization (ACSM) will be needed to achieve the global targets for tuberculosis control as detailed in the Global Plan to Stop TB 2006–2015. In 2005, the ACSM Working Group (ACSM WG) was established as the seventh working group of the Stop TB Partnership to mobilize political, social and financial resources; to sustain and expand the global movement to eliminate TB; and to foster the development of more effective ACSM programming at country level in support of TB control. It succeeded an earlier Partnership Task Force on Advocacy and Communications.

This workplan focuses on those areas where ACSM has most to offer and where ACSM strategies can be most effectively concentrated to help address four key challenges to TB control **at country level**:

- Improving case detection and treatment adherence
- Combating stigma and discrimination
- Empowering people affected by TB
- Mobilizing political commitment and resources for TB.

The workplan supports the ACSM contribution to the Global Plan to Stop TB 2006–2015 and sets out a 10-year strategic framework for country-level ACSM programming that complements strategic work at the global advocacy level designed to exert pressure on governments and other authorities to prioritize TB control.

The workplan is divided into two parts:

Part 1 – the call for action

- describes the key challenges to be addressed;
- defines important terms – programme communication, advocacy, social mobilization and capacity building;
- summarizes the current evidence of ACSM contribution and lessons learnt;
- sets out the key principles underpinning the workplan.

Part 2 – the framework for action

- explains the vision, goals, objectives and targets of the country-level ACSM strategic framework;
- outlines the framework's basic components;
- examines how progress could be monitored and evaluated;
- explores key partnerships and roles;
- presents and justifies the budget.

The vision of this workplan is one where all communities at all levels are empowered to remove the threat of TB to human health. By applying ACSM strategies from health-care settings to households, TB patients are supported and treated effectively with dignity and respect. Furthermore, those most affected by TB will be involved in shaping the response.

Over the next 10 years, this framework aims to establish and develop country-level ACSM as a core component of TB prevention and treatment efforts. The framework has the following goals:

- To provide guidance for Global Plan to Stop TB 2006–2015 goals and targets as these translate into national ACSM initiatives.
- To foster participatory ACSM planning, management and evaluation capacity at regional, national and subnational levels.
- To support and develop strategies to achieve key behavioural and social changes, depending on local context, that will contribute to sustainable increases in TB case detection and cure rates.

The following strategic objectives have been identified:

- By 2008, at least 10 endemic countries will have developed and will be implementing multisectoral, participatory ACSM initiatives and generating qualitative and quantitative data on ACSM's contribution to TB control.
- By 2010, at least 20 priority countries will be implementing multisectoral, participatory-based ACSM initiatives, and monitoring and evaluating their outcomes.
- By 2015, multisectoral, participatory ACSM methodologies will be a fully developed component of the Stop TB Strategy.
- By 2015, all priority countries will be implementing effective and participatory ACSM initiatives.

These objectives will be achieved through a mix of five key strategic components:

1. Building national and subnational ACSM capacity
2. Building inclusion of patients and affected communities
3. Ensuring political commitment and accountability
4. Building country-level ACSM partnerships
5. Learning, adapting and building on good ACSM practice.

The framework for action proposes a dual strategy of intensively supporting ACSM activities in five high-TB burden countries per year over the next five years, and then sustaining that support throughout the 10-year period of the Global Plan to Stop TB 2006–2015. The framework is designed to implement intensive, sustainable and detailed communication strategies in all high-burden countries, as well as support strategies in medium-burden countries.

The framework does not attempt to provide a rigid blueprint for countries to follow in implementing communication activities in support of TB control, since decisions on the most appropriate ACSM strategies need to be taken according to the specific situations and demands of TB-affected countries. Instead, the framework offers a series of interrelated components, approaches and tools from which country partners can select. The framework draws upon the latest research, recent agreements in the TB control community and existing documentation on how ACSM programming can contribute to TB prevention and control.

The total estimated budget for global advocacy, country-level communication and mobilization, capacity building, monitoring and evaluation, research and ACSM WG requirements is estimated to be US$ 3.2 billion for the 10-year period. Support for global advocacy equates to 6% of the total budget. Support for country-level communication and social mobilization represents 90% of the total budget. Technical assistance constitutes 1% of the budget, operations research, monitoring and evaluation around 2%, and Working Group administrative and networking requirements about 0.6%.

It is assumed that funding for the coordination of global and regional strategic planning, technical assistance and evaluation will come from grants to the Stop TB Partnership Secretariat from bilateral donors. The bulk of funding for country-level ACSM activities will come from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and bilateral sources in the short term, and increasingly from national government allocations in the longer term. Partners at country level should also contribute by committing realistic proportions of their budgets to ACSM activities.

Monitoring and evaluation of this framework will take place at several levels. At global level, annual technical reviews will be commissioned to analyse the progress being made in national ACSM capacity building and the contribution and cost-effectiveness of ACSM to Global Plan to Stop TB 2006–2015 goals and targets. ACSM WG and subgroup meeting reports will also be used to track this plan's progress. Frequent international, regional and national meetings will be held to document and disseminate evidence to date, good practices and lessons learnt. Regular technical advisory missions provided under technical service contracts with highly experienced communication partners will offer many opportunities for national TB control programmes (NTPs) to monitor and supervise national and subnational ACSM activities. Country-level ACSM initiatives will develop their own participatory monitoring and evaluation processes, including appropriate indicators and reporting systems. Finally, existing information systems, methods, indicator banks, and techniques used within and beyond NTPs will be used and adapted where necessary to strengthen the monitoring and evaluation of this workplan. Rigorously derived evidence of country-level ACSM contribution to TB control should begin to accumulate by the end of 2007.

ACSM strategies to make a substantial contribution to tackling TB exist. In terms of increasing case detection, improving treatment adherence, tackling stigma, empowering people affected by the disease and raising political commitment. Such strategies have, however, not been prioritized by NTPs or internationally, either in terms of strategic emphasis or in building capacity to implement effective ACSM programmes. This document lays out a 10-year workplan to rectify this situation in order to contribute to global TB control.

Introduction

This workplan focuses on how ACSM can support NTPs and initiatives at a country level. It has been produced to support the contribution of ACSM to the Global Plan to Stop TB 2006–2015 and sets out a 10-year strategic framework for ACSM programming. The workplan complements strategic work at the global advocacy level designed to exert pressure on governments and other authorities to prioritize TB control.

This workplan does not attempt to provide a rigid blueprint for countries to follow in implementing communication activities in support of TB control, since decisions on the most appropriate ACSM strategies need to be taken according to the specific situations and demands of TB-affected countries. It does, however, seek to provide a framework for action from which countries can map out the most effective strategies to suit their own circumstances over the next 10 years.

While the precise combination of approaches needs to be determined at a country level, this workplan has one prime message – NTP's need to prioritize ACSM if TB control targets are to be achieved.

This workplan is divided into two parts:

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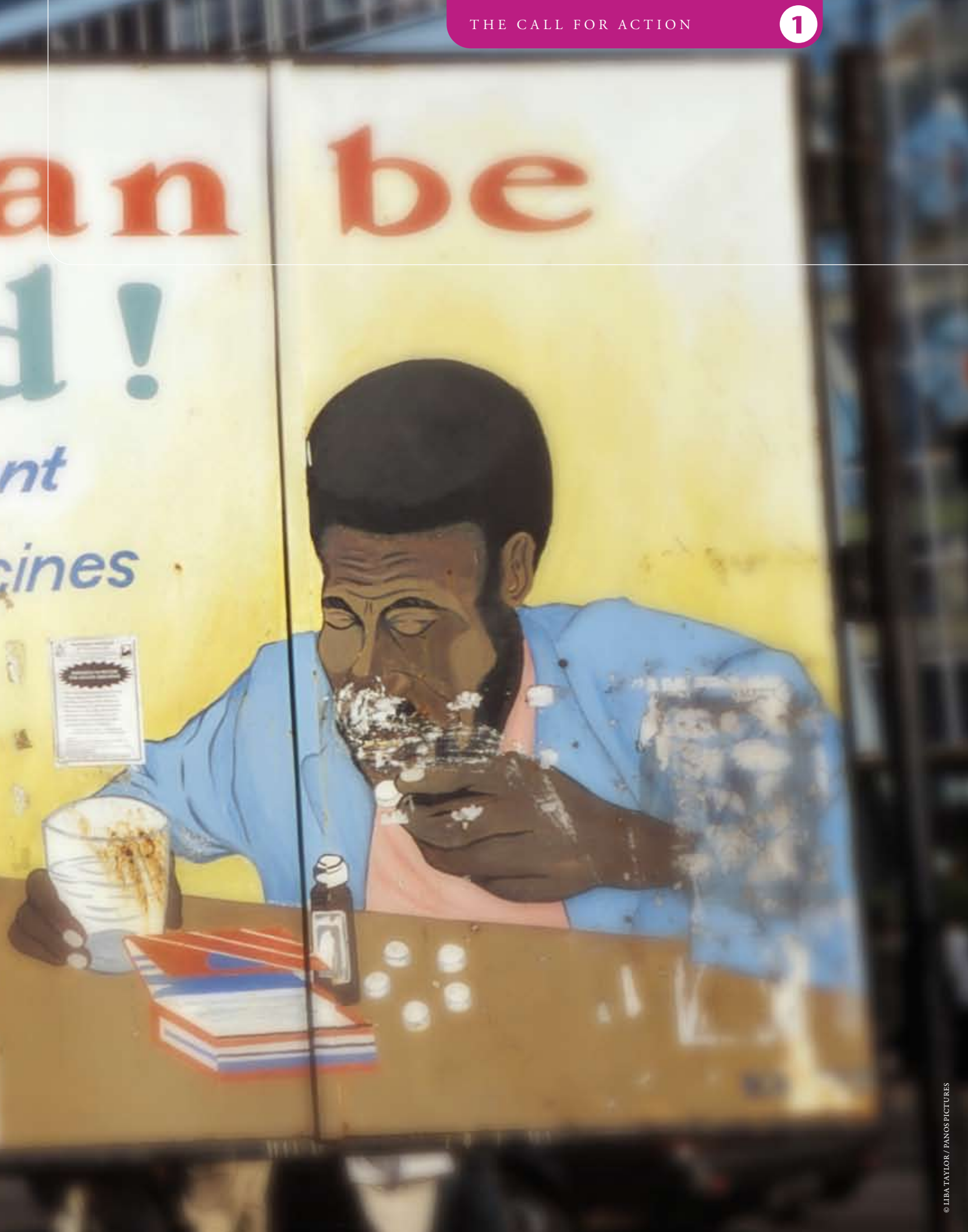
1 THE CALL FOR ACTION



Communication can make a contribution to TB control

It is important at the outset to be explicit about why ACSM strategies are becoming vital in controlling TB, and the specific problems this workplan seeks to address. There are many challenges to be confronted in reaching global TB targets, but this workplan is focused on those areas where ACSM has most to offer and where ACSM strategies can be most effectively concentrated. This workplan brings together the latest research, recent agreements in the TB control community and existing documentation into a coherent framework designed to use ACSM to help address four key challenges:

- Improving case detection and treatment adherence
- Combating stigma and discrimination
- Empowering people affected by TB
- Mobilizing political commitment and resources for TB.

These challenges will not be met without far greater prioritization and improvement in TB-related communication activities. In addressing each of these issues, there are strong organizational synergies with efforts to combat HIV/AIDS.

1.1
Improving case detection and adherence

The United Nations Millennium Development Goals commit the international community to have halted and begun to reverse the incidence of TB by 2015 and to have reduced TB prevalence rates by 50% compared with the year 1990. These goals build on and complement earlier targets, ratified by the World Health Assembly in 1991, aimed at detecting 70% of new infectious TB cases and successfully curing 85% of these cases. Currently, around 50% of the estimated of new cases each year are reached, detected and treated.

These targets – which are considered too conservative by many groups – can only be met if the response from the TB community shifts more decisively from passive case-finding to active case detection.

Social, cultural, behavioural, epidemiological, economic, and political factors affect not only provision of services for TB diagnosis and treatment (1-2). Critical factors affecting demand and use of services include: HIV/AIDS, multidrug-resistant TB (MDR-TB), stigma and discrimination, gender inequality, public service reforms, population displacement and mobility, and changing communication environments.

Strategic and intensive deployment of communication and social mobilization strategies is increasingly acknowledged as necessary to encourage and support at-risk populations who have a cough for more than three weeks to seek treatment; and to adopt other health-seeking behaviours related to TB (3).

The link between a lack of communication and poor case detection has been repeatedly demonstrated. Studies, including from Ethiopia, India, Mexico, Nigeria, Pakistan and Thailand, have shown that patients with low knowledge

about the symptoms of TB are more likely to postpone seeking care and getting tested. Studies in the United Republic of Tanzania found that in some communities, patients with low knowledge are more likely to visit traditional healers and pharmacists than DOTS providers. NTPs have been shown to do a better job at holding, rather than finding, cases and in increasing case detection (4).

Communication is also seen as having an important role in improving treatment adherence. Progress towards the target of 85% treatment success has been much more marked than that against case detection, although every effort must be made to maintain cure rates in many countries. Communication and social mobilization programmes ensuring patient education, combined with broader community support and empowerment initiatives, are essential if cure rates are to improve and be sustained.

1.2
Combating stigma and discrimination

Stigma and discrimination associated with TB are among the greatest barriers to preventing further infections, providing adequate care, support, and treatment (5). TB-related stigma and discrimination are universal*. Stigma is harmful, both in itself, since it can lead to feelings of shame, guilt and isolation of people living with TB, and also because negative thoughts often lead individuals to do things, or omit to do things, that harm others or deny them services or entitlements (i.e. discrimination).

For example, health workers are often a key source of stigmatizing behaviour through their treatment of people with TB; hospital or prison staff may deny health services to a person with TB. Or employers may terminate a worker's employment on the grounds of his or her actual or presumed TB-positive status. Families and communities may reject and ostracize those living, or believed to be living, with TB. Such acts constitute discrimination based on presumed or actual TB-positive status.

Studies repeatedly demonstrate that stigma deters people from seeking care and diagnosis and that women bear the highest burden of stigmatizing behaviours (6). Stigma and discrimination are triggered by many forces, including lack of understanding of the disease, myths about how TB is transmitted, prejudice, lack of access to diagnosis and treatment, irresponsible media reporting, the link between HIV/AIDS and TB, and fears relating to illness and death.

Lack of access to TB diagnosis and treatment is a key issue that enhances or advances TB-related stigma and discrimination in many countries. The perceived "untreatability" of TB is a key factor contributing to the stigmatization of many of those affected.

The challenge of reducing stigma and discrimination needs to be addressed within public and private health sectors and among health workers on the ground. Fear, lack of knowledge, and misconceptions are deep-rooted. The ways of looking at patients in general and patients with infectious diseases like TB need to be radically changed. Services need to have a more patient-oriented approach.

Stigma results in part from misinformation or a lack of information. Misinformation about what causes TB, how it is transmitted and whether it can be cured is linked to the stigmatization of TB and of people with TB. Various cultures associate TB with socially and morally unacceptable behaviour. TB is also widely believed to be inherited, and people who have TB are sometimes considered unmarriageable. Such beliefs, generated by misinformation, have led to people being physically isolated, discriminated against and dismissed from work. Public education and awareness-raising programmes designed to counteract myths and to encourage greater inclusion of people with TB are an essential element of any effort to combat stigma associated with TB.

Stigma has its roots not only in lack of information but also in deep-seated social mores and structures. Stigma particularly affects women because social pressures and status often make them especially vulnerable to marginalization

*Stigma has been defined as "an attribute that is significantly discrediting" and "an attribute used to set the affected person or groups apart from the normalized social order, and this separation implies a devaluation". Stigmatization therefore describes the process of devaluation within a particular culture or setting, where certain attributes are seized upon and defined as discreditable or not worthy.

and discrimination with the consequences of contracting TB sometimes leading to divorce, desertion and separation from their children (7). Stigma as a "disease of the poor", well documented historically, persists and has been compounded more recently by the link with HIV/AIDS. HIV/AIDS stigma that affects TB patients has been shown in high-HIV prevalent communities, including Ethiopia, Pakistan and Thailand, demonstrating that TB patients with HIV suffer a double stigma.

Any ACSM strategy designed to confront these issues has to focus on social as well as individual behavioural challenges. ACSM programmes are essential in empowering people with or affected by TB to take community action to confront stigma, and to educate broader communities to reduce stigma. Any communication strategy designed to combat TB needs to support both a process of social change in society to tackle stigma and marginalization of people with TB, and a process of behavioural change designed to persuade people to seek treatment.

1.3
Empowering people and communities affected by TB

A third major challenge for ACSM programmes is to combat insufficient inclusion of people most affected by TB and related diseases in the design, planning and implementation of TB control strategies. An important lesson from other health crises, particularly HIV/AIDS, is that the greater the inclusion of those most affected in the response to these crises, the greater the impact such responses are likely to achieve and sustain (8).

Communication strategies have much to offer in this regard, both in terms of advocacy interventions and in how different communication actions/programmes can enable people with and affected by TB to have their voices heard in the public domain.

Contemporary health communication strategies are increasingly preoccupied with providing spaces and channels, particularly through the media, where people affected by health issues can make their voices heard, engage in dialogue and debate and achieve greater visibility and profile as people with important perspectives that deserve attention. An important component of this workplan reflects this priority.

Community empowerment has also been shown to be critical to successful implementation of DOTS programmes, and some of the most successful examples of TB programming have been rooted in strategies with a strong community empowerment component (see Section 7.1).

1.4
Political commitment and securing resources for TB control

Political commitment has been recognized as a crucial element of DOTS. Lack of political will has hampered both the *development* of appropriate TB control policies and the successful *implementation* of those policies at the central, district, and local levels. Even when good TB policies exist, there is often a gap between the policies and the programmes on the ground. Experience suggests that TB control services are negatively affected without strong commitment from different sectors of society, particularly decision-makers and influential political and community leaders. Challenges in relation to insufficient political commitment can include:

- Insufficient resources—both human and financial
- Lack of local ownership and buy-in of NTPs
- Weak leadership in the NTP and/or a loss of coherence
- Weak capacity of the NTP to provide guidance to district- and local-level programmes (both public and private providers)
- Lack of accountability for results among the ministry of health (MoH), NTP, and health providers
- Low levels of knowledge among policy-makers and other stakeholders about TB
- Lack of integration of NTPs with other MoH programmes
- Lack of clear and relevant ACSM guidance available locally and weak capacity to develop effective ACSM programmes
- Weak advocacy and communication capacity to advocate upwards for TB programme prioritization, particularly with ministers of health and finance.

Advocacy needs to be an inherent part of a country-based ACSM strategy.

Defining key terms: advocacy, communication, social mobilization capacity building

It is important to be clear about the definitions of communication that are used in this workplan, particularly the terms "communication", "advocacy" and "social mobilization". "Capacity building" is another process of particular importance to this workplan and a definition is provided below.

2.1
Communication as an overarching theme

The term "communication" is an overarching one meaning the process people use to exchange information about TB. All communication activities make use of some form of media or channel of communication (e.g. mass media, community media, interpersonal communication). While much of the communication effort on TB is concerned with transmitting a series of messages to people affected by TB, nearly all communication practitioners stress that to be effective, communication should be understood as a two-way process, with "participation" and "dialogue" as key elements.

Within this overarching term, there are three linked, overlapping and complementary communication strands – programme communication, advocacy, and social mobilization. The degree of overlap between these terms (particularly between social mobilization and advocacy) has caused confusion in the past, and these definitions are the subject of continuous debate in the public health and communication communities. This workplan is concerned with building an integrated response, applying all communication approaches and methodologies as they are relevant to tackling the four key challenges outlined in Section 1. In this workplan, "communication" is used interchangeably with "ACSM".

2.2
Programme communication to inform and empower

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

Programme communication also works to create an environment through which communities, particularly affected communities, can discuss, debate, organize, and communicate their own perspectives on TB. It is aimed at changing behaviours (such as persuading people with symptoms to seek treatment) but can also be used to catalyse social change (such as supporting community or other communication-for-social-change processes that can spark debate, and other processes to shift social mores and barriers to behaviour change).

2.3
Advocacy to change political agendas

Advocacy denotes activities designed to place TB control high on the political and development agenda, foster political will, increase financial and other resources on a sustain-

able basis, and hold authorities accountable to ensure that pledges are fulfilled and results achieved.

Policy advocacy includes data and approaches to advocate to senior politicians and administrators about the impact of the issue at the national level, and the need for action. *Programme advocacy* is used at the local, community level to convince opinion leaders about the need for local action. Related forms of advocacy include *media advocacy* to generate support from governments and donors, validate the relevance of a subject, put issues onto the public agenda, and encourage the media to cover TB-related issues regularly and in a responsible manner (9).

In the global context, advocacy for TB control is to be understood as a broad set of coordinated interventions directed at placing TB control high on the political and development agenda, for securing international and national commitment, and mobilizing necessary resources.

In country contexts, advocacy efforts broadly seek to ensure that national governments remain strongly committed to implementing national TB control/elimination policies. Advocacy at country level often focuses on administrative and corporate mobilization through parliamentary debates and other political events; press conferences; news coverage; TV and radio talk shows; soap operas; summits, conferences and symposia; celebrity spokespeople; meetings between various categories of government and civil society organizations, patients organizations, service providers, and private physicians; official memoranda; and partnership meetings.

2.4
Social mobilization to build partnerships

Social mobilization is the process of bringing together all feasible and practical intersectoral allies to raise awareness of and demand for a particular programme, to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance (10). "Allies" include decision - and policy - makers, opinion leaders, nongovernmental organizations (NGOs) such as professional and religious groups, the media, the private sector, communities and individuals. Social mobilization generates dialogue, negotiation and consensus, engaging a range of players in interrelated and complementary efforts, taking into account the needs of people. Social mobilization, integrated with other communication approaches, has been a key feature in numerous communication efforts worldwide. Some prominent examples include: (a) *Soul City's* campaign against domestic violence in South Africa, (b) the polio eradication campaign in Uttar Pradesh, (c) HIV/AIDS prevention in Uganda and Thailand, and (d) eliminating the vitamin A deficiency disorder in Nepal.

Social mobilization recognizes that sustainable social and behavioural change requires many levels of involvement—from individual to community to policy and legislative action. Isolated efforts cannot have the same impact as collective ones. *Advocacy* to mobilize resources and effect policy change, *media* and *special events* to raise public awareness, *partnership building* and *networking,* and *community participation* are all key strategies of social mobilization (11). Specific activities include group and community meetings, partnership sessions, school activities, traditional media, music, song and dance, road shows, community drama, leaflets, posters, pamphlets, videos, and home visits.

2.5
Capacity building to sustain and multiply health gains

Capacity building can be defined as the process of developing competencies and capabilities in individuals, groups, organizations, sectors or countries that will lead to sustained and self-generating performance improvement. ACSM capacity building often consists of at least three core activities: (1) building infrastructure to deliver ACSM programmes, (2) building partnerships and organizational environments to sustain ACSM programmes – and health gains; and (3) building problem-solving capability.

This last element is particularly crucial. As one capacity building expert puts it, "There is little value in building a system that cements in today's solutions to today's problems. We need to create a more innovative capability so that in the future the system or community we are working with can respond appropriately to new problems in unfamiliar contexts"(12).

Capacity is built for the following reasons:

- to improve the managerial skills of individuals and in ways that they can lead particular programmes and respond to particular issues;
- to develop independent capabilities over time, so as to make programmatic responses sustainable.

The rationale for building ACSM capacity within government and nongovernmental agencies working on TB control at country level is clear: by building ACSM capacity, TB partners can sustain and increase health gains many times over.

Disease and transmission

- **TB is a contagious disease that spreads through the air.**
- **Only people with pulmonary TB are infectious.**
- **Each person with infectious TB will infect on average between 10 and 15 people every year.**
- **Someone in the world is newly infected every second.**
- **Overall, one-third of the world's population is currently infected.**
- **People infected with TB will not necessarily get sick. The immune system 'walls off' the TB germs, which can lie dormant for years.**
- **5–10% of people who are infected with TB become sick at some time during their life.**

Evidence and lessons learnt

3.1
What is the current evidence for ACSM contribution to TB control?

Evaluations of public health programmes, including promotion of new behaviours and new medical products (such as contraceptives, drugs and vaccines), have shown repeatedly that ACSM plays a powerful role (13-16). Studies in Africa have demonstrated continuing correlations between exposure to mass media, exposure to specific health messages, and desired behavioural change (17-18). Unobtrusive measures such as increased sales of condoms in Ghana and Nicaragua testify to the effectiveness of these promotions (19, 20). In the global polio elimination programme, the Taylor Commission (1995) reported: "Social mobilization as utilized by the [polio programme] has relied on massively utilizing IEC [information-communication-education], including mass media, strengthening existing community organization, and involving political and community leaders ... The three components were identified as having strong positive effects." The report also declares social mobilization as "the variable with the most positive effects in all countries" (21). Major donors and international organizations such as USAID, UNICEF, DFID, and the World Bank are now actively promoting the use of ACSM (22-25).

Although there is little documented evidence of the scale of ACSM contribution to TB control, this workplan draws upon recent evaluation meta-analyses in other public health communication fields to propose that, at a minimum, ACSM for TB control should help to ***maintain*** current case detection and case cure rates in most countries (26-28). In situations where DOTS services are assured, well-planned and fully-resourced ACSM could ***increase*** these rates by as much as 5–10%, although accounting for all confounding variables in the final analysis will be problematic and make the impact of ACSM difficult to quantify.

The *Report of the Meeting of the Second Ad hoc Committee of the TB Epidemic* examined the constraints and solutions to TB control/elimination through a comprehensive consultative process. The report identified ACSM as a strategic means to enable achievement of the goals of the Stop TB movement. The report strongly recommended the rapid strengthening of ACSM at both global and national levels (29).

In July 2003, a declaration from an expert consultation on communication and social mobilization stated that:

...In terms of available treatments and an existing health infrastructure, more had been achieved to tackle TB than almost any other current health issue. However, for these interventions to achieve their full potential in TB case detection and treatment compliance, the central strategic challenge is now one of advocacy, communication and empowerment" (30).

A clear conclusion from the ACSM WG is that communication strategies to make a substantial contribution to tackling TB exist in terms of increasing case detection, improving adherence, tackling stigma, empowering people affected by the disease, and raising political commitment. Such strategies have, however, not been prioritized by NTPs or internationally, either in terms of strategic emphasis or in building capacity to implement effective ACSM programmes. Finally, while many effective and proven ACSM strategies exist, they are neither a magic bullet for TB control nor a simple template that can be applied universally. While Part 2 of this workplan outlines and recommends a series of methodologies for scaling up communication programming, ACSM strategies will need to be developed from within countries according to the specific realities of each country.

3.2
What lessons have been learnt so far?

There is a substantial body of good practice to draw upon in designing effective TB communication programming. The most important lesson learnt is that ACSM strategies are most effective when their design is led by and appropriate to specific country processes and experiences. In other words, they are effective when ACSM programming fully and broadly engages governments, NGOs, patients and their families,

communities, and other sectors of society such as private enterprises and the media.

Two of the most successful and best documented uses of communication in tackling TB are derived from the experiences of Mexico and Peru. Both experiences have demonstrated some clear principles of any communication strategy.

In Peru, there was a clear conclusion that, "in the fight against TB it is crucial to understand that the problem of TB originates in poverty, and that any strategy which does not take this account will surely fail. Therefore the problem of TB should be approached in a comprehensive manner where the constant dialogue with the patients and their organizations will show us the other side of the coin".

In similar vein in Mexico, "Today, it is unthinkable anymore to defend the idea that public health problems such as TB, can be solved without regard to the economic, social and cultural context where the disease originates and develops".

In both cases, the centrality of understanding the context of TB, particularly that of poverty, is emphatically articulated; and the process of bringing about change is based on empowering communities to play a lead role in that process. These experiences have been echoed repeatedly and consistently in discussions on effective programme communication. In Bangladesh, increasing prioritization of ACSM is rooted carefully in a social empowerment framework (see Annex 1).

The Mexican model, which has the commitment of the Ministry of Health, is strongly rooted in the process-oriented tradition of participatory approaches, and is based on five strategic elements: (1) community-joined diagnosis of health issues; (2) community-joined review and assessment of the operations of health programmes; (3) continuous communication between government and communities on the status of health and welfare; (4) articulation of all social actors in the field – government, private sector and social organizations; (5) joint evaluation of progress and outcomes between health promoters and communities.

In the project areas of Mexico, communication mechanisms have been implemented at the community level in the form of networks of community facilitators, health promoters and local authorities, that are supported by the use of appropriate community and local mass media. Communities, health promoters and health experts jointly analyse and create collective knowledge about the population's health situation, assess community knowledge about available services and their quality, maintain continuous communication between the government and the community, share information and experiences, and finally evaluate progress jointly. The overarching theme of the entire process is that information

"We have a unique historic opportunity to stop tuberculosis, but we must act now." The challenge is for people to work together in putting the plan into action, in order to stop one of the oldest and most lethal diseases known to humanity. This plan tells the world exactly what we need to do in order to defeat this global killer."

Dr Marcos Espinal, Executive Secretary of the Stop TB Partnership at the launch of the Global Plan to Stop TB 2006–2015, Davos, Switzerland, 27 January 2006

must be translated into knowledge, and knowledge into a permanent change in behaviour. While ACSM was one of several contributions, it is important to note that Mexico recently achieved and surpassed international case detection and case cure targets for TB control.

In Peru, the patient-centred mobilization revealed the inherently unequal power relations between health personnel and patients. However, the process of organizing the patients into groups/networks was in itself transformative at many levels. Aside from creating spaces for patients to exchange information and share concerns, the process also helped in resolving their sense of isolation and exclusion. Besides treatment and cure, the process empowered poor and marginalized sections of society to demand their rights. The growing voice and public presence of the TB patients in the wider society helped create citizenship awareness about the complexity of TB, and brought in the commitment of new actors in the fight against TB (31).

Experiences in Mexico and Peru strongly demonstrate that the process of social mobilization to fight TB can transform and bring about changes that assist the wider project of social development. It is important to note that in these and other countries where intensive and effective communication has been critical to boosting case detection and reducing stigma (such as Viet Nam), there was no separate communication strategy(32). Rather, the communication activities were integrated into the national TB control/DOTS strategy. In both countries, activities were intensive and sustained over time. These included advocacy activities, mass and local media, interpersonal communication and counselling, and community mobilization. Political will was high, and TB was high on the political agenda. It is important to note that in all these countries, it took many years of work before results became apparent. In Viet Nam, for example, it took about five years to attain 100% DOTS coverage, with adequate clinical services and human resources. When case detection was passive, the rate was steady. When communication was added, the case detection rate increased rapidly.

Tuberculosis

- **TB kills 2 million people per year.**
- **The breakdown in health services, the spread of HIV/AIDS and the emergence of multidrug-resistant TB (MDR-TB) are contributing to the worsening impact of the disease.**
  - **It is estimated that between 2000 and 2020, nearly one billion people will be newly infected.**
  - **200 million people will get sick.**
  - **35 million people will die from TB if control is not further strengthened.**

Global Plan to Stop TB 2006–2015

Clear principles underpinning this work

The central strategic challenge in applying good practice to future communication programming is matching the technical methodologies designed to achieve behavioural change with the social processes required to ensure strong political and community ownership. The technical methodologies that can be drawn upon are outlined in Part 2, but at least six fundamental principles for action can be learnt from the most successful experiences of the past:

- Knowledge is critical
- Knowledge is not enough
- ACSM should be integral and proportionate to NTPs
- ACSM should be nondiscriminatory and rights-based
- ACSM requires country-led approach, and investment in national and subnational capacity.

4.1
Knowledge is critical

TB is transmitted by proximity, but also by ignorance. The lack of knowledge that having a cough for more than two weeks is a possible symptom of a fatal but curable disease prevents millions of people from seeking treatment. Studies repeatedly show that if people have that knowledge they are far more likely to seek treatment. Without it, they generally will not. In this sense, no active case detection and adherence strategy can hope to succeed without a major communication component.

In terms of traditional communication, educating people with the knowledge and persuading people to seek treatment for TB has challenges but is considered by many communication organizations to be a relatively straightforward process. Other communication issues, such as persuading people to alter their sexual behaviour to prevent transmission of HIV, or reduce the number of children they have, are far more challenging and complex. There are many examples of success in TB communication programming, and a wealth of experience drawn from other fields (both in health and in others such as agriculture) that demonstrate the impact of communication programmes in generating knowledge.

A theme running throughout this workplan is an insistence that strategies need to be determined at a local level, but in terms of the core knowledge that people need to have to change their behaviour, the following are essential (but not sufficient):

- Knowledge of TB symptoms
- Knowledge of how TB is transmitted
- Knowledge that TB is curable
- Knowledge that TB treatment is free-of-charge
- Knowledge that potential TB cases should rigorously seek professional care
- Knowledge that active TB cases should adhere to a treatment regimen.

This knowledge cannot simply be targeted at individuals. Households are the primary producers of health and constitute the primary actors of the health system, which includes communities and health institutions, both public and private. Primary "diagnosis and treatment" are often made at the household level, as well as the decision to seek (or refuse) professional health care(33). In many ways, mothers serve as "first responders" to illness, followed by their spouses, parents, in-laws and other relatives. In many countries, professional health providers are sought only when household and traditional healers have failed. Any behaviour change campaign needs to understand the role of men and women in decision-making in different cultural settings.

4.2
Knowledge is not enough

"Tuberculosis is not (only) a health problem. It is a social, economic and political disease. It manifests itself wherever there is neglect, exploitation, illiteracy and widespread violation of human rights", argued Kunda Dixit, former director of Panos South Asia (34).

While studies consistently demonstrate that increased knowledge is critical to increasing the chances that people will seek treatment or comply with treatment regimens, educating people with a series of facts about TB is insufficient to induce widespread behavioural change. Few studies suggest that transmitting a series of messages to targeted populations to persuade them to seek treatment in themselves has a sufficient effect in changing behaviour. The vast majority of people affected by TB face substantial problems in accessing treatment even when treatment facilities exist. These include:

- *Stigma and marginalization.* As outlined earlier, stigma, marginalization, discrimination, and poverty are major factors in preventing sick people from seeking treatment. Stigma, low risk perception combined with economic and physical difficulties may continue to delay care seeking and cause default.
- *Gender.* Worldwide, TB is the greatest single infectious cause of death in young women. While fewer women than men are diagnosed with TB, a greater percentage of women die from the disease. The stigma attached to having TB falls far more heavily on women. Conveying the message to women that they should seek treatment for the symptoms of TB will not always induce treatment-seeking behaviour unless it is accompanied by programmes that confront the obstacles women face in seeking behaviour. Such programmes will often be broader social programmes aimed at empowering women, but many opportunities exist for weaving in empowering measures into TB communication programmes.
- *Distance.* People most affected by TB are often those with least proximity to health services. In such circumstances, encouraging people to seek treatment for what they may consider to be a non life-threatening illness is a major behavioural challenge.
- *Time and effort.* In comparison with other diseases, particularly HIV, the detection and treatment of TB is considered "simple". Three sputum examinations are necessary for all infectious cases; X-rays are required for some specific cases. Case treatment depends on a "straightforward" proven regimen: standardized for each case type; directly observed by a suitable trained person with patient counselling; drugs may be taken daily or three times a week (for at least six months); health workers can administer treatment once a week, a trained volunteer on other days; treatment can be administered at a health facility, patient's home or community centre; treatment follow-up is systematic in content at fixed times and based on inexpensive sputum smear microscopy. For people with TB, however, this is not a simple process. Most would have to take two days of out of their life to get to a health facility for the TB test, cough and spit for sputum once at the facility, then take a plastic cup home and cough-and-spit the next morning, come back to the facility that second day, cough-and-spit once more for sputum at the facility, and wait there for the test result. If the result is TB positive, then (under the current treatment regimen) they will need to come back to the facility or some other spot (hopefully nearer their homes) every day for two months and take a set of pills under the watchful eyes of a health worker (or some other designated responsible person), do another cough-and-spit sputum test, and then continue taking a set of pills every other day for another six months (35).
- *Lack of health efficacy.* Populations that are most vulnerable to TB often have high rates of illiteracy, poor health knowledge, and feelings of powerlessness when confronting the health system.

All of these factors are exacerbated by and are particular obstacles to those living in poverty. These issues are well recognized in TB control strategies and need to be addressed in any effective communication strategy. The framework outlined in this document proposes a combination of communication methodologies aimed at achieving behavioural change but also at catalysing a process that can shift social mores, which often prevent individuals from changing their behaviour.

4.3
ACSM must be integral to NTPs

Communication practitioners have a dual role: advocacy and social mobilization seek to increase resources, commitment and priority given to TB at all levels thereby increasing services for TB. In this respect, increasing communication creates pressure to create services. At the same time, a principal task of communication and social mobilization is to stimulate demand among publics for TB services. It is critical that, while advocacy efforts put pressure on authorities to increase services, communication and social mobilization efforts generate demand only for services that are available. Much harm can be inflicted in persuading people to seek services that do not exist. In other words, any communication and social mobilization strategy needs to be carefully integrated into an national TB control plan, generating demand and supporting efforts that are available.

4.4
ACSM should be nondiscriminatory and rights-based

The principle of nondiscrimination is fundamental to public health and human rights', thinking and practice, and underpins this workplan. Freedom from discrimination is a key principle in international human rights', law and has been interpreted, in regard to the right to health, as prohibiting "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health"(36).

Article 19 of the *Universal declaration of human rights* states that everyone "shall have the right to ... seek, receive and impart information and ideas of all kinds ...". The provision of and access to health-related information is considered an "underlying determinant of health" and an integral part of the realization of the right to health (37).

Neglect of the right to information can have substantial health impacts, and no health programme can be successful if those who could potentially benefit from it lack the information they need. Education and information can promote understanding, respect, tolerance, and nondiscrimination for people with TB.

This workplan also assumes that it is desirable that, wherever possible, a higher institution (e.g. international institution or government) should give over authority to the community what the community can accomplish by its own enterprise, sometimes known as the principle of subsidiarity (38). This requires discussion and acceptance by the parties of clear terms of reference. It is combined with principles of solidarity (the expression by citizens of the need to be united, to share the needs and problems of others, and to recognize and defend the dignity of each individual) and of responsibility (which refers to the need for individual citizens and social groups in exercising their rights to have regard for the rights of others, do their own duties to others and seek the common good of all). The principle of subsidiarity is aimed at empowering local communities, but it requires a responsibility at the national level for funding, and should not be an excuse to derogate or avoid responsibility for national-level prioritization and planning for TB control initiatives.

4.5
ACSM requires a country-led approach, and investment in national and subnational capacity

This workplan demonstrates that there is a wealth of information, experience and expertise available to TB managers on TB communication programming in all its forms. This experience and expertise reside both within countries and internationally, but a key principle underpinning this workplan is that ACSM strategies are likely to be most effective when they are led by and framed within specific countries, societies and communities in the context of NTPs.

Country programmes have identified a series of ACSM capacity weaknesses requiring urgent strengthening:

- Technical capacity to ensure high-quality ACSM action
- Programme capacity to actively empower and involve TB patient groups.

In 2002, an in-depth assessment of ACSM capacities and activities was conducted with 10 NTPs – Cambodia, China, India, Indonesia, Kenya, Myanmar, Philippines, South Africa, Uganda, and the United Republic of Tanzania (39). The assessment revealed the following:

- Of the 10 NTPs, 6 had established reasonably strong national advocacy mechanisms, but subnational advocacy mechanisms were weak. All 10 NTPs requested assistance in strengthening advocacy activities at national level but especially at district level where, as a consequence of health reforms, many budgetary and human resource decisions are now made.
- Social mobilization and communication activities in all 10 NTPs varied in terms of intensity and reach. No NTPs had documented ACSM impact. All 10 NTPs requested technical support to improve the planning, management and evaluation of social mobilization and communication activities.
- Having designated managerial staff with appropriate qualifications and experience has been shown to be vital in coordinating and implementing ACSM (40). Only 3 of the 10 NTPs reported having a designated ACSM manager.
- Having a well-researched, detailed implementation plan designed on the basis of widespread consultation has proved vital for ACSM programmes (41). Only 1 of the 10 NTPs reported having developed a definitive plan to manage, monitor and evaluate ACSM.
- Access to appropriate agencies from which technical advice can be regularly sought and to which specialized work can subcontracted is crucial for building and sustaining ACSM capacity (42). All 10 NTPs had access to Ministry of Health and United Nations public relations/communication officers. Nevertheless, all NTP representatives (government and nongovernmental) stated they would welcome longer-term partnerships with specialized ACSM training agencies.

These results indicate that all NTPs wish to build and sustain national and subnational ACSM capacity. In the era of decentralization, ACSM planning and management is often required at district and community level. Evidence and experience to date strongly suggest that the scarcity of skills at the district level contributes substantially to most programme implementation failures. In addition, staff at public and private health institutions, NGOs and community-based organizations (CBOs) need technical support in planning, implementing, monitoring and evaluating ACSM. There is also a clear need for country-level ACSM to be informed and supported by participatory research and evaluation, and it is equally clear that human resources must be strengthened in these fields, especially at subnational level.

The 2002 report concluded as follow:

- NTPs should ensure that the complex, multi-level ACSM activities required to support DOTS expansion and other TB programme elements are managed by a designated, full-time, well-qualified staff member or team.
- Comprehensive training programmes to build capacity in ACSM planning, implementation, monitoring and evaluation are urgently required. Capacity building programmes could include: short courses, in-service distance education, and on-the-job technical assistance to field staff. Centralized or regional training teams could be established so that one or more teams of "master trainers" travel to various locations to deliver high-quality training. This strategy offers the advantage of providing participants with a more standardized package of skills-building activities.
- NTPs should actively seek support from multinational and national commercial corporations, not just in finding or other resources, but in terms of skills. These linkages may result in substantial benefits to NTPs as well as serving as a useful public relations exercise for the corporations concerned. Resource groups that are available within country to help plan, develop and implement ACSM need to be identified. These would include media professionals, production agencies, patient organizations, NGOs and professional bodies that could operate as key NTP partners.

There is no evidence to suggest that the findings of the 2002 report are any less relevant today. Given that little has occurred to address these concerns, there is much to suggest that they are as relevant now as they have ever been.

The second capacity constraint centres of the difficulty people most affected by TB (also often affected by HIV) to influence and shape TB control programmes. There is an urgent need for processes that will facilitate and empower communities most affected by TB to participate in, take ownership of and drive the agenda for the elimination of TB.

Bearing these key challenges, definitions, lessons learnt and principles in mind, Part 2 presents the 10-year strategic framework for ACSM action that will contribute to TB control.

The number of patients treated in DOTS programmes in the 22 high-burden countries (i.e. the top 22 ranked by number of incident TB cases) more than doubled over five years, from two million in 2000 to a projected figure of over four million in 2005. Total spending on TB control in the 22 high-burden countries increased from US$ 800 million in 2000 to a projected figure of US$ 1.2 billion in 2005.

Global Plan to Stop TB 2006–2015

2 THE FRAMEWORK FOR ACTION

Framework for action

Almost 80% of the global TB burden is carried by 22 high-burden countries, principally in Asia and Sub-Sahara Africa. Five of these countries – Bangladesh, China, India, Indonesia and Nigeria – account for 50% of the global burden. Most TB control efforts are focused on these 22 high-burden countries.

This framework for action proposes that while the greatest ACSM efforts need to be targeted at where the greatest burden exists, this should not be to the exclusion of effective ACSM efforts in medium-burden countries.

Not all high-burden countries have similar case detection rates and, taking other factors into account, priority for ACSM activities should generally be given to those countries with the weakest case detection rates (case detection rates vary from between 9% and 100% in high-burden countries).

The framework for action proposes a dual strategy of intensively supporting ACSM activities in five high-burden countries per year over the next five years, and then sustaining that support throughout the 10-year period of the Global Plan to Stop TB 2006–2015.

This 10-year framework for action is based on the premise that ACSM represents an important means of engaging policy-makers, local government officials, public and private health professionals, traditional and religious leaders, community leaders, patients and their families in bringing about sustainable behavioural and social changes that will in turn contribute to a reduction in TB burden. ACSM also plays a crucial role in expanding the number and range of services for both TB and HIV/AIDS.

This framework draws on and brings together more than four years of discussions on how ACSM programming can contribute to TB prevention and control. While there remain important areas requiring further development, and communication programming has to constantly adapt to changing environments and needs, substantial agreement exists on a TB ACSM strategy within affected countries.

This framework is not a predetermined roadmap that TB-affected countries should follow in implementing communication activities. Instead, the framework offers a series of interrelated components, approaches and tools from which country partners can select.

Strategic vision and goals

6.1 Vision

Our vision is one where all communities at all levels are empowered to remove the threat of TB to human health. By applying ACSM strategies from health-care settings to households, TB patients are supported and treated effectively with dignity and respect. Furthermore, those most affected by TB will be involved in shaping the response.

6.2 Goals

Over the next 10 years, this framework aims to establish and develop country-level ACSM as a core component of TB prevention and treatment efforts. The framework has the following goals:

- to provide guidance for Global Plan to Stop TB 2006–2015 goals and targets as these translate into national ACSM initiatives;
- to foster participatory ACSM planning, management and evaluation capacity at regional, national and subnational levels;
- to support and develop strategies to achieve key behavioural and social changes, depending on local context, that will contribute to sustainable increases in TB case detection and cure rates.

In Section 7.1, different ACSM approaches are summarized and recommended for use in TB control, but these are outlined not as templates for adoption but as options available for in-country programming. The heart of this strategic framework is its focus on building up country-level ASCM capacity so that appropriate, effective, country-led communication strategies can be developed, prioritized and implemented. The bottom line, however, is that many of the tools and methodologies for action exist; the resources now need to follow.

6.3 Strategic objectives and targets

This framework is designed to implement intensive, sustainable and detailed communication strategies in all high-burden countries, as well as support strategies in medium-burden countries over the next 10 years. Such work will be phased to ensure maximum strategic intensity. In the first five years of this workplan, an intensive process of capacity building and strategic planning will take place in all high-burden countries. This will be a phased process, focused on five countries per year.

The following strategic objectives have been identified:

- By 2008, at least 10 endemic countries will have developed and will be implementing multisectoral, participatory ACSM initiatives and generating qualitative and quantitative data on ACSM's contribution to TB control.
- By 2010, at least 20 priority countries will be implementing multisectoral, participatory-based ACSM initiatives, and monitoring and evaluating their outcomes.
- By 2015, multisectoral, participatory ACSM methodologies will be a fully developed component of the Stop TB Strategy.
- By 2015, all priority countries will be implementing effective and participatory ACSM initiatives.

In addition, a series of process targets have been identified:

- By the middle of 2006, a detailed ACSM capacity building implementation plan will have been developed aimed at ensuring the appointment/recruitment of senior-level communication strategists focused explicitly on tackling TB in all high-burden countries. Such a plan will draw heavily on the experience, expertise and insight of NTPs and partners.
- By the end of 2006, a strategy will have been developed with medium-burden countries detailing the communication support necessary (including technical advice, resource materials and other mechanisms) to meet TB targets in those countries.
- By the beginning of 2006, a process will have started to form strategic agreements with international technical support organizations able to offer technical support to countries. By the middle of 2006 at least five of these will have been agreed and implementation begun.

These objectives and targets will be achieved through a mix of five key strategic components.

A five-point framework

This 10-year workplan addresses four key challenges to TB control:

- Improving case detection and treatment adherence
- Combating stigma and discrimination
- Empowering people affected by TB
- Mobilizing political commitment and resources for TB control.

It does so by presenting a framework for action consisting of five components and the methodologies and resources available to implement these components:

1. Building national and subnational ACSM capacity
2. Fostering inclusion of patients and affected communities
3. Ensuring political commitment and accountability
4. Forging country-level ACSM partnerships within the context of NTPs
5. Learning, adapting and building on good ACSM practices and knowledge exange

7.1
Building national and subnational ACSM capacity

In the area of programme planning, most countries have a well-established or improving plan for DOTS expansion, but only rarely is this complemented by a well-developed, technically sound and written plan for communication activities. There is a high demand from within countries for technical assistance in developing appropriate communication tools, training, proposal writing, planning and material's development. There is widespread agreement that a substantial increase in country-level capacity is required if NTPs are to design, develop and implement effective ACSM programming.

To combat capacity shortages at national level, more dedicated and specifically trained communication staff need to be recruited to NTPs and allied programmes who are qualified to plan, implement and evaluate complex large-scale communication interventions; resources need to be made available for this. This framework recommends that:

- all high- and medium-burden countries appoint a national ACSM coordinator and that this person:
  - has a strong understanding of all aspects of ACSM;
  - has strong management skills relevant to ACSM;
  - is capable of engaging, working and reaching populations outside the capital;
  - is normally employed in a dedicated post but in some cases could hold a joint HIV ACSM function in some countries.
- all endemic countries carry out an ACSM needs assessment from which a 10-year ACSM strategy can be developed in partnership with other stakeholders.
- each country needs to have an agreed, prioritized, budgeted ACSM workplan and that budgets are specifically allocated for this work and explicitly built into GFATM proposals.
- regular, structured meetings (at least every two months) need to happen with infected/affected communities and NTP programme.

Capacity building in ACSM must not be viewed as a one-off event. ACSM capacity building needs, as articulated by one expert, "to continue to reach individuals and institutions in all parts of a country; to influence different types of agencies, from ministries and NGOs to advertising agencies; to spread new skills and technologies as they develop; and to teach new cohorts of communication professionals ... [Training] needs to continue, even after other elements of technical assistance may diminish or end" (43). In some circumstances, it may be necessary to establish new country-level organizations specializing in ACSM. Past examples include centres for communication programmes developed by Johns Hopkins University in Bangladesh, Bolivia, the Philippines, Uganda and Zambia.

Based on a 2002 ACSM needs assessment, the major international investment required in this workplan will be multi-year technical service contracts to engage various international and national communication partners to help build sustainable national and subnational capacity in ACSM. These measures are designed to guarantee the provision of high-quality technical assistance required for the strategic planning, implementation, monitoring and evaluation of ACSM.

The main aims of these contracts will be to:

- Improve country partner access to timely and quality-assured technical assistance in agreed priority areas
- Encourage a collaborative approach to the delivery of technical assistance in support of country partner-owned and partner-led ACSM plans
- Assist in the professional development of national institutions as well as national and regional ACSM consultants.

Depending on country requests and resource availabilities, ACSM capacity building will be rolled out, starting with five countries each year between 2006–2008 (Figure 1). NTPs not immediately in receipt of this focused technical assistance will benefit from regional support activities as described below. Technical service contracts will initially last on average no more than three years. Depending on country-level need, however, some contracts may require extension.

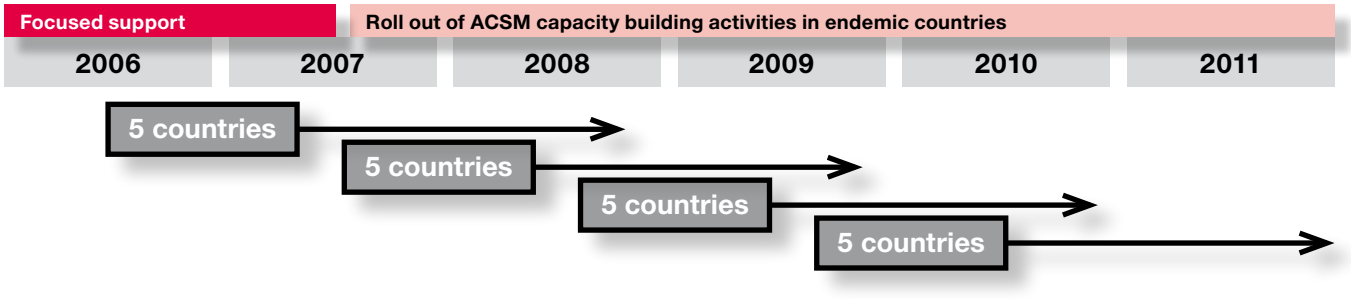
Many international communication partners have already been involved in providing technical support to TB communication-related activities, and others are are well qualified to do so (44).

Regional and national communication partners might include: population media centres; national centres for communication programmes; national social marketing organizations; advertising firms; NGOs, CBOs and patients associations with communication capacity; traditional healers; and health promotion/communication departments within ministries of health.

These contracts will be prepared by the Stop TB Partnership in collaboration with country partners. Contracts will specify capacity building needs, preferred methods of training and support, together with deliverables, milestones, and evaluation requirements. Each three-year technical service contract will be worth around US$ 175 000.

Capacity building activities will benefit from recent advancements in the art and science of ACSM. There is an ever-growing literature on cross-cutting issues such as poverty, gender, stigma and TB-HIV/AIDS policy (45-57). ACSM training pro-

Figure 1: Roll-out of ACSM capacity building activities (example)



grammes, short-courses, and computer-based software have multiplied. Country-level advocacy tools designed for other health issues, particularly HIV/AIDS, could be adapted for TB (58-59). There are several state-of-the-art information databases on ACSM and finally, the range of evaluation methods, indicators and techniques has steadily improved (60).

Several research tools are available for ACSM planning as well as strategic planning tools and models, field guides that provide detailed operational steps and tips to improve strategic plan implementation (see Annex 1). These tools, models and guides all emphasize the need for:

- Adopting evidence-based planning. ACSM interventions need to be based on a nuanced understanding of reasons why different populations are not timely diagnosed or confront difficulties for completing treatment.
- Having a multiple-level understanding of the factors that explain delay in diagnosis and incomplete treatment.
- Identifying ACSM strategies that carefully consider local conditions (political, social, economic, cultural, etc.).
- Conducting regular monitoring and evaluation of activities to provide feedback to plans, adjust interventions, and measure impact.
- Ensuring wide participation from a variety of political and social actors in ACSM activities to promote local ownership and sustainability.
- Combining the use of different strategies and channels to maximize effectiveness.
- Tackling a variety of communication factors that account for delay in diagnosis as well as lack of adherence to full treatment. This includes not only knowledge and awareness issues but also attitudes as well as structural factors. Also, ACSM need to address challenges at different levels and among a variety of actors. For example, stigma needs to be tackled among patients, families and groups, and health workers.

Approaches described in detail in Annex 1 include:

- Johns Hopkins University's **P Process**: lays out a logical framework for a communication intervention—analysis, strategic design, development and testing, implementation and monitoring, and evaluation and re-planning, which has been applied to a wide range of health issues.

- The **Communication-for-Behavioural-Impact** (COMBI) approach developed by the WHO Social Mobilization and Training Team: an approach to mobilize social and personal influences to prompt behavioural change and maintenance at individual and family levels.

- Johns Hopkins University's **Outcome Map** to strengthen the DOTS strategy: a planning tool for matching communication responses to programme needs, and for outlining key planning and measurement indicators. The outcome map retrofits communication interventions on to the well-established but medically-oriented DOTS strategy for TB control. It enhances DOTS to include demand generation for high-quality DOTS services and suggests strategies for encouraging adherence and treatment completion.

- Academy for Educational Development's **Cough to Cure Pathway**: a diagnostic and planning tool to help TB control programmes identify where drop-outs are occurring. It identifies six steps to ideal behaviour in TB control, as well as the most common barriers at the individual, group and systems levels. It is premised on the idea that understanding patients' behaviours is fundamental to designing interventions to strengthen NTPs, including communication interventions.

- The **Communication for Social Change** approach advocated by the Communication for Social Change Consortium: a process of public and private dialogue through which people define who they are, what they need and how to get what they need in order to improve their own lives. It utilizes dialogue that leads to collective problem identification, decision-making and community-based implementation of solutions to development issues. It is communication that supports decision-making by those most affected by the decisions being made and is especially appropriate for strategies where social mores – such as stigma – act as a barrier to behavioural change.

- Proposed by the patient advocacy organization "tbtv", **Positively Empowered Partnerships** are agreements of mutual technical assistance between organizations of people with tuberculosis and/or HIV, and the health

professionals seeking to control the diseases. It promotes the need to research and develop new tools to increase case detection and adherence, and to monitor and evaluate the impact of patient participation; and to provide a structure for facilitating research and studies of patient participation.

ACSM strategies are only successful when they are culturally and context specific. These approaches and tools are presented in Annex 1 as options for deployment, adoption and adaptation by countries and as examples of the technical support that have already been developed in response to country-level requests for ACSM support. Decisions on which strategies and approaches are most appropriate need to be taken at a country level within the context of NTPs.

Based on extensive ACSM capacity building experience gained by UNICEF in the Polio Eradication Initiative, methods of capacity building detailed in each technical service contract might include one or a combination of the following:

- *Mentoring* – one-to-one relationships between ACSM specialists and in-country TB staff (government and nongovernmental).
- *Training* – well-organized opportunities for participants to acquire the necessary understanding and skills to carry out one or more specific tasks. Training may occur in classrooms, on-the-job, via self-instructional materials, or via radio or other communication technology.
- *Networking* – connecting in-country TB staff to professional networks, including regional meetings, e-mail exchange, and joint country missions.
- *Distance consultation and support* – provision of technical assistance from a distance, including transfer of knowledge, provision of feedback and advice, and assistance in accessing information that might otherwise be difficult to obtain.
- *Development and dissemination of support materials* – see Annex 2 for an indicative list of such materials.
- *Strategic addition* of personnel, equipment or supplies to an organization to enhance its performance (61).

At the regional level, the major activities for capacity building proposed by this workplan are ensuring that ACSM expertise is included in DOTS Expansion Working Group monitoring missions and that ACSM specialists and NTP communication staff participate in regional TB meetings. For NTPs yet to be reached by capacity building activities delivered through technical service contracts with communication partners (described above), regional communication workshops will also be held to ensure good practices and lessons learnt are further disseminated. Finally, funding will be required to deploy regional TB strategic communication officers with the primary responsibility of coordinating regional activities and communicating constantly with NTPs to ensure effective global-to-national linkages are maintained. In addition to supporting the Global Plan to Stop TB 2006–2015 ACSM milestones, regional activities will ensure that by 2010, ACSM support is integrated with regional TB control activities. The budget required to accomplish these regional activities over the 10-year period is equivalent to US$ 0.6 million per year.

7.1.1
A handbook for communication programming

A comprehensive handbook providing guidance to country communication programme officers is a critical and increasingly urgent resource if country-level ACSM activities are to be expanded and accelerated.

Such a handbook has already been commissioned, following a bidding process, from the Academy for Educational Development/PATH by the Stop TB Partnership. Progress and production of this handbook needs to be accelerated, and needs to incorporate and describe a range of behavioural and social change methodologies and approaches. The key components of an existing draft handbook on the COMBI methodology (see above) should be incorporated into the overall handbook so that there is one key reference document and resource for country programme officers and planners. The handbook should be updated regularly as new approaches are developed, and this should happen every two years.

7.1.2
Needs assessment tools

Any ACSM planning needs to be rooted in a thorough country-led needs assessment. A needs assessment tool has been developed by the Stop TB Partnership to assist in country-level planning (62).

The Stop TB Partnership has also produced an advocacy and communication checklist, which has been produced to assist in a systematic review of the advocacy and communication component of an NTP (63). The checklist should prove most beneficial to NTPs that have good DOTS coverage but lower than expected numbers of patients presenting for initial TB diagnosis and/or high numbers of defaulters among those who commence TB treatment.

The Partnership has also developed planning guidance, a summary of which can be found in Annex 1.

7.2
Fostering inclusion of patients and affected communities

Strategic activities and specific resource allocation are required to ensure the effective inclusion of patients (TB, TB-HIV, MDR-TB) and affected communities in TB control. Approaches that include patients are not only more ethical: they are also more effective.

Among the steps necessary to support this are:

- The creation of an environment that empowers patients and affected communities to participate effectively in programme design, implementation and monitoring.
- Support for nurturing of TB and TB/HIV patient organizations and networks.
- Piloting and investment in methodologies and tools developed by patients to improve TB control programmes (for example, the methodology of Positively Empowered Partnerships - PEP - as outlined in Annex 1).
- Training programmes for patients to become community TB educators, monitors, and advocates.
- Capacity building for NTP staff at all levels in involving patients in TB programming.
- The development and advocacy of behavioural change strategies targeted at health workers to reduce stigma.
- Operational research to document good and innovative approaches that empower and involve patients and affected communities.
- Employement of patient representative in the Stop TB Secretariat to act as a focal point for action, support and representation.
- Active support strategies to enable patients/those most affected to participate effectively in programme design, implementation and monitoring.

An important focus for ACSM activities in stigma reduction needs to be on health workers, and specific strategies for stigma reduction within the health-care system need to be strengthened, in some cases drawing on the tools outlined here and through other strategies.

7.3
Ensuring political commitment and accountability

Advocacy is necessary at all levels, from the national to the subregional to the local. Advocacy to parliamentarians, ministries and ministers of health and of finance, business leaders, religious leaders, civic and cultural institutions, civil society organizations and other decision-makers are necessary for mobilizing political support and resources at the country level for TB control efforts.

Often equally important are advocacy efforts aimed at local political and other leaders whose support is critical for the successful implementation of TB control programmes. Advocacy efforts need to be sustained and timely. This workplan focuses only on those advocacy efforts made within the framework of NTPs and similar structures.

There are numerous examples of tools and models available for effective advocacy (some of these are listed in Annex 2). To help generate political and financial commitment for effective TB control among decision-makers at the country level, the subgroup will develop a detailed guide on effective advocacy activities that NTPs may adapt and apply to address their identified needs and challenges. This guide will include a wide variety of approaches and activities but is not intended to be an exhaustive list of all advocacy strategies or a detailed prescription for implementation. Rather, the guide will present NTPs with a comprehensive set of effective mechanisms from which they can select based on their specific context, particularly taking into account existing levels of political commitment, health systems, communication environments, government structure, etc.

Tools/strategies might include the following:

- The establishment of formal and informal national partnerships composed of a broad coalition of stakeholders, including representatives from the affected/infected community, academic institutions, donors, private sector, NGOs, media, etc. These partnerships should build upon the experiences and successes of existing national Stop TB partnerships.
- The promotion of TB champions from both within government, specifically in parliament and the ministries of finance and health, and outside government (such as in the private sector). Promotion can take place through a range of activities including policy briefings, field visits, media events, programme reviews, etc.

7.4
Forging country-level ACSM partnerships within the context of NTPs

In most countries the NTPs do not have the resources, knowledge or capacity to develop and carry out ACSM strategies and activities, and are in need of involving other national and local partners. In many countries there are local initiatives and capacity to carry out different components of ACSM. They may not necessarily be focused only on TB, but have experience and knowledge from working and empowering the communities, and have more insight in social and cultural approaches. Creating an enabling environment where all these important stakeholders can participate could strengthen the local and national capacity for ACSM.

The NTP needs to take the lead in forming an all inclusive partnership at national level, where all stakeholders, from both the health sector and other relevant areas, are involved. This should include the affected community, CBOs/NGOs, health authorities and providers – both public and private, faith-based organization, media, etc. Membership should be flexible and open for new stakeholders. The NTP does not necessarily have to continue to be the leading agency of the partnership. It might be one of the other stakeholders that takes the responsibility to coordinate the partnership. In the absence of a national Stop TB Partnership, this coalition might be the initiating force for such an establishment. There is a need to develop a legal and organizational framework in order for national partnerships to function smoothly and effectively.

This partnership should participate actively in the regular planning of the ACSM part of the NTP's strategic and annual workplan. The partnership will be an active driving force in forming strategies, defining activities and in implementation, monitoring and evaluation. Promoting operational research would also be an important task of the partnership to analyse and evaluate activities, document best practices and explore new and/or more innovative strategies and activities.

7.5
Learning, adapting and building on good ACSM practices and knowledge exchange

Many good ACSM practices have already been developed. Some of these are referenced above in the experiences of Mexico, Peru and Viet Nam. These and other experiences suggest there is a common foundation for what constitutes good practice in communication for TB control. The Stop TB Partnership has developed an initial analysis documenting elements of good practice in ACSM programming, which can be found in Annex 1.

A critical strategy to build national and subnational ACSM capacity is to document and share good practice. There is a wealth of good communication practice on TB, much of which resides within large international technical organizations. This workplan proposes mechanisms (described above) to make that knowledge and expertise available to NTPs and other country-level TB control efforts. However, there is also a wealth of experience and knowledge created and generated from within affected countries and communities, much of it unknown beyond those countries and a very small number of practitioners.

Mechanisms now exist for collecting, collating and making available such experiences relatively inexpensively and dynamically. Knowledge exchange facilities work well on other health communication issues, and it is proposed that such a facility be established to capture these lessons on TB control. Examples are provided by the Communication Initiative (www.comminit.com), Health Communication Exchange and HDNet.

"There are great numbers of unfortunate people who have tuberculosis, and many others who may contract the disease. We must let people know that there is help available. My task is to promote the prevention and treatment of TB. I'll be like a bullhorn for the respected professionals at the Stop TB Partnership of WHO. Hopefully, the tandem of CHAIF and the Stop TB Partnership of WHO will change people's lives for the better."

Vladimir Shakhrin,
Lead singer of the Russian rock group CHAIF
Russian Federation's Goodwill Ambassador of the Stop TB Partnership
Global Plan launch, Moscow, 27 January 2006

Monitoring and evaluation

Monitoring and evaluation (M&E) of this framework will occur at several levels. At global level, annual technical reviews will be commissioned to analyse the progress being made in national ACSM capacity building and the contribution and cost-effectiveness of ACSM to the Global Plan to Stop TB 2006–2015 goals and targets. ACSM Working Group and subgroup meeting reports will also be used to track this plan's progress. Frequent international, regional and national meetings will be held to document and disseminate evidence to date, good practices, and lessons learnt. Regular technical advisory missions provided under technical service contracts with highly experienced communication partners will offer many opportunities for NTPs to monitor and supervise national and subnational ACSM activities. Country-level ACSM initiatives will develop their own participatory monitoring and evaluation processes, including appropriate indicators and reporting systems. Finally, existing information systems, methods, indicator banks, and techniques used within and beyond NTPs will be adapted where necessary to strengthen the monitoring and evaluation of this workplan. Rigorously derived evidence of country-level ACSM contribution to TB control should begin to accumulate by the end of 2007.

Annex 3 presents a range of indicator sets and M&E processes to be further developed by individual countries.

Links to other development processes

9.1
The Global Fund to Fight AIDS, Tuberculosis and Malaria

The GFATM, which was created to finance a dramatic turnaround in the fight against HIV/AIDS, TB and malaria, will be one of the principal sources of financing for global TB control efforts. Together, these three diseases kill over 6 million people each year and the numbers are growing. The fund was founded on the following set of principles:

- Operate as a financial instrument, not an implementing entity.
- Make available and leverage additional financial resources.
- Support programmes that reflect national ownership.
- Operate in a balanced manner in terms of different regions, diseases and interventions.
- Pursue an integrated and balanced approach to prevention and treatment.
- Evaluate proposals through independent review processes.
- Establish a simplified, rapid and innovative grant-making process and operate transparently, with accountability (64).

The purpose of the GFATM is to attract, manage and disburse resources to fight AIDS, TB and malaria. It does not implement programmes directly, relying instead on the knowledge of local experts.

As a financing mechanism, the GFATM works closely with other multilateral and bilateral organizations involved in health and development issues to ensure that newly funded programmes are coordinated with existing ones. In many cases, these partners participate in local country coordinating mechanisms (CCMs), providing important technical assistance during the development of proposals and implementation of programmes (65).

The GFATM is committed to relying on existing financial management, monitoring and reporting systems, where possible. The GFATM application does not make specific reference to ACSM activities nor indicate how they should be included as part of a country application. However, there are a number of entry points for countries to consider ACSM as part of their application.

The Stop TB Partnership Secretariat has produced a full outline of the ACSM/GFATM conceptual framework and implementation plan, which illustrates how an ACSM plan could be designed and integrated into a country application for TB control. In addition to the conceptual framework, a detailed list of examples of activities and indicators have been included in this workplan's annexes to illustrate possible ACSM interventions that could be framed to satisfy the reporting requirements of the GFATM. The CCMs should determine the best mix of ACSM activities and indicators.

This workplan recommends that capacity building workshops are conducted to assist CCMs in preparing GFATM applications modelled on successful workshops already facilitated by the Stop TB Partnership.

9.2
Other funding sources

While the GFATM is clearly a critical actor in financing ACSM programmes, many other donors are also able to play this role, and strategies need to be developed to demonstrate to a range of donors the value and impact of ACSM programming. This includes both bilateral donors (such as USAID and DFID) and multilateral organizations (such as the World Bank and the African Development Bank).

"I know how debilitating this disease can be. I contracted TB at the age of 14 and was hospitalized for 20 months. I'm here to witness that TB is a curable and preventable disease. ... Treating patients and saving lives is a moral and ethical imperative. We need you to help, we have a global partnership, a global strategy and a new Global Plan, help us to stop TB!"

Archbishop Desmond Tutu

9.3
National policy processes

Development policy and action are becoming increasingly coordinated as donor spending is focused more on channelling funds through budget support to governments within the framework of nationally agreed comprehensive development frameworks. Poverty reduction strategy papers (PRSPs), for example, originally initiated by the World Bank, have been the most widely used of these frameworks. Such frameworks are designed to be country led, and development priorities are increasingly designed to be shaped by processes driven from within and determined by countries.

For TB in general, and TB ACSM efforts in particular, to be prioritized in national health strategies, both advocacy and effective planning and engagement in PRSPs and similar processes are required at a country level to ensure that national health plans include a focus on TB ACSM.

9.4
HIV/AIDS

TB as a disease is inextricably linked with HIV. In many countries community and national action and activism on TB have been inspired or rooted in HIV/AIDS civil society movements. Health strategies on TB and HIV are increasingly converging. The communication challenges provided by TB are not the same as those provided by HIV, and the behavioural challenges in particular of addressing sexual behaviour and mores pose different challenges to the behavioural challenges set out in this workplan. Nevertheless, a great deal can be learnt from HIV/AIDS communication strategies, in terms of both successes and mistakes, and the key lesson of community involvement in communication programming applies strongly to TB control. Continued communication and lesson learning between these communication communities and strategies is critical. All TB ACSM strategies need to be developed taking into account the strong level of coinfection between the two epidemics, particularly by maximizing ACSM-related dialogue between NTPs and national AIDS control programmes.

The role of the country-level ACSM subgroup

In 2005, the Advocacy, Communication and Social Mobilization Working Group (ACSM WG) was established as the seventh working group of the Stop TB Partnership to mobilize political, social and financial resources; to sustain and expand the global movement to eliminate TB; and to foster the development of more effective ACSM programming at country level in support of TB control. It succeeded an earlier Partnership Task Force on Advocacy and Communications.

There are two subgroups within the ACSM WG – one focused on global advocacy, the other on country-level ACSM. The role of the country-level ACSM subgroup is developing. Some suggestions are outlined below.

10.1
Strategic guidance

The role of the subgroup is to provide strategic guidance on regional and national ACSM activities. It can do this by:

- Providing strategic guidance and frameworks for national and regional ACSM strategies, such as those found in this workplan, and by providing oversight of international technical agreements, progress of key elements of recommendations made in this workplan, the production of key documents (such as an ACSM country-level handbook) and other elements of strategic support;
- Helping to ensure that sufficient, and sufficiently senior, human resources are available at all levels (international and national) to implement and ensure the prioritization of the programmes outlined in this workplan;
- Providing an ongoing forum for discussion and lesson learning on the most effective and appropriate communication strategies and methodologies in supporting TB control efforts;
- Commissioning regular technical reviews of ACSM contribution to the Global Plan to Stop TB 2006–2015 goals and targets based on country-level data and reports, including cost-effectiveness research and tool development;
- Making recommendations to the Stop TB Partnership's Coordinating Board and the Scientific Technical Advisory Group (STAG) on the strategic direction and financing of ACSM activities;
- Acting as a reference point for the whole TB community on ACSM strategies and initiatives;
- Holding regular meetings to monitor progress and ensure targets are met and ACSM is demonstrating its value to meeting the goals and targets set out in Global Plan to Stop TB 2006–2015;
- Monitoring and understanding broader communication and media processes and trends to ensure that ACSM strategies keep pace with rapidly changing media and communication environments.

10.2
Strategic relationships with other working groups

The ACSM WG will implement this framework in close co-ordination with the Stop TB Partnership's other operational working groups (particularly DOTS Expansion, DOTS-Plus for MDR-TB, TB/HIV), NTPs, academic institutions, civil society groups, health sector organizations, and local leadership at the grassroots level, with the aim of expanding access to effective TB treatment for poor, vulnerable and hard-to-reach populations.

Relatively few structured mechanisms exist to ensure communication, interaction and mutual learning between the

ACSM and other Stop TB working groups. It is critical that such mechanisms are created and prioritized. ACSM activities need to support and be integrated into the plans of other working groups, particularly the DOTS Expansion Working Group (DEWG), and there is much to learn from the experience of these working groups in terms of effective communication approaches to TB control.

Similarly, other working groups have made important assumptions about the work of the ACSM working group, and if ACSM activities at the country level are to meet these expectations and assumptions, consistent and structured communication will need to exist between them.

This workplan has sought as much as possible to reflect relevant country-level priorities of other working groups, but this is not a comprehensive audit of expectations from other working groups and such an audit is necessary. In the course of producing this workplan it has been apparent that there is a lack of clarity over the expected contribution of ACSM activities and of gaps in understanding of the methodologies that are proposed to support other working group strategies. A more structured and consistent process is required if the ACSM WG is to be successful in supporting the plans of these other working groups.

This framework recommends that a mutual ACSM focal point be appointed in each of the other working groups to:

- Identify how ACSM can contribute to relevant working group strategies;
- What those groups can contribute to ACSM;
- Foster communication mechanisms across the working groups.

10.3
Regional groups

The communication challenges, communication environments and TB realities are very different in different countries and regions. A global level subgroup focused on ACSM strategies can reflect this diversity only to a certain degree. There is an argument to suggest that regional-level advisory groups could also play a useful role. Such a group has already been convened in Latin America under the auspices of the Pan American Health Organization with support from the Stop TB Partnership Secretariat and facilitated by the Academy for Educational Development. Such groups could provide an effective model for further development and for other regions. It is also recommended that, where strong demand exists from NTPs and other actors, a regional communication coordinator be appointed to coordinate and act as a lesson learning and organizational focal point for regional ACSM interaction.

The budget and its justification

It is now clear that country-level ACSM is fundamental if NTPs are to achieve and maintain TB control targets. National TB control stakeholders, however, will ultimately need to decide what level of funding for ACSM is appropriate given the unique circumstances and the particular status of their TB control programmes. Whatever decisions are made, NTPs need to secure or "quarantine" appropriate and sustainable funds for ACSM in advance rather than have small or sporadic amounts of funding as is currently the norm.

The total estimated budget for global advocacy, country-level communication and mobilization, capacity building, monitoring and evaluation, research, and ACSM Working Group requirements is estimated to be US$ 3.2 billion for the 10-year period. Support for global advocacy equates to 6% of the total budget. Support for country-level communication and social mobilization represents 90% of the total budget. Technical assistance constitutes 1% of the budget, operations research, monitoring and evaluation around 2%, and ACSM WG administrative and networking requirements about 0.6% (Table 1).

It is assumed that funding for the coordination of global and regional strategic planning, technical assistance and evaluation will come from donations to the Stop TB Partnership Secretariat from bilateral donors. The bulk of funding for country-level ACSM activities will come from the GFATM and bilateral sources in the short term and increasingly from national government allocations in the longer term. Partners at country level should also contribute by committing realistic proportions of their budgets to ACSM activities.

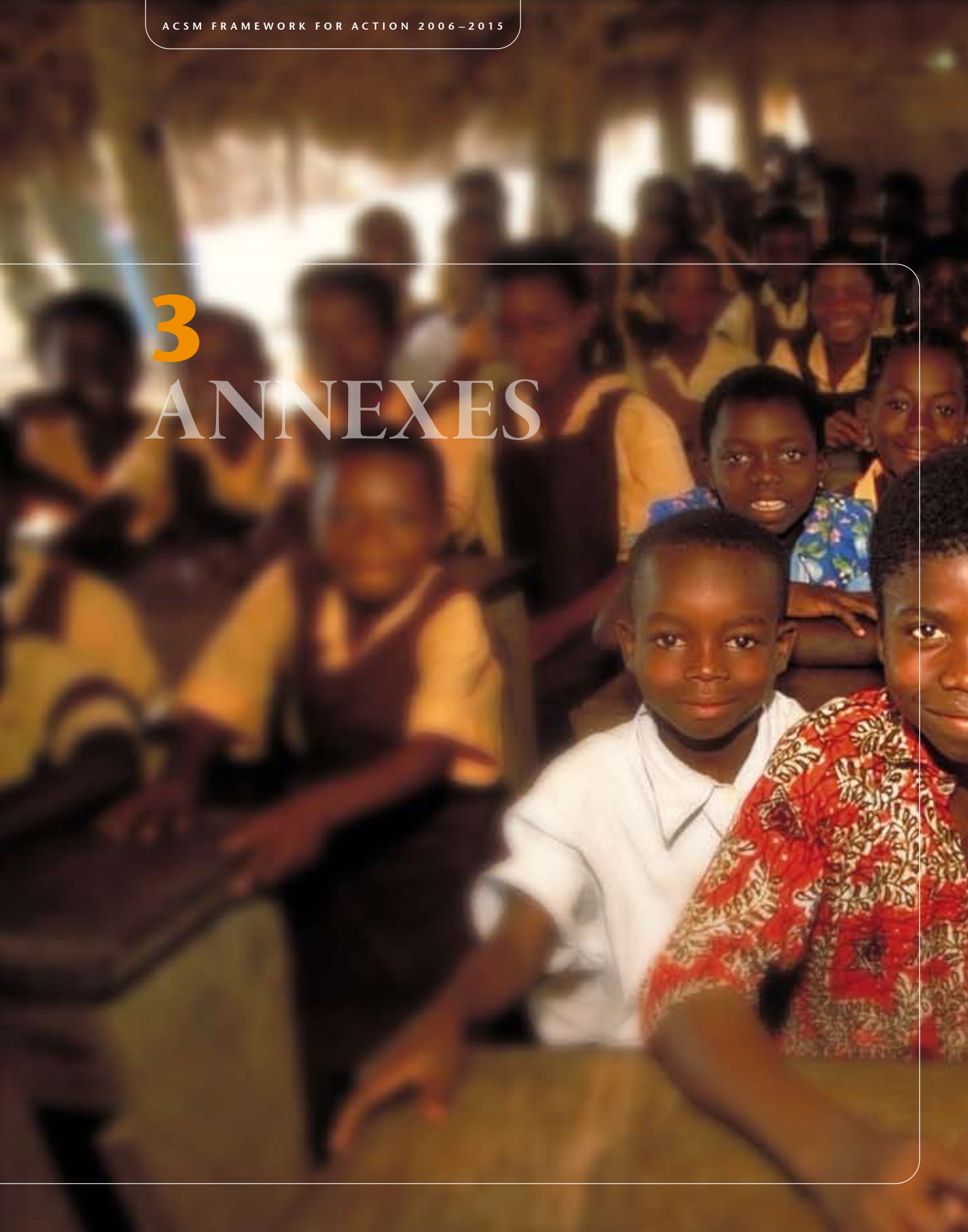
A total of 90% of the required funding is dedicated to supporting in-country ACSM activities. This percentage represents the equivalent of 5–15% of total investments in TB control in particular WHO regions. This percentage scale has been calculated using two benchmarks:

- a careful analysis of the best developed proposals submitted and reviewed by the GFATM;
- extensive experience in other health issues suggesting that an overall 5–15% of total NTPs budget should be allocated to country-level ACSM activities.

Annex 4 examines the budget justification in detail. It offers advice on how to determine ACSM budgets from within the 5–15% range and how to allocate budgets across the strategic mix ACSM.

Strategic plan budget (US$ millions)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	ALL YEARS	% TOTAL
Advocacy	**10.5**	**12.5**	**14.5**	**17.5**	**20.5**	**21.5**	**23.5**	**23.5**	**24.5**	**25.5**	**194**	**6%**
Donor country (66)	1.2		2.4	3.6	5.8	8	9	9	9	9	10	67
Endemic country	.8	1.6	2.4	3.2	4	4	6	6	7	6	41	
Global & regional	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	9	86	
Communication & social mobilization in endemic countries	**242**	**236**	**249**	**257**	**282**	**295**	**308**	**323**	**337**	**353**	**2882**	**90%**
AFRO-high	61	63	66	69	74	78	82	86	91	95	767	24%
AFRO-low	30	31	32	35	37	39	42	44	46	49	386	12%
EEUR	19	20	21	21	22	23	23	24	25	26	224	7%
EMR	33	31	32	33	34	36	38	40	42	44	365	11%
LAC	10	11	11	12	12	13	13	14	14	15	124	4%
SEAR	57	57	59	61	64	67	70	73	76	79	663	21%
WPR	30	23	26	26	38	39	41	42	44	45	353	11%
ACSM WG & TA needs	**11**	**11**	**12**	**14**	**15**	**13**	**13**	**13**	**14**	**14**	**130**	**4%**
Technical assistance and patient empowerment (67)	**2**	**2**	**3**	**4**	**3**	**2**	**2**	**2**	**3**	**3**	**27**	**1%**
Strategic and technical support	0.8	0.8	1.3	1.7	1.4	.9	1.0	1.0	1.0	1.0	11	0%
Capacity building	1.2	1.2	1.9	2.6	2.0	1.4	1.4	1.5	1.5	1.6	16	1%
Monitoring and evaluation	**3**	**3**	**3**	**3**	**4**	**4**	**4**	**4**	**4**	**4**	**37**	**1%**
Impact	0.5	0.5	1.1	1.1	1.1	1.2	1.2	1.2	1.3	1.3	10	0.3%
Planning/ implementation	2	2.1	2.1	2.2	2.3	2.3	2.4	2.5	2.5	2.6	23	0.7%
Financial monitoring	0.2	0.2	0.2	0.2	0.2	0.3	0.5	0.5	0.5	0.5	3.4	0.01%
Operational research and policy development	**5**	**5**	**5**	**5**	**6**	**5**	**5**	**5**	**4**	**4**	**49**	**2%**
Working Group and subgroup operations	**1**	**1**	**1**	**2**	**2**	**2**	**2**	**2**	**3**	**3**	**20**	**0.6%**
TOTAL NEEDS	**263**	**260**	**278**	**291**	**318**	**330**	**345**	**360**	**374**	**391**	**3,208**	



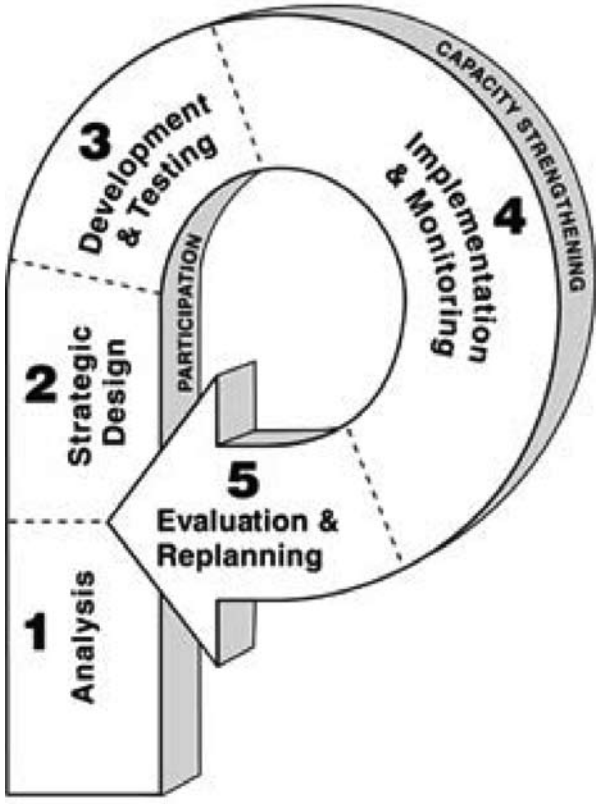
3 ANNEXES

Planning models and approaches

1.
Communication for behavioural change

Perhaps the best known and most widely utilized communication planning tool is the P Process developed by Johns Hopkins University Centre for Communication Programming. The **P Process** is a framework that enables the user how to develop a strategic health communication programme. The P Process lays out a logical framework for a communication intervention—analysis, strategic design, development and testing, implementation and monitoring, and evaluation and re-planning (Figure B). Community participation and capacity building are embedded into each step of the process. It has been applied to a wide range of health issues.

Figure B: The new P-Process, JHUCCP



At every stage of the **P Process**, there are basic principles for strategic communication programmes:

- **Strategic thinking:** Identify communication not as posters and brochures or even television spots and radio dramas, but as a continuous, direct, and major influence on behaviour and policy. Mobilize and deploy the power of communication at all levels to promote and support good health practices.
- **Leadership support:** Build support among national and local leaders continuously, from the initial assessment to the sharing of evaluation results. Enable political, religious, and community leaders to share credit for programme accomplishments.
- **Audience participation:** Encourage your audience to be actively involved at every stage assessing their needs, planning the strategy, carrying out local activities, assisting in monitoring and evaluation, and engaging in advocacy. Develop key messages around the needs of the audience and the benefits for the audience.
- **Interdisciplinary approach:** Work with people from different disciplines and backgrounds, including nurses, marketing professionals, social scientists, auxiliary health personnel, physicians, pharmacists, epidemiologists, anthropologists, and communication specialists throughout the life of the programme to secure the diverse skills and technical expertise needed.
- **Coordination with service providers:** Design communication programmes to identify and reinforce service facilities and to promote access and quality. Encourage and train health-care providers to use or refer to appropriate materials and messages in dealing with clients. Encourage communication experts to highlight the role of good providers.
- **Public-private partnerships:** Build partnerships among government agencies, NGOs, and the commercial sector to reinforce communication programmes and to share materials, messages, training, and other resources. Learn from one another.
- **Multiple channels:** Establish a lead agency and a lead channel to carry the message and reinforce it with other appropriate mass, community, and interpersonal media.

Use media that reach the intended audiences best to achieve the most cost-effective programme.

- **Enter-educate approaches:** Never underestimate the power of entertainment to reach and persuade audiences, especially young people and those who are not health professionals. Develop and adapt entertaining materials for mass media and community distribution.
- **Training and capacity building:** At every step, train individuals and build institutional capabilities to carry out effective programmes. Use educational sessions and on-the-job training to create a critical mass of communication experts.
- **Monitoring and evaluation:** Plan for evaluation from the start to measure changes in the intended audiences and to know whether objectives are achieved. Monitor project outputs regularly and make necessary adjustments. Share findings widely to improve future programmes.
- **Continuity and sustainability:** Plan for continuity from the start with activities that can become sustainable over time. Expand programmes, services, activities, and coalitions as appropriate to build a larger base for advocacy and community support.
- Over 15 years of experience, the **P Process** has been revised to reflect better the needs of the field and improvements in knowledge. The revised **P Process** adds the following new elements to the original formulation:
  - emphasis on national communication strategies and positioning of products, practices, and services;
  - more effective message development using the Seven Cs of Communication (command attention; Cater to the Heart and Head; Clarify the Message; communicate a benefit; create trust; convey a consistent message; call for action);
  - management for results;
  - building a positive organizational climate;
  - theory-based impact evaluation with multiple data sources;
  - and early planning for resource generation and sustainability.

2.
Communication for behavioural impact (COMBI)

Since 2001, the WHO Social Mobilization and Training Team (SMT) has been applying an approach know as COMBI (Communication-for-Behavioural-Impact) in the design and implementation of social mobilization and communication plans for the adoption of healthy behaviours. (68)

COMBI is *social mobilization directed at the task of mobilizing all societal and personal influences on an individual and family to prompt individual and family action* (69). It is a process which strategically blends a variety of communication interventions intended to engage individuals and groups in considering recommended healthy behaviours and to encourage the adoption and maintenance of those behaviours. COMBI incorporates the many lessons of the past 50 years of health education and communication in a behaviour-focused, people-centered strategy. COMBI also draws substantially from the experience of the private sector in consumer communication.

COMBI is an integrated programme made up of five components:

- Public relations/advocacy/administrative mobilization: for putting the particular healthy behaviour on the business sector and administrative/programme management agenda via the mass media – news coverage, talk shows, soap operas, celebrity spokespersons, discussion programmes; meetings/discussions with various categories of government and community leadership, service providers, administrators, business managers; official memoranda; partnership meetings.
- Community mobilization: including use of participatory research, group meetings, partnership sessions, school activities, traditional media, music, song and dance, road shows, community drama, leaflets, posters, pamphlets, videos, home visits.
- Sustained appropriate advertising and promotion: in m-rip fashion – massive, repetitive, intense, persistent – via radio, television, newspapers and other available media, engaging people in reviewing the merits of the recommended behaviour vis-à-vis "cost" of carrying it out.

- Personal selling/interpersonal communication/counselling: involving volunteers, school, children, social development workers, other field staff, at the community level, in homes and particularly at service points, with appropriate informational literature and additional incentives, and allowing for careful listening to people's concerns and addressing them.
- Point-of-service promotion: emphasizing easily accessible and readily available TB diagnosis and treatment.

The COMBI approach assumes a series of steps in how people change their behaviour in response to a message. First, people Hear about TB, its cause and its solution (presenting for a sputum test and taking the drug treatment); then, they become Informed about the disease, its cause and solution. Later, they become Convinced that the solution is worthwhile adopting and decide to do something about their conviction, and take action on the new behaviour. They then await Reconfirmation that their action was a good one and if all is well, they maintain the behaviour (returning for another sputum test if the same TB-like symptoms appear again).

The COMBI approach has already been piloted in several countries, including India and Kenya, and a review has been commissioned by the Stop TB Partnership Secretariat to assess the impact and lessons learned from this experience. A very detailed explanation of the COMBI process, and the thinking it rests on, has been produced by the Stop TB Partnership.

3.
Communication for social change

This workplan has stressed throughout that the communication challenge in tackling TB is not simply a behavioural one, it is also a social one and that communication strategies that focus purely on achieving narrow behavioural outcomes have little chance of succeeding.

Mass education campaigns aimed at changing individual behaviour play an essential role, but experience shows that individual change is hard to sustain unless broader social and community changes also occur. That is, individual behavioural change must be reinforced by shifts in what are considered acceptable beliefs and practices. This can include such things as cultural traditions, commonly shared stories, or how the community members think, behave, talk and act. The term "changes in community norms" are often used to describe such shifts. Communication aimed at achieving social change often needs to complement and be integrated into behavioural change outcomes.

Communication for social change (CFSC) is a process of public and private dialogue through which people define who they are, what they need and how to get what they need in order to improve their own lives. It utilizes dialogue that leads to collective problem identification, decision-making and community-based implementation of solutions to development issues. It is communication that supports decision-making by those most affected by the decisions being made.

CFSC's focus is on the dialogue process through which people are able to remove obstacles and build structures-methods to help them achieve the goals they have outlined and defined. Rather than focusing on persuasion and information dissemination, CFSC promotes dialogue, debate and negotiation from within communities.

CFSC practitioners use a "bottom-up" approach by placing ownership, access, and control of communication directly in the hands of affected communities. This shifts control of media, messages, tools and content of communication from the powerful to the traditionally powerless. Ultimately, using such skills, previously powerless communities can become "self-renewing" – able to manage their own communication processes for their own good.

Similar to other participatory communication approaches, the *process* of CFSC is often more important than the products. CFSC does not attempt to anticipate which media, messages or techniques are better. The participation of social actors, who are in turn communicators, takes places within a process of collective growth that precedes the creation of messages and products such as a radio programme, a video documentary or a pamphlet. Messages and their dissemination are just additional elements of the communication process.

The driving forces of CFSC can be synthesized as follows:

- The societies in which TB has the greatest impact are changing rapidly. The way in which people receive, interpret and

act on information, the way in which they communicate with each other, the way in which they make their voices heard within their own communities and nationally – all these have undergone a profound transformation over the past decade or so. In most high-burden countries, the media has undergone a revolution, with formerly monolithic media structures (capable of disseminating simple messages to much of the population) have given way to much more fragmented media landscapes. Radio, often the most important source of information for poor people, has been particularly transformed, in both its structure and its character. People listen more to talk shows, phone-ins, conversations, and radio is arguably catalysing a renewal of the oral character and richness of many developing country societies. Information and communication technologies, although extremely restricted in their reach, are also contributing to a more horizontal, noisy, and discussion-oriented communication environment. Such an environment makes the simple conveying of messages through mass media more difficult (because there are more channels and people have a greater choice in what they pay attention to) but also provides important new opportunities for health communication programmes. CFSC programmes have particularly sought to adapt communication strategies to these new environments.

- During several decades the same models, messages, formats and techniques were utilized – and still are today – in distinct cultural contexts. The communication process cannot ignore or deny the specificity of each culture and language; rather, it should support them to acquire legitimacy thereby supporting "cultural renewal"(70). Cultural interaction, or the exchanges between languages and cultures, is healthy when it happens within a framework of equity and respect, through critical dialogue, debate of ideas and solidarity.
- Vertical models of communication for development take for granted that poor communities in developing nations lack "knowledge" (71). Access to information generated in industrialized countries is sometimes seen as a "magic bullet". CFSC is cautious of the linear model of transmission of information from a central sender to an individual receiver, and promotes instead a cyclic process of interactions focused on shared knowledge and collective action. CFSC strengthens local knowledge and promotes exchanges in equal terms, learning through dialogue, in a process of mutual growth. CFSC should be empowering, horizontal versus top-down, give a voice to previously unheard members and be biased towards local content and ownership.

In short, CFSC is concerned with culture and tradition, respect towards local knowledge, and dialogue between development specialists and communities. CFSC is about engaging people to want to change, to define the change and required actions, and to carry them out. The goal of CFSC is self-renewing societies.

There are comparatively few examples of CFSC applied to TB control. In Bangladesh, the NGO BRAC is pioneering a new process called Participation, Interaction and Mobilization (the PIM Process). It is aimed at providing a comprehensive approach that locates social empowerment as the critical engine of behavioural change and argues that social empowerment means active community participation by civil societies in disease management by providing help to formal health service providers as well as community health agents. BRAC uses *Shastho shebikas* – key health agents - who have emerged from the community. Through a process catalysed by these health agents, community members participate in *creating awareness,* mobilization, household level visits and stigma reduction through social-interaction, disabling stigma generation and creating a sense of a common goal. It does not replace any agency or approach but utilizes the meaning of partnership. It is good, argues BRAC, for monitoring, social auditing and messages delivery. Ultimately the approach is aimed at transferring ownership and agency of TB disease management from a smaller group of health managers at various levels to include civil society as a whole including various socials groups like youths, household leaders, women, clubs, religious groups, etc.

CFSC has many similarities and complementarities to a community DOTS approach and is particularly appropriate to tackling issues of stigma and community inclusion in DOTS. Any CFSC approach does focus essentially on the communication process, whether through media or at an interpersonal level.

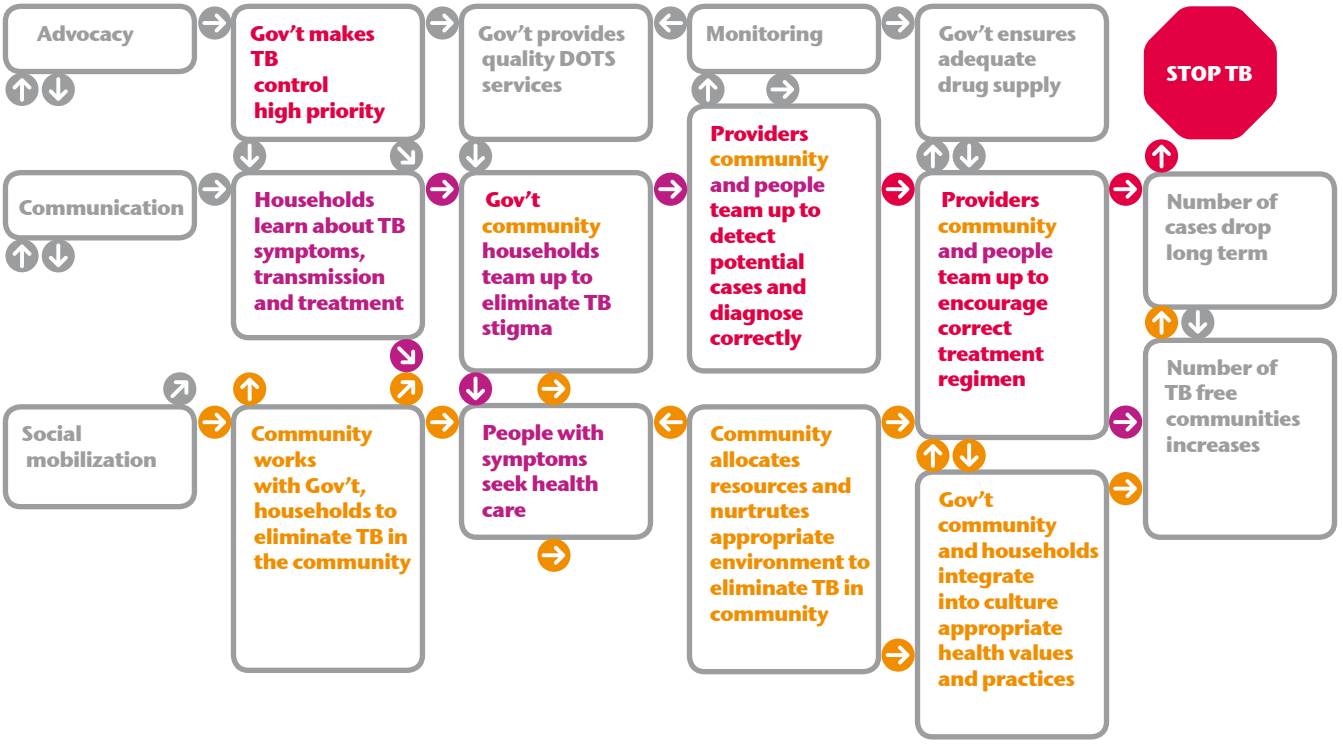
Many of the best examples of CFSC practice are created and driven at a local level. It has been recommended that the Stop TB Partnership have a facility for tracking good practice in all forms of communication for sharing among practitioners and NTPs. This applies particularly to highlighting examples at the community as well as the national level which are often poorly detected.

Diagnostic and planning tools

1.
JHU outcome map to strengthen DOTS

Johns Hopkins University has developed **an outcome map to strengthen the DOTS strategy to Stop TB** (72). This is recommended as a potentially highly effective planning tool for matching communication responses to programme needs, and for outlining key planning and measurement indicators. The outcome map retrofits communication interventions on to the well-established but medically-oriented DOTS strategy for TB control. The model includes suggested activities and performance indicators (Figure C). It does not replace or complicate the DOTS strategy; rather it enhances it to include demand generation for high-quality DOTS services and suggests strategies for encouraging treatment adherence and completion. The model introduces the idea of a "TB-free community," which allows for ownership of the entire strategy at the community level by community members and health-care providers.

Figure C: Extract from JHU outcome map for TB control



2.
The cough to cure pathway

Understanding patients' behaviours is fundamental to design interventions to strengthen NTPs, including communication interventions. Communication interventions need to identify key challenges to control TB among intended populations. To assist in identifying these barriers it is useful to map them out along a preferred behavioural continuum from the first sign of symptoms (cough) to treatment completion (cure). The Academy for Educational Development has developed a diagnostic and planning tool: the ***cough-to-cure pathway*** (Figure D).

The pathway is designed to help NTPs identify where TB drop-outs are occurring, and for each step of the pathway it lists the most common barriers at the individual, group and systems levels. It outlines six steps and identifies the behavioural barriers to people taking these steps at each stage.

- First, to seek timely care;
- Second, to go a DOTS facility;
- Third, to get an accurate diagnosis;
- Fourth, to begin treatment;
- Fifth, to persist in getting treatment;
- Sixth, to complete treatment.

Baseline studies need to be conducted to identify key barriers to completing ideal behaviours. Then, programmes need to weigh the relevance of different barriers in order to prioritize courses of action and the focus of communication interventions.

Figure D: The Cough to cure pathway (AED)

3.
Developing positively empowered partnerships

Proposed by the patient advocacy organization "tbtv", *positively empowered partnerships* (PEP) are envisaged as agreements of mutual technical assistance between organizations of people with TB and/or HIV, and the health professionals seeking to control the diseases. They provide a framework in which innovative collaboration can flourish, and new tools tested and brought to bear. This component's main aims are:

- to research and develop new tools to increase case detection and adherence, and to monitor and evaluate the impact of patient participation;
- to provide a structure for facilitating research and studies of patient participation;
- to develop a leadership training programme of TB "champions", empowering key patients from the community to take responsibility for local initiatives;
- to establish and organize patient "clubs" to play a dynamic role in local TB control, education and advocacy/social mobilization;
- to advocate, on the ground, for the local implementation of the International Standards for Tuberculosis Care (ISTC) and its accompanying Patient's Charter for Tuberculosis Care; and
- to turn words into actions, implemented on the ground, with positive results, evidenced.

Each local PEP initiative would be developed around the leading activities of two "champions", trained and equipped to perform under terms of reference established by the partners. They will be responsible for setting up and overseeing a club or outreach group in their community, and to liaise with local partners and health authorities. During the initial stage, TBTV.ORG will provide the required legal structure through its network of registered studios, as well as communications support (73).

This model has not yet been tested but it is envisaged that the first PEP agreements will be implemented in Cameroon, Democratic Republic of the Congo, Côte d'Ivoire and Kenya, supported through local TBTV studios, registered "in-country" sections of TBTV.ORG. In each community, a form of a "TB club" will be organized to take the lead in research and development.

4.
Stop TB Partnership Secretariat: guidelines for planning ACSM components to the Global Fund proposals

The national TB programme and the Country Coordination Mechanism (CCM) established for the GFATM are two of the central strategic planning frameworks for communication programming. In going forward with planning and implementation, the NTPs and the CCM of the GFATM could consider the following as a step-by-step guide.

1. Using the CCM, create a specific ACSM committee/task force/partnership charged with the planning, implementation and evaluation of all operational and programmatic activities at the national and sub-national level. (Disregard step one if such an entity already exists.)
2. Conduct a systematic needs assessment to determine behavioural goals, target audiences, social-behavioural barriers to treatment seeking or treatment adherence behaviour, identify stakeholders and available resources. Conduct analysis of media viewer-ship, listener-ship and readership trends and habits of segmented audiences.
3. Using the results of the needs assessment, develop a national strategic communication workplan and budget for TB control where behavioural goals, targeted audiences and activities are matched with appropriate coverage and impact indicators. In developing a national strategic communication workplan and budget, efforts should be made to encourage the establishment baseline and change indicators and use of qualitative and quantitative technical and behavioural data in the planning, implementation and evaluation of the overall national strategic workplan.
4. Direct the development of district and/or provincial level ACSM work plans and budgets targeting sustainable behavioural change. Work-plans must evidence-based and results driven. Once approved, workplan budgets should be fully funded.
5. Secure qualified communication focal point(s) in the NTP at national and sub-national levels to coordinate and implement national/sub-national work-plans.

6. Develop, pre-test and produce IEC materials. Implement ACSM activities according to established and approved national and sub-national work plans.
7. Confirm ACSM benchmarks and baselines and incorporate process and impact indicators in district/provincial/national TB reporting formats. Establish tracking mechanisms to review progress on an ongoing basis.
8. Develop and implement a communication capacity/competency-building plan to improve human resource skills and institutional capacity.

5.

Stop TB Partnership Secretariat: elements of good ACSM practice

This is an evolving checklist of initiatives that have been shown to constitute good practice in ACSM programming.

- *Engage NTPs in priority designation.* Insofar as possible, the subgroup will include NTPs as members, and will consult others in identifying country-level priorities and needed tools development. This will include discussion regarding communication and social mobilization programmes, as well as NTP advocacy vis-à-vis the private sector and other actors.
- *Conduct multisectoral participatory planning.* Engage as many pertinent divisions of the Ministry of Health and other ministries as possible. This will mobilize support in the fight against TB and acknowledge the links among vulnerability to TB and other illnesses and exclusion. Such planning would also avoid the development of messages that may clash with other ACSM initiatives, such as those around HIV/AIDS. NGOs addressing populations that are most affected by TB (including patient's organizations) can complement information gathered during assessments, providing needed insight into social mobilization possibilities and communication activity appropriateness as well as community buy-in.
- *Orient the WG as well as country-level ACSM activities towards affected community empowerment.* Programme planning and implementation should explicitly seek to increase health literacy and efficacy and to build governmental and nongovernmental capacity in high-burden communities.
- *Forge linkages among the community, state, and national level.* Create connections among national, state (or provincial) and community-based structures and programmes to expand the scope of TB control efforts and to create a supportive social and political environment. Where they exist, local health committees should play a role in designing locality-specific ACSM programmes.
- *Combat stigma.* Develop or encourage the development of societal-wide initiatives to address misperceptions and stigma associated with TB and HIV. Including TB-affected individuals where feasible would also contribute to affected/infected community empowerment.
- *Develop clear policy messages.* Prototype ACSM messages, materials, images and strategies – concurrent with WHO's TB control policies – are essential to brand, market, and align global, national and local ACSM activities. For example, the establishment of a "universal standard for TB care" for public and private service providers could facilitate commitment to improving the quality of TB services. Aiming for "TB-free communities" could mobilize community involvement and commitment to eradicating TB.
- *Utilize the influence of media.* The media are critical for facilitating policy dialogue, debate and mobilization, and there has been a significant correlation between media visibility and increased funding for the control of infectious diseases. The media can be a powerful partner in country level ACSM activities, as well as in fostering global understanding of the efficacy of ACSM in fighting TB.
- *Establish national TB partnerships.* National TB partnerships can provide the basis for building larger TB ACSM coalitions and, in endemic countries, improve coordination of communication efforts designed to influence health-seeking behaviour, build health literacy, and encourage client-centered care.
- *Engage TB patients and representatives from high-burden communities.* Inclusion is intrinsically important, as it recognizes the moral imperative of including people who are affected/infected. Moreover, it will likely increase the feasibility and appropriateness of planned activities and contribute to the development of health efficacy in communities that are particularly vulnerable to ill health.
- *Foster parliamentarian or congressional champions.* Organizing missions for elected officials to witness first-

hand global TB control efforts significantly increases their (and in turn, political) engagement and commitment.

- *Mainstream TB into larger health and development initiatives*. The WG as well as country-level actors can increase support for country-level ACSM (as well as for TB control overall) by working to include TB in larger development initiatives. Inclusion of TB also provides leverage for NTPs wishing to illustrate the importance of TB control to overall development. Finally, including TB in these plans facilitates cooperation among actors addressing various elements of health status and overall development. Relevant larger development initiatives include, among others, the MDGs and National Millennium Campaigns, PRSPs, future G8 Summits, UNGASS, and the WHO Commission on the Social Determinants of Health which will analyse and advocate on the "causes behind the causes of ill health".
- *Develop ACSM guidelines and handbooks*. These are likely to include assessment and problem definition tools, allowing NTPs and others to identify goals and define gaps in political commitment and communication and social mobilization opportunities. Materials will also include concrete country experiences and tools relating to communication programming, community involvement in health, ACSM human resource development, patient involvement, strategic planning, operational research, monitoring and evaluation and others.
- *Invest in research and development*. Commissioned studies and operational research are needed to document good practices and constantly improve ACSM methodology, particularly at country level. This will build global support for the necessity of ACSM, and will
- *Create a technical assistance framework*. Develop a technical assistance framework among ACSM Working Group members to assist countries with ACSM planning, activities and evaluation.
- *Enhance web and electronic information sharing*. This includes increasing information exchange, discussion and transparency; coordinating the participation of new and existing partners; facilitating long-distance learning; and encouraging cross-fertilization of ideas.

6.
Other tools

There are a wealth of other tools available to ACSM programmers on TB. Country-level advocacy tools such as the AED's PROFILES and the AIDS Impact Model (AIM) from the POLICY project of the Futures Group could be adapted for TB (74-75). There are several state-of-the-art information databases on ACSM including The communication initiative's anthology of health communication materials and the communication for social change consortium's body of knowledge. A more detailed and comprehensive list of resources is contained in annex 2.

Communication materials and resources

There follows a list of resources that may be relevant to communication planners and NTP programme managers. Few of these have been designed explicitly for TB communication, but all are potentially relevant or helpful in compiling a TB communication strategy. They are reproduced here to give an impression of the wealth of materials and resources that are available beyond those already highlighted in this workplan.

Most of these have been compiled by the World AIDS Campaign 2005 and our thanks goes to the campaign for allowing us to reproduce them, and to the Communication Initiative where much of the research in compiling this list was carried out. Additional TB-specific resources have been compiled by Thaddeus Pennas and James Deane. These materials are available on the Stop TB web site at:

www.stoptb.org/wg/advocacy_communication/sgcountrycommunication.asp

STOP TB PARTNERSHIP SECRETARIAT LIST OF ACSM DOCUMENTS, PRODUCTS AND TOOLS

STB advocacy and communication assessment checklist (W. Parks)

ACSM lessons learnt
- Power point: 50 years of development communication (S. Waisbord)
- Guide for treatment supporters (WHO)
- Family tree of development communications theories (S. Waisbord)
- The impact of media-based health education on tb diagnosis (E. Jaramillo)
- Public communication campaign evaluation (part 1-4)

ACSM needs assessment checklist
(Stop TB Partnership Secretariat--T. Pennas)

AED's cough-to-cure pathway (S. Waisbord)

Cancun presentations
- Powerpoint presentations (various presenters)
- Final report (S. Sarkars)

COMBI for TB
- Project outline Kenya (H. Everold)
- Project outline Kerala, India (H. Everold)
- COMBI TB handbook (W. Parks et. al.)

Communication indicators
- Compendium of indicators for monitoring and evaluation for TB control programmes (WHO)
- Developing indicators for social mobilization for TB control (W. Parks)
- Monitoring and evaluation toolkit for gfatm applications

Community-based TB care
- Community based TB care (WHO)

GFATM-ACSM project (Cairo Workshop)
- Framework (T. Pennas)
- Bangladesh (GFATM proposal)
- CCP/JHU–ACSM TB outcomes maps (Cairo Workshop)
- Final report (CCP-JHU)
- GFATM workshop for WHO technical consultants (January 2005)
- Powerpoint slides form Cairo ACSM consultants workshop (various authors)

JHU case studies
- Peru ACSM case studies
- Summary report of Peru and Viet Nam case studies
- Viet Nam ACSM case study

Stop TB Partnership Secretariat strategic communication initiative
- Strategic communication initiative (T. Pennas)
- Operational workplan (T. Pennas)
- Strategic communication initiative for TB year 1 (T. Pennas)

Training workshops
- AMRO Workshop (June 05) (M. Luhan/T. Pennas/S. Waisbord)
- Introduction to advocacy, communication, social mobilization workshop (P. Heitkamp/T. Pennas)
- EURO Moscow (February 05) (M. Berdy M. Luhan/T. Pennas)
- Kenya needs assessment training workshop (September 2004)
  Training workshop (T. Pennas)
- Stop TB Partnership training workshops (Syllabi only)
  Needs assessment (T. Pennas/P. Heitkamp)
  Introduction to ACSM (P. Heitkamp/T. Pennas)

INITIAL PLANNING RESOURCES

Communication programme planning worksheet is a format that systematically breaks down a probable project into sub-components such as identification of partners, identification of problem, target audience, secondary target audience, communication goals and objectives, communication channels, evaluation, etc. This approach was developed by UNICEF.
http://www.comminit.com/planningmodels/pmodels/planningmodels-22.html

Community driven development (CDD) principles is a set of principles to empower people, entrust responsibility and decision-making in their hands, and make institutions more accountable to them. This approach was developed by the World Bank.
http://www.comminit.com/planningmodels/pmodels/planningmodels-108.html

EvaluLEAD framework is an approach to design and understand evaluation of leadership development programmes. It stresses on flexibility in evaluation design while listing two broad types of evaluation approaches, three levels of effects of leadership development intervention outcomes and six domains of outcome elements. This approach was developed by PLP.
http://www.popldr.org/pr/nlpdf/evaluleadframeworkweb.pdf

Future search is an approach that brings diverse people in a community together to reflect on their past, present and future, to express their fears and opinions, to ascertain their common needs and to formulate a path of action. This approach was developed by Future Search.
http://www.futuresearch.net/index.cfm

Involving local individuals and groups is a list of steps to involve local communities and individuals in projects and activities. This could help a better understanding of the needs of a community and assist in garnering the support of the local community.
http://erc.msh.org/mainpage.cfm?file=2.2.10.htm&module=health&language=English

Planning together: how (and how not) to engage stakeholders is a tool that lays down scenarios and caveats (in the form a matrix) to help ensure that participation is meaningful, that it makes proceedings democratic instead of becoming a tool for the powerful.
http://www.community-problem-solving.net/CMS/viewPage.cfm?pageId=200

Population leadership programme (PLP) leadership framework was designed for global health programmes of USAID and draws on theories in transformational leadership to arrive at meanings of leadership, desirables of leadership, and the expectations of leadership.
http://www.popldr.org/leadership/frame1.pdf

A guide to fundraising is a list of steps to help small organisations raise funds for their activities. It is based on the fundraising model developed by Ernie Hayes. This guide is a product of work done by Network Learning.
http://www.networklearning.org/books/fundraising.html

Community problem solving network is an arena that gives people and institutions a platform to facilitate work on a wide array of developmental and social issues. It offers strategy tools, programme tools and a community to interact with.
http://www.community-problem-solving.net/cms/

RESOURCES FOR INITIAL ORGANIZATION

CDCynergy, a multimedia CD-ROM used for planning, managing, and evaluating public health communication programmes, does not regard communication alone as the panacea to public health but places it in the larger context of issues, possible strategic options to choose from and a comprehensive plan to implement an identified strategy. Developed by CDC, it could benefit public health professionals.
http://www.cdc.gov/communication/opportunities/opps_training.htm

COAST is a model of communication that lays great stress on dialogue among stakeholders, brainstorming to identify alternatives, mutual goal and standards setting and through all this building of trust among diverse stakeholders. This tool was developed by Ratzen, Payne, and Massett.
http://www.comminit.com/planningmodels/pmodels/planningmodels-18.html

COAST: a visual model is an illustrated diagram that depicts the linkages among communication, identification of options, dialogue between stakeholders, participatory goal setting and building of trust. It was presented by Scott Ratzen to the CHANGE mini forum.
http://www.comminit.com/planningmodels/pmodels/planningmodels-19.html

Diffusion of innovations is a theory that attempts to explain why and how some innovations/new ideas spread and get accepted while others don't. It lays down some guiding principles for change agents to bear in mind. This theory was adapted and detailed by Everett M. Rogers.
http://www.med.usf.edu/~kmbrown/Diffusion_of_Innovations_Overview.htm

Eleven deadliest sins of knowledge management is a list of pitfalls that can make knowledge redundant or even counterproductive. Enumerated by RYZE Business Networking, this tool could benefit all those involved in managing and transmitting/managing knowledge/information for change.
http://www.ryze.com/postdisplay.php?confid=228&messageid=26826

Health campaigns: stages in planning is an illustrated diagram depicting various stages of planning and conducting a health campaign. It was developed at the National Cancer Institute, USA.
http://www.comminit.com/planningmodels/pmodels/planningmodels-43.html

MARch approach to key features of successful behavioural interventions details the components of a successful strategy to bring about behavioural change. It could thus be a very useful tool for designing communication or other strategies aimed at behavioural change. It was developed by Galavotti et al.
http://www.ajph.org/cgi/content/abstract/91/10/1602

Population leadership programme (PLP) leadership framework was designed for global health programmes of USAID and draws on theories in transformational leadership to arrive at meanings of leadership, desirables of leadership, and the expectations of leadership.
http://www.popldr.org/leadership/frame1.pdf

Project HOPE - seven steps for planning a community initiative is a step-by-step guide to identify problems besetting a community and building the capacity of the community to design and launch an initiative.
http://www.comminit.com/planningmodels/pmodels/planningmodels-71.html

Strategic planning (Veenema) is a tool to enable organizations to define their aims, set their goals, implement planning as a tool for organizational change, etc. In other words it could be used as a tool for introspection by and reorientation of an organization. It was developed by Pearl Veenema, Managing Director of Campaigns University Health Network.
http://www.canadianfundraiser.com/newsletter/article.asp?ArticleID=1404

Techniques and practices for local responses to HIV/AIDS: a UNAIDS toolkit is a set of tools developed by the Royal Tropical Institute (KIT) to help actors involved with HIV/AIDS to learn from experiences around the world. It provides a host of examples that could be adapted to suit local needs as also steps for documenting experiences, techniques and modus operandi.
http://www.kit.nl/frameset.asp?/development/html/publications_db.asp&frnr=1&ItemID=1462

Renewing our voice: code of good practice for NGOs responding to HIV/AIDS is a document that lists a number of issues that organizations working in the area of HIV/AIDS should keep in focus such as protecting and promoting human rights, and applying public health principles in NGO work. This document was Published by The NGO HIV/AIDS Code of Practice Project
http://www.ifrc.org/cgi/pdf_pubs.pl?health/hivaids/NGOCode.pdf

NGO capacity analysis: a toolkit for assessing and building capacities for high quality responses to HIV/AIDS, a toolkit from HIV/AIDS Alliance aims to help funding and technical support organizations to develop capacities and reach of implementing organizations.
http://synkronweb.aidsalliance.org/graphics/secretariat/publications/cat0704_Capacity_analysis_toolkit_eng.pdf

RESOURCES ON MAPPING

CHANGE strategic approach emphasizes the need to understand an issue and its core needs, juxtapose these to available knowledge, tools and models of behaviour change to arrive at new tools to be implemented in the field. It was developed by Academy for Educational Development.
http://www.changeproject.org/

COAST is a model of communication that lays great stress on dialogue among stakeholders, brainstorming to identify alternatives, mutual goal and standards setting and through all this building of trust among diverse stakeholders. It was developed by Ratzen, Payne, and Massett.
http://www.comminit.com/planningmodels/pmodels/planningmodels-18.html

COAST: a visual model is an illustrated diagram that depicts the linkages among communication, identification of options, dialogue between stakeholders, participatory goal setting and building of trust. It was presented by Scott Ratzen to the CHANGE mini forum.
http://www.comminit.com/planningmodels/pmodels/planningmodels-19.html

HIV/AIDS continuum of care is an illustrated diagram depicting the linkages between and synergies that could be drawn from different levels and types of agencies starting from individual and peer groups and going up to specialized tertiary health care. This is documented by WHO/UNAIDS.
url:http://www.unaids.org/publications/documents/care/general/WHOUNAIDSCARE.doc

Project HOPE - seven steps for planning a community initiative is a step-by-step guide to identify problems besetting a community and building the capacity of the community to design and launch an initiative.
http://www.comminit.com/planningmodels/pmodels/planningmodels-71.html

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http://synkronweb.aidsalliance.org/graphics/secretariat/publications/cat0704_Capacity_analysis_toolkit_eng.pdf

RESOURCES FOR PARTICIPATORY PLANNING AND CONCEPTUALIZATION

The "A Frame" for advocacy gives a step by step guide to advocacy approaches. This is for civil society actors and health planners to use when planning advocacy campaigns. It was developed by Johns Hopkins University in partnership with USAID.
http://www.infoforhealth.org/pr/advocacy/index.shtml

Future search is an approach that brings diverse people in a community together to reflect on their past, present and future, to express their fears and opinions, to ascertain their common needs and to formulate a path of action. This approach was developed by Future Search.
http://www.futuresearch.net/index.cfm

Health promotion: Ottawa charter, through an illustrated diagram shows the interlink ages between personal, communal, and governmental action to ensure a healthy life for individuals. This tool is sourced from the Canadian Public Health association.
http://www.comminit.com/planningmodels/pmodels/planningmodels-46.html

Planning together: how (and how not) to engage stakeholders is a tool that lays down scenarios and caveats (in the form a matrix) to help ensure that participation is meaningful, that it makes proceedings democratic instead of becoming a tool for the powerful. It was developed by Community Problem Solving.
http://www.community-problem-olving.net/CMS/viewPage.cfm?pageId=200

Project HOPE - seven steps for planning a community initiative is a step by step guide to identify problems besetting a community and building the capacity of the community to design and launch an initiative.
http://www.comminit.com/planningmodels/pmodels/planningmodels-71.html

Campaigning toolkit for civil society organizations engaged in the Millennium Development Goals is a CIVICUS manual that aims to help civil society organizations involved with the Millennium Development Goals (MDGs) and provides them with a framework to plan a campaign strategy. It touches on MDGs, framework for planning a campaign, toolkit for a campaign and links to support organizations.
http://www.civicus.org/mdg/title.htm

Civil society planning toolkits, developed by CIVICUS, is a set of tools aimed at helping organizations with a variety of issues, starting from writing skills and going on to developing media, handling media, planning, evaluation, financial control and budgeting.
http://www.civicus.org/new/civicus_toolkit_project.asp

Involving the community: a guide to participatory development communication, a book from IDRC aims to instruct researchers and practitioners in ways to design participatory development communication and ways to involve communities.
http://web.idrc.ca/en/ev-52226-201-1-DO_TOPIC.html

AIDS toolkits: HIV/AIDS and community based natural resource management, developed by Development Alternatives Inc and University of Natal is aimed at ministries involved with Natural Resources Management. It throws light on how the ministry and its work are affected by HIV/AIDS and helps identify responses.
http://www.cbnrm.net/pdf/dai_001_aidstoolkit_v2.pdf

RESOURCES ON HOW TO INVOLVE PARTNERS

BEHAVE framework is a behavioural framework tool for planners to achieve maximum effectiveness. It emphasizes the need to place audience at the centre and act to maximize the benefits accruing to audience from an activity and minimize barriers to audience acceptance. It was developed by Academy for Educational Development, this tool could be used by planners and project managers.
http://www.childsurvival.com/documents/workshops/BEHAVE!/BEHAVE1.cfm

Future search is an approach that brings diverse people in a community together to reflect on their past, present and future, to express their fears and opinions, to ascertain their common needs and to formulate a path of action. This approach was developed by Future Search.
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http://erc.msh.org/mainpage.cfm?file=2.2.10.htm&module=health&language=English

Isang Bagsak: planning participatory development communication lays stress on community involvement, from the stage of inception, in a project. It emphasizes the need to build the capacity of community while implementing a project/activity. It presents a schematic diagram, depicting stages in getting involved with a community and implementing a project.
http://www.isangbagsak.org/pages/intro.html

Participatory change: 10 steps in supporting grassroots rural development is a list of ten steps to ensure greater and more meaningful participation of local communities in designing and bringing about social change. This approach combines developments in the fields of community organization, popular education and participatory development. It was developed by Centre for Participatory Change.
http://www.cpcwnc.org/

Planning together: how (and how not) to engage stakeholders is a tool that lays down scenarios and caveats (in the form a matrix) to help ensure that participation is meaningful, that it makes proceedings democratic instead of becoming a tool for the powerful. It was developed by Community Problem Solving.
http://www.community-problem-olving.net/CMS/viewPage.cfm?pageId=200

Project HOPE - seven steps for planning a community initiative is a step-by-step guide to identify problems besetting a community and building the capacity of the community to design and launch an initiative.
http://www.comminit.com/planningmodels/pmodels/planningmodels-71.html

Soul city - developing partnerships is a schematic diagram that stresses the need for people managing edutainment projects/ programmes to develop networks with different stakeholders and resources sources to make edutainment programmes more effective. Central to the concept is the assumption that people managing the projects are in touch with target communities and therefore understand the needs of the community well. This tool has been developed by Soul City.
http://www.soulcity.org.za/

Supporting community engagement in antiretroviral treatment: a participatory tool is a tool that introduces grassroots organizations to HIV/AIDS and antiretroviral (ARV) treatment . It is aimed to provide such organizations with tools and skills that would enable them to help HIV/AIDS patients and their communities by outlining the treatment options available to patients, among other things. This tool has been developed by International HIV/AIDS Alliance.
http://synkronweb.aidsalliance.org/graphics/secretariat/publications/FS01.doc

Techniques and practices for local responses to HIV/AIDS: a UNAIDS toolkit is a set of tools developed by the Royal Tropical Institute (KIT) to help actors involved with HIV/AIDS to learn from experiences around the world. It provides a host of examples that could be adapted to suit local needs as also steps for documenting experiences, techniques and modus operandi.
http://www.kit.nl/frameset.asp?/development/html/publications_db.asp&frnr=1&ItemID=1462

Community problem solving network is an arena that gives people and institutions a platform to facilitate work on a wide array of developmental and social issues. It offers strategy tools, programme tools and a community to interact with.
http://www.community-problem-solving.net/cms/

Involving the community: a guide to participatory development communication, a book from IDRC aims to instruct researchers and practitioners in ways to design participatory development communication and ways to involve communities.
http://web.idrc.ca/en/ev-52226-201-1-DO_TOPIC.html

RESOURCES FOR SELECTING OBJECTIVES

AED's process for building a communications capacity is a detailed flow chart that enumerates steps to match goals and objectives of an organization with its external and internal environment, with the aim to build communications capacity. It was developed by Academy for Education Development.
http://www.comminit.com/planningmodels/pmodels/planningmodels-8.html

Audience participation based message design emphasizes the need to assess the topic of campaign and lifestyle of audience(s) in detail to choose the medium of communication. It lays down steps to set goals and measure impact for future use. It featured in Development Communication Report 79.
http://www.comminit.com/planningmodels/pmodels/planningmodels-10.html

BEHAVE framework is a behavioural framework tool for planners to achieve maximum effectiveness. It emphasizes the need to place audience at the centre and act to maximize the benefits accruing to audience from an activity and minimize barriers to audience acceptance. It was developed by Academy for Educational Development.
http://www.childsurvival.com/documents/workshops/BEHAVE!/BEHAVE1.cfm

CHANGE strategic approach emphasizes the need to understand an issue and its core needs, juxtapose these to available knowledge, tools and models of behaviour change to arrive at new tools to be implemented in the field. It was developed by Academy for Educational Development.
http://www.changeproject.org/

COAST: a visual model is an illustrated diagram that depicts the linkages among communication, identification of options, dialogue between stakeholders, participatory goal setting and building of trust. It was presented by Scott Ratzen to the CHANGE mini forum.
http://www.comminit.com/planningmodels/pmodels/planningmodels-19.html

COMBI design process (CDP) is a series of steps to design COMBI, a strategy for social mobilization that aims to garner all personal and societal influences on individuals and families to encourage them to adopt healthy behaviour and maintain it. COMBI draws on people centered approaches in the fields of health education and communication that aim at changing behaviours of people.
http://www.comminit.com/pdf/Combi4-pager_Nov_14.pdf

Community action in the health field: a general framework by the European Union is a set of reflections on the purpose of aid, the objectives of aid, and the goals and priorities of aid. Though prepared for bilateral aid, it could be built upon and adapted to micro level.
http://www.comminit.com/planningmodels/pmodels/planningmodels-26.html

Community driven development (CDD) principles is a set of principles to empower people, entrust responsibility and decision-making in their hands, and make institutions more accountable to them. It was developed by the World Bank.
http://www.comminit.com/planningmodels/pmodels/planningmodels-108.html

Future search is an approach that brings diverse people in a community together to reflect on their past, present and future, to express their fears and opinions, to ascertain their common needs and to formulate a path of action. This approach was developed by Future Search and could be of help to social workers and health workers.
http://www.futuresearch.net/index.cfm

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http://www.soulcity.org.za/

Strategic planning (Veenema) is a tool to enable organizations to define their aims, set their goals, implement planning as a tool for organizational change, etc. In other words it could be used as a tool for introspection by and reorientation of an organization. It was developed by Pearl Veenema, Managing Director of Campaigns University Health Network
http://www.canadianfundraiser.com/newsletter/article.asp?ArticleID=1404

Community problem solving network is an arena that gives people and institutions a platform to facilitate work on a wide array of developmental and social issues. It offers strategy tools, programme tools and a community to interact with.
http://www.community-problem-solving.net/cms/

RESOURCES FOR DEVELOPING A COMMUNICATION STRATEGY

AED's process for building a communications capacity is a detailed flow chart that enumerates steps to match goals and objectives of an organization with its external and internal environment, with the aim to build communications capacity. It was developed by Academy for Education Development.
http://www.comminit.com/planningmodels/pmodels/planningmodels-8.html

Agents for change is an article on communication strategies and models adopted by Thompson social, a communications group in India, to bring about social change. It was written by Kunal Sinha.
http://www.comminit.com/planningmodels/st2003/thinking-97.html

Audience participation based message design emphasizes the need to assess the topic of campaign and lifestyle of audience(s) in detail to choose the medium of communication. It lays down steps to set goals and measure impact for future use. It featured in Development Communication Report 79.
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http://www.childsurvival.com/documents/workshops/BEHAVE!/BEHAVE1.cfm

CDC's health communication wheel is similar to Audience Participation Based Message Design. It is a step-by-step guide to design, launch and monitor communication strategies. It was developed by Centre for Disease Control, Atlanta.
http://www.comminit.com/planningmodels/pmodels/planningmodels-14.html

CDCynergy, a multimedia CD-ROM used for planning, managing, and evaluating public health communication programmes, does not regard communication alone as the panacea to public health but places it in the larger context of issues, possible strategic options to choose from and a comprehensive plan to implement an identified strategy. It was developed by CDC.
http://www.cdc.gov/communication/opportunities/opps_training.htm

Communication programme planning worksheet is a format that systematically breaks down a probable project into sub-components such as identification of partners, identification of problem, target audience, secondary target audience, communication goals and objectives, communication channels, evaluation, etc. It was developed by UNICEF.
http://www.comminit.com/planningmodels/pmodels/planningmodels-22.html

Consumer based health communication is a communication model that brings together research in the fields of health and consumer behaviour to formulate a communication strategy to bring about desired behavioural change. It featured in Public Health Reports, Nov/Dec 1995, Vol. 110.
http://www.comminit.com/planningmodels/pmodels/planningmodels-32.html

Designing communication strategies: guiding principles is, as the name suggests, guideline for effective communication. It lays stress on adapting communication strategy to local needs and incorporating local content wherever possible. It was elaborated upon by Ricardo Ramirez, The International Support Group.
http://www.comminit.com/majordomo/faocomm/msg00022.html

Health campaigns: stages in planning is an illustrated diagram depicting various stages of planning and conducting a health campaign. It was developed at the National Cancer Institute, USA.
http://www.comminit.com/planningmodels/pmodels/planningmodels-43.html

Health communication: 12 generalizations about organizational factors is a list of factors that could have a bearing on the success or failure of a health communication campaign. It pertains to the organization responsible for the campaign. The list is by Backer and Rogers.
http://www.comminit.com/planningmodels/pmodels/planningmodels-45.html

Health communication strategies is a list of broad categories of strategies that could be adopted to bring about behavioural and social change. Developed by Scott Ratzan, it could be handy for planners, media, and civil society.
http://www.comminit.com/planningmodels/pmodels/planningmodels-44.html

JHU/CCP's communication strategy outline is a schematic diagram for designing a communication strategy. It outlines four important aspects and presents a step-by-step guide for each of these aspects of communication strategy. It was developed by Johns Hopkins Bloomberg School of Public Health/Centre for Communication Programmes.
http://www.jhuccp.org/pubs/fg/02/02.pdf

Seven C's of effective communication is a list of features that make a communication effective and to that extent should be incorporated in any communication strategy. It was developed by JHU/CCP/PCS.
http://www.comminit.com/planningmodels/pmodels/planningmodels-77.html

Social Marketing - A 7-step approach is a tool that attempts to dispel the notion that education/awareness alone can lead to behavioural change. It then lists a set of conditions (each expressed as barrier to change) whose sequential fulfillment could bring about behavioural change. It also stresses the need to research into barriers to change and gives pointers in that direction. It was developed by Social Change Media.
http://www.socialchange.net.au/

Social marketing -implementing is a step-by-step guide to implementing a successful social marketing strategy. It lays stress on detailed research, realistic and objective goal setting and proper profiling of audience and options. It was developed by Community Toolbox.
http://ctb.ku.edu/ADS/generalsearchresults.jsp

USAID diverse communications channels: different benefits and challenges is a schematic diagram that arranges various media alternatives along the parameters of ease of boundary control and the ease of message control.
http://www.comminit.com/planningmodels/pmodels/planningmodels-95.html

A field guide to designing a health communication strategy, a manual designed by JHU/CCP. It lists the essentials of a good strategic communication and lays down steps to designing a strategic communication initiative employing Process of Behaviour Change (PBC) framework.
http://www.jhuccp.org/pubs/fg/02/

Involving the community: a guide to participatory development communication, a book from IDRC aims to instruct in ways to design participatory development communication and ways to involve communities.
http://web.idrc.ca/en/ev-52226-201-1-DO_TOPIC.html

RESOURCES FOR DEVELOPING A WORKPLAN

Audience participation based message design emphasizes the need to assess the topic of campaign and lifestyle of audience(s) in detail to choose the medium of communication. It lays down steps to set goals and measure impact for future use. It featured in Development Communication Report (79).
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http://www.comminit.com/planningmodels/pmodels/planningmodels-26.html

Soul City's guide to 'how to make edutainment work for you' is a model that divides a programme into broad categories of activities such as planning, development, production, marketing, and evaluation and assigns time to be spent on each.
http://www.soulcity.org.za/

Strategic planning (Veenema) is a tool to enable organizations to define their aims, set their goals, implement planning as a tool for organizational change, etc. In other words it could be used as a tool for introspection by and reorientation of an organization. It was developed by Pearl Veenema, Managing Director of Campaigns University Health Network.
http://www.canadianfundraiser.com/newsletter/article.asp?ArticleID=1404

Sustainability focus - ways to incorporate into strategy is a tool that combines strategic analysis and strategic planning to determine funding trends, issues that need to be sustained and ways to make sustainability central to project design, implementation, and monitoring. This tool was developed by Harvard Family Research Project.
http://www.gse.harvard.edu/hfrp/eval/issue23/theory.html

Civil society planning toolkits, developed by CIVICUS, is a set of tools aimed at helping organizations with a variety of issues, starting from writing skills and going on to developing media, handling media, planning, evaluation, financial control and budgeting.
http://www.civicus.org/new/civicus_toolkit_project.asp

RESOURCES FOR CONSULTING A WORKPLAN

Future search is an approach that brings diverse people in a community together to reflect on their past, present and future, to express their fears and opinions, to ascertain their common needs and to formulate a path of action. This approach was developed by Future Search.
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Techniques and practices for local responses to HIV/AIDS: a UNAIDS toolkit is a set of tools developed by the Royal Tropical Institute (KIT) to help actors involved with HIV/AIDS to learn from experiences around the world. It provides a host of examples that could be adapted to suit local needs as also steps for documenting experiences, techniques and modus operandi.
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RESOURCES FOR DEVELOPING CAMPAIGNS

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http://www.cdc.gov/communication/opportunities/opps_training.htm

CHANGE strategic approach emphasizes the need to understand an issue and its core needs, juxtapose these to available knowledge, tools and models of behaviour change to arrive at new tools to be implemented in the field. It was developed by Academy for Educational Development.
http://www.changeproject.org/

Community action framework for youth development is a framework for the development of youth. It aims to proceed by identifying goals/targets for youth, indicators to monitor progress, estimation of resources needed, and changes that a community must initiate to provide support, resources, and a conducive environment to youth. It was developed by Gambone & Associates/ Institute for Research and Reform in Education.
http://irre.org/pdf_files/connell.pdf

Dynamic facilitation is an approach whereby a facilitator does not steer and manage change but allows change to organize itself along a trajectory. This is achieved by enabling people to appreciate what they desire and how they intend to achieve it. It was developed by Jim Rough and Associates, Inc.
http://www.tobe.net/

HEALTHCOM's 5-step methodology is a step-by-step guide to design an effective communication strategy and monitor it.
http://www.comminit.com/planningmodels/pmodels/planningmodels-48.html

HIV/AIDS Continuum of Care is an illustrated diagram depicting the linkages between and synergies that could be drawn from different levels and types of agencies starting from individual and peer groups and going up to specialized tertiary health care. This tool was documented by WHO/UNAIDS.
url:http://www.unaids.org/publications/documents/care/general/WHOUNAIDSCARE.doc

Isang Bagsak: planning participatory development communication lays stress on community involvement, from the stage of inception, in a project. It emphasizes the need to build the capacity of community while implementing a project/activity. It presents a schematic diagram, depicting stages in getting involved with a community and implementing a project.
http://www.isangbagsak.org/pages/intro.html

MARCH approach to key features of successful behavioural interventions details the components of a successful strategy to bring about behavioural change. It could thus be a very useful tool for designing communication or other strategies aimed at behavioural change. It was developed by Galavotti et al.
http://www.ajph.org/cgi/content/abstract/91/10/1602

SCOPE - from JHU/CCP PCS, a computer simulation programme is used for designing an implementing health communication programmes. It uses the P-Process, the five-stage communication planning process of JHU/CCP.
http://www.jhuccp.org/

Social marketing - implementing is a step-by-step guide to implementing a successful social marketing strategy. It lays stress on detailed research, realistic and objective goal setting and proper profiling of audience and options. It was developed by Community Toolbox.
http://ctb.ku.edu/ADS/generalsearchresults.jsp

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http://www.gse.harvard.edu/hfrp/eval/issue23/theory.html

HIV/AIDS NGO/CBO support toolkit, electronic library of resources about NGO/CBO support, accessible on CD-ROM as well as on the website, is a toolkit for people establishing, managing or studying such HIV/AIDS NGO/CBO. It is designed for programmes that deliver funding or technical support to local NGOs. It is a resource from International AIDS Alliance.
http://ngosupport.aidsalliance.org/ngosupport/

RESOURCES FOR MONITORING AND EVALUATION

Communication for social change (2005). Who measures change?: an introduction to participatory monitoring and evaluation of communication for social change.
http://www.communicationforsocialchange.org/

This report is an introduction to establishing a Participatory Monitoring and Evaluation (PM&E) process to assist in the measurement of Communication for Social Change (CFSC) initiatives. It is based on the premise that CFSC practitioners should facilitate the development of Monitoring and Evaluation (M&E) questions, measures and methods with those most affected and involved rather than apply pre-determined objectives, indicators and techniques to measure CFSC on those most affected and involved. The report's primary purpose is to support communication strategies following CFSC principles in HIV/AIDS prevention and care programmes. The information contained in this report, however, may have broader applications. After defining CFSC and the broad purpose of monitoring and evaluation, the report explains why a participatory approach to monitoring and evaluating CFSC is useful. It goes on to discuss key PM&E principles and «moments» or steps in establishing a PM&E process. Two «tools» are offered to help readers to learn more about and discuss: (1) potential monitoring and evaluation questions and indicators; and (2) PM&E data collection techniques. Additional documents on the same site include *Measuring Change*, and *Who Measures Change?*

EvaluLEAD framework is an approach to design and understand evaluation of leadership development programmes. It stresses on flexibility in evaluation design while listing two broad types of evaluation approaches, three levels of effects of leadership development intervention outcomes and six domains of outcome elements. It was developed by PLP.
http://www.popldr.org/pr/nlpdf/evaluleadframeworkweb.pdf

Communication for social change: an integrated model for measuring the process and its outcomes
www.communicationforsocialchange.org

Gender evaluation methodology (GEM) for Internet and ICTs is an approach to evaluate the impact of Information and Communication Technology on the lives of women and gender relations. Developed by the APC Women's Networking Support Programme, it is more than an evaluation tool; it could be used to ensure that gender issues are assimilated in project planning.
url:http://www.apcwomen.org/gem/

Monitoring and evaluation manual for NGOs working in HIV and AIDS is a tool that elaborates on the importance of monitoring and evaluation and offers organizations with guidelines and indicators to design effective and affordable monitoring, evaluation, and reporting systems. The manual was developed by Pact.
http://www.pactworld.org/reach/documents/building_mer_systems.pdf

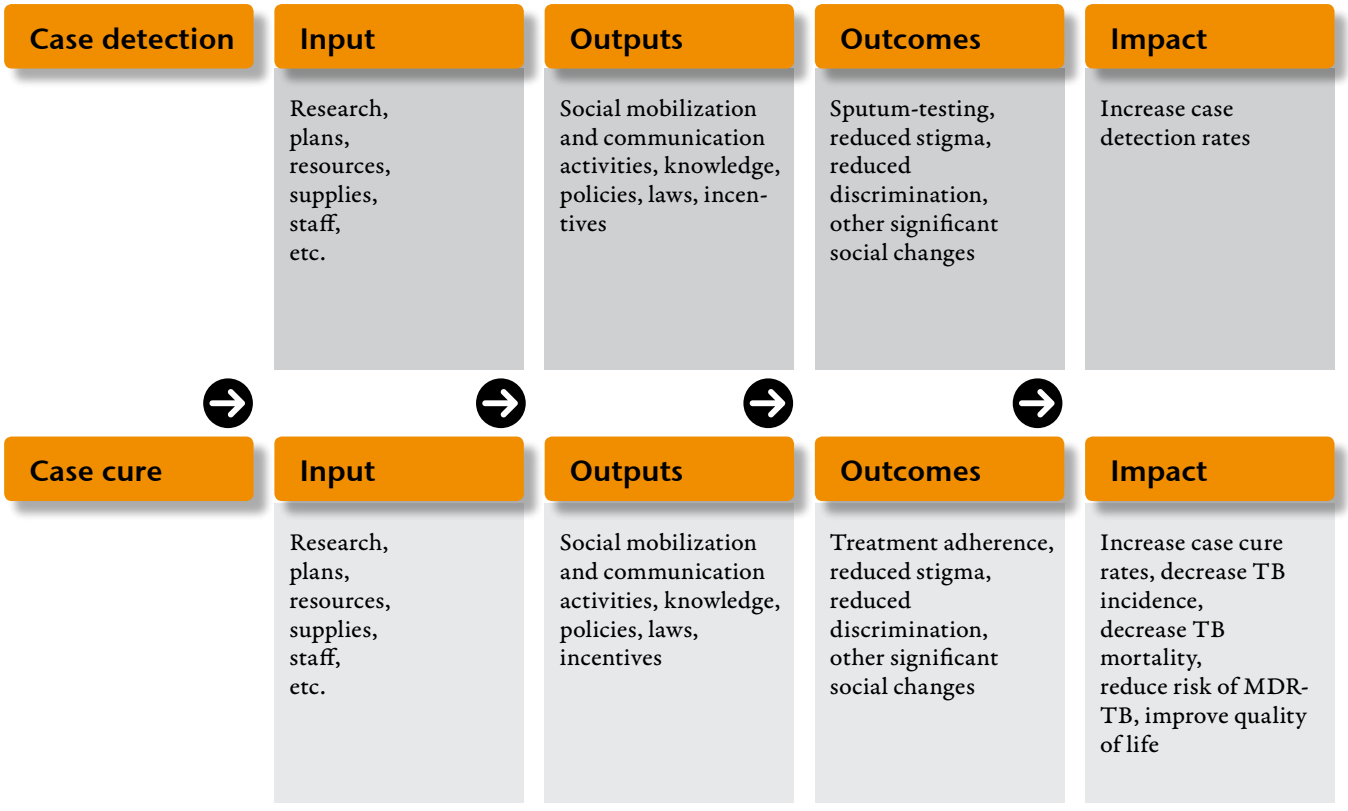
Civil society planning toolkits, developed by CIVICUS, is a set of tools aimed at helping organizations with a variety of issues, starting from writing skills and going on to developing media, handling media, planning, evaluation, financial control and budgeting.
http://www.civicus.org/new/civicus_toolkit_project.asp

Monitoring and evaluation: some tools, methods and approaches, prepared by the World Bank, is a guide to monitoring and evaluation and provides tools, methods, approaches, and other details to monitoring and evaluation.
http://lnweb18.worldbank.org/oed/oeddoclib.nsf/24cc3bb1f94ae11c85256808006a0046/a5efbb5d776b67d285256b1e0079c9a3/$FILE/MandE_tools_methods_approaches.pdf

Monitoring and evaluation toolkit: HIV/AIDS, tuberculosis and malaria is a manual by WHO that targets policy makers and programme managers. It aims to sensitize them to basic concepts and frameworks in monitoring and evaluation, specific indicators for the three diseases, and crosscutting indicators.
http://www.dec.org/pdf_docs/PNACY981.pdf

Monitoring and evaluating ACSM for TB control

The purpose of this annex is to present key sets of indicators and monitoring and evaluation (M&E) processes to assess progress made by NTPs towards two key behavioural goals – stimulating use of DOTS services and assuring treatment adherence. These indicator sets and processes are linked as inputs, outputs, and outcomes contributing to increases in case detection and case cure rates according to following framework (76).



Each indicator set is described in the context of the two main NTP goals: 70% TB case detection and 85% TB case cure. For most indicators, the data requirements are summarized, and reference is made to the instruments required or tool kits already available. These indicators could be included in comprehensive monitoring and evaluation guidelines which could also strengthen in-country M&E systems.

The annex is intended to foster debate and negotiation among TB programme stakeholders about what they envisage will be achieved by ACSM in relation to TB and thus what might be measured. The collection is not intended to be exhaustive but to act as a step in the longer-term process of compiling a more comprehensive set of approaches, indicators and questions. One proviso would be that programme teams only "dip into" this annex when stakeholders are struggling to determine what should be measured. Discussion over the range of frameworks presented here may result in a selection of indicators that supplement locally created measures of dialogue, community communication capacity, and ownership of communication processes.

ASSESSING SOCIAL MOBILIZATION AND COMMUNICATION CAPACITY / inputs

The first indicator set relates to programme capacity to design, implement and evaluate strategic social mobilization and communication plans that stimulate use of DOTS services and assure treatment adherence (the two key behavioural goals). As such, this indicator set can be considered indicative of DOTS service inputs in terms of research, planning, staff, supplies, and resources required to design, implement and evaluate social mobilization and communication activities.

Other indicators (simultaneously measuring advocacy efforts) might include:

- Percentage increase of national budget spent on TB control activities over time.
- Percentage of national budget spent on advocacy, communication, and social mobilization.

N°	Indicator	Calculation	Level	Means of collection
1	% of districts/provinces with designated social mobilization and communication staff with appropriate experience[1λ]	Numerator: # of districts/provinces with designated staff for social mobilization and communication Denominator: Total # of districts/ provincial TB control units [2*]	Provincial District	Interview with sample of Provincial and District TB managers
2	Designated national TB social mobilization and communication manager with appropriate experience	Yes/No	NTP	Interview NTP manager
3	% of districts/provinces with access to social mobilization and communication staff with appropriate experience	Numerator: # of districts/provinces with access to staff for social mobilization and communication Denominator: Total # of districts/provincial TB control units	Provincial District	Interview with sample of Provincial and District TB managers
4	Access at national level to social mobilization and communication staff with appropriate experience	Yes/No	NTP	Interview NTP manager
5	% of districts/provinces with *written* social mobilization and communication plan with clearly stated behavioural goals[3φ]	Numerator: # of districts/provinces with social mobilization and communication plan Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers
6	*Written* national TB social mobilization and communication plan with clearly stated behavioural goals	Yes/No	NTP	Interview NTP manager
7	% of district/provincial plans derived from an in-depth understanding (e.g., via situation market analysis, needs assessment, qualitative research) of current behaviours and actions needed to promote desired behaviours	Numerator: # of districts/provinces with research-based social mobilization and communication plan Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers

N°	Indicator	Calculation	Level	Means of collection
8	National level provides guidelines, training, supervision and funding to encourage sub-national planning and implementation of social mobilization and communication	Yes/No	NTP	Interview NTP manager
9	100% of all relevant levels have active inter-agency committees or teams contributing to the planning and management of social mobilization and communication[4α]	Numerator: # of districts/ provinces with active inter-agency committees contributing to the planning and management of social mobilization and communication Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers
10	National social mobilization plan derived from an in-depth understanding of current behaviours and actions needed to promote desired behaviours	Yes/No	NTP	Interview NTP manager
11	% of district/provincial units that have detailed operational plans for social mobilization as well as more general plans[5π]	Numerator: # of districts/provinces with detailed operational social mobilization and communication plan Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers
12	National programme has detailed operational plan for social mobilization as well as more general plan (if necessary)	Yes/No	NTP	Interview NTP manager
13	% of district/provincial units that regularly review, monitor and update social mobilization and communication plans	Numerator: # of districts/provinces conducting regular reviews of social mobilization and communication plan Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers
14	National programme regularly reviews, monitors and updates the national social mobilization and communication plan	Yes/No	NTP	Interview NTP manager
15	% of all relevant levels with sufficient trained communication personnel to conduct planned activities[6β]	Numerator: # of districts/ provinces with sufficient training communication personnel Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers
16	% of all relevant levels with sufficient communication materials to conduct planned activities	Numerator: # of districts/ provinces with sufficient communication materials Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers
17	% of all relevant levels with sufficient funding to conduct planned activities	Numerator: # of districts/ provinces with sufficient funding for social mobilization and communication activities Denominator: Total # of districts/provincial TB units	Provincial District	Interview with sample of Provincial and District TB managers

ASSESSING DELIVERY OF ACSM ACTIVITIES / outputs

This second set of indicators measures the delivery of the above inputs in terms of social mobilization and communication activities or outputs. Some knowledge indicators are proposed and relate to knowledge that a chronic cough (coughing for 3 weeks) could be a sign of TB, knowledge that sputum-testing is the best way to diagnosis TB, knowledge that sputum-testing is free at DOTS facilities, knowledge of nearest location for free sputum-testing, knowledge that TB is curable, and knowledge that TB-treatment through DOTS is free (see next page).

While these could be considered "outcomes" of ACSM activities, they are included here as outputs because the ultimate measure of ACSM success is whether there is sustainable behavioural and social change. Knowledge change, it was noted earlier, while critical, is not enough.

Other possible indicators to assess examples of ACSM activity include:

Example of ACSM activity	**Possible indicators**
Use of radio, TV, print media as a distance learning tool (Public Service Announcements - PSAs)	# PSAs produced
Point-of-service promotion	# brochures listing location of DOTS centres distributed
Patient information cards	# of cards distributed
Interpersonal communication (IPC) skills development	# of service providers trained in IPC # of service providers trained # of peer educators active
Civil society engagement	# of organizations reached # of organizations active # community-based organizations distributing information # number of community workshops/forums
TB patient activism	# of TB support groups # of workshops for public/private/professional and NGOs a patient-centered care.
Use of radio, TV, print media	# of TV, radio and print programmes produced # of broadcast time or newspaper spaced purchased
Press conferences Journalism trainings and workshops	# press conferences organized # of articles generated # of journalists trained in TB issues
World TB Day promotional materials	# promotional materials distributed
Support or expand national and local networks of advocates and champions	# of organizations reached # of organizations active

No.	Indicator	Calculation	Level	Means of collection
1	% of districts/provinces with established and active monitoring system for social mobilization and communication activities	Numerator: # of districts/provinces with established and active monitoring for social mobilization and communication activities Denominator: Total # of districts/ provincial TB control units	Provincial District	Interview with sample of Provincial and District TB managers
2	% of population who are aware that a chronic cough (coughing for 3 weeks) could be a sign of TB	Numerator: # of people who correctly identify cough that lasts for 3 weeks as possible sign of TB Denominator: Total # of people surveyed	Population	DHS TB Module?
3	% of population who know that sputum-testing is the best way to diagnosis TB	Numerator: # of people who correctly answer that sputum-testing is the best way to diagnosis TB Denominator: Total # of people surveyed	Population	DHS TB Module?
4	% of population who know that sputum-testing is free at DOTS facilities	Numerator: # of people who correctly answer that sputum-testing is free at DOTS facilities Denominator: Total # of people surveyed	Population	DHS TB Module?
5	% of population who know the location of their nearest sputum-testing facility	Numerator: # of people who correctly name the location of their nearest sputum-testing facility Denominator: Total # of people surveyed	Population	DHS TB Module?
6	% of population who know that TB is curable	Numerator: # of people who correctly answer that TB is a curable disease Denominator: Total # of people surveyed	Population	DHS TB Module?
7	% of population who know that TB treatment through DOTS is free	Numerator: # of people who correctly answer that TB treatment through DOTS is free Denominator: Total # of people surveyed	Population	DHS TB Module?

Assessing sputum-testing Outcomes

A suitable combination of indicators already proposed by USAID and WHO for smear diagnosis can be used to measure the behavioural outcome of social mobilization and communication activities in terms of people presenting themselves or family members for sputum-testing. From a social mobilization and communication standpoint (as opposed to a clinical standpoint), behavioural impact is simply the measure of the numbers of people who present at DOTS facilities requesting the TB sputum test. Whether they receive the test or not, and whether the test is accurate or not is **not** a social mobilization and communication issue and requires other indicators!

NTPs could develop their own measures for monitoring behavioural impact. For example, an NTP could establish a base-line measure of the current number of people coming in for the test at a random sample of "sentinel clinics" in the three month period before a social mobilization and communication programme is implemented. The NTP could then monitor the numbers presenting at these sentinel clinics during a defined period (e.g. 1 year) and a final comparative figure can be arrived at the end of the year. The NTP could issue interim reports at 4 months and 8 months into the social mobilization and communication programme.

Assessing treatment adherence Outcomes

A suitable combination of indicators already proposed by USAID and WHO for DOTS (e.g. % of new smear-positive cases cured (cure rate), % of new smear-positive cases who completed treatment (completion rate), proportion of all cases under DOTS following DOT as described in national guidelines, etc.) can be used to measure the behavioural outcome of social mobilization and communication activities in terms of TB-patients complying with treatment. Monitoring smear-conversion from positive to negative smear after the initial 2 – 3 months of treatment is the most effective way to assess that the patient has taken prescribed medications. Indicators that provide relevant data on a sample of treatment "drop-outs" at various levels of the health system (those who are diagnosed smear positive but do not commence treatment or those who are diagnosed smear positive, commence treatment, but do not complete) needs to be considered (e.g. % of new smear positive cases who default, % of new smear positive cases who were transferred to another district.) (77).

This indicator set should also contain an indicator or indicators that measure the establishment and implementation of pro-poor incentive schemes to encourage treatment adherence. For example, **% of districts/provinces that have active pro-poor incentive schemes for TB patients on DOTS**.

"Incentives" given to patients or a patient's family (e.g. donated gifts, free food, small financial investments that accrue interest during the time a patient is on treatment, etc.) to encourage poor or marginalized populations to complete treatment are examples of possible outputs of social mobilization and communication (e.g. persuading private business to donate gifts, arranging for local community groups to provide regular meals for patients, etc.). At the same time, one could consider incentives as a form of input if they are viewed as "resources" a programme provides (but without well-planned social mobilization and communication, these resources could not be generated in the first place). The essential point is the need to recognize incentives as assisting treatment adherence (78).

Assessing stigma and discrimination Outcomes

The efforts being made to expand DOTS services should help to reduce stigma and discrimination and indicators used to measure the progress towards DOTS expansion can act as proxies for reductions in stigma and discrimination.

Nevertheless, strengthening the legal framework to protect the human rights of people with TB (and HIV/AIDS) is also seen as paramount. A human rights framework provides avenues for people who suffer discrimination on the basis of their actual or presumed TB-positive status to have recourse through procedural, institutional and monitoring mechanisms. At national level, these include courts of law, national human rights commission, ombudsmen, law commissions and other administrative tribunals. **Input/output indicators measuring the establishment of these legal institutions could be developed.** Simultaneously, communities need to be empowered to understand and use policy and the law to obtain the care and support they require. **Outcome indica-**

tors measuring use of these legal institutions could be considered.

Policy and legal reform, however, will have limited impact unless supported by values and expectations of a society as a whole. Widespread and enduring changes in social attitudes are required if we are to make headway against TB-related stigma and discrimination. It is thus considered vital to create supportive environments to reduce TB-related stigma through national and community-based social mobilization and communication initiatives to combat fear and misinformation and to increase use of DOTS services. Various indicators proposed in Indicator Set B could be used to measure implementation of social mobilization and communication initiatives directly addressing stigma and discrimination. In addition, indicators could be developed to measure the extent to which social mobilization and communication plans and activities address topics such as TB/HIV, discrimination against female patients, and the professional conduct of private physicians, government health workers, prison staff, and employers.

Indicators to consider in this set might include:

- % of people expressing accepting attitudes towards people with TB, of all people surveyed aged 15-49. This could be based on hypothetical questions about men and women with TB – it reflects what people are prepared to say they feel or would do when confronted with various situations involving people with TB.
- % of formal-sector employers sampled with non-discriminatory policies and non-discriminatory practices in recruitment, advancements and benefits for employees with TB. The indicator should be disaggregated to look separately at company policies and practices.
- % of district/provinces that have established the legal framework to protect the human rights of people with TB.
- % of district/provinces that organize communication activities (e.g. training programmes) to empower communities to understand and use policy and the law to obtain the care and support they require for TB patients.
- % of district/provinces that can show evidence of enforcing current legislation against mandatory TB-testing and testing without consent.
- % of districts/provinces that have set in place codes of ethics and professional conduct for health workers (both government and private) such as confidentiality and mechanisms for their effective implementation at all levels.
- % of national/provincial/district level health worker training curricula that teach codes of ethics and professional conduct as they relate to TB (and HIV/AIDS).
- % of district/provinces providing training and support for existing legal aid institutions, alongside creation of lawyers' collectives specializing in TB-related concerns.

Measuring most significant changes Outcomes

The most significant change (MSC) technique was developed by Rick Davies in Bangladesh in 1994 (79). MSC is a systematic methodology in which all stakeholders in a programme or initiative are involved in deciding the sorts of change to be recorded. MSC is systematic in that the same questions are asked of everyone and resulting stories are rigorously and regularly collected. These stories are then subject to analysis, discussion and selection, verification and documentation.

There are at least four differences between MSC monitoring and conventional monitoring practice:

- MSC focuses on the unexpected – it draws meaning from actual events, rather than being based on indicators.
- Information about unexpected events is documented using text rather than numbers. The stories capture changes in the lives of "beneficiaries", their colleagues and in the character of their participation. The method also helps to identify why change happens.
- Analysis of that information is through the use of explicit value judgments made by stakeholders in a participatory process of review and debate;
- Aggregation of information and analysis takes place through a structured social process.

MSC involves at least three stages (the latest MSC guide describes 10 steps): (1) establish domains of change; (2) set in place a process to collect and review stories of change; and (3) secondary analysis of the stories and monitor the process. M&E teams may move backwards and forwards between each Stage (80).

Stage one: establishing domains of change

This stage of the process involves TB control programme stakeholders identifying the "domains" of change that they think need to be monitored: for example, changes in community communication capacity. The process of identifying the domains of change can be through interviews, group discussions, meetings, workshops, or short questionnaires. For example, in the people's participatory development programme (PPRDP) in the Rajshahi zone of western Bangladesh, the domains of interest decided upon by *shomiti* (association) members working with the Christian Commission for Development in Bangladesh (CCDB) were phrased as follows:

- "Changes in people's lives"
- "Changes in people's participation"
- "Changes in the sustainability of people's institutions and their activities."

Initially field level staff of CCDB were left to interpret what issues (in the stories that they subsequently collected from *shomiti* members) they felt was a change belonging to any one of these categories. One additional type of change was included – *"any other type of change."* The intention was to leave one completely open window through which field level staff could define what was important and report accordingly.

Stage two: collecting and reviewing the stories of change

The next stage involves the collection and review of stories of significant change (according to the defined 'domains' of change that have been nominated in stage one).

Generating stories

Stories are generated by asking a simple question in the following form: "During the last [time period, e.g., month], in your opinion, what do you think was the most significant change that took place in the lives of people participating in [the project/initiative]?"

Answers are usually recorded in two parts. The first part is *descriptive*: what happened, who was involved, where did it happen, when did it happen? The intention should be to gather enough information so that an independent person could visit the area, find the people involved and verify that the event took place as described.

The second part of the answer is *explanatory*. The respondent explains why they thought the change was the most significant out of all the changes that took place in that time period. In particular, what difference did it make already, or will it make in the future?

Collecting and reviewing stories

The stories can be collected by a group of TB program stakeholders. Stories can be collected from diaries, interviews, or group discussions. A series of review fora are then arranged to allow selection of those stories that stakeholders think represent the most significant accounts of change. Story selection may take the form of an iterative voting process, where several rounds of voting occur until consensus is achieved. At the various review fora, participants are required to document which stories they selected and why. This information is then fed back to the original storytellers and wider networks of stakeholders. It is intended that the monitoring system should take the form of a slow but extensive dialogue throughout the networks of TB control programme stakeholders.

Annually, all the stories that have been selected over the year are circulated amongst stakeholders. The stories are accompanied by the criteria that the review fora used in selection.

Stage three: secondary analysis of the stories

In addition to the production of a document containing selected stories and readers' interpretations, the story process itself is monitored and additional analysis is carried out. Jessica Dart reports that monitoring of a 12-month MSC process implemented by agriculture extension staff and diary farmers involved in a statewide dairy extension project in Victoria, Australia, revealed several outcomes beyond the identification of significant changes. For example, extension staff felt that they gained a better understanding of impact and a more fully shared vision between all the project collaborators. Feedback from the project committees suggested that learning also occurred in terms of increased skill in conceptualizing and capturing impact; over the year, the storytellers became better at capturing impact and responding to the suggestions that were provided in the feedback from the story review process.

Based on Dart's insights, the aims of the MSC process applied to TB ASCM monitoring might be to:

- Move towards a better understanding between all NTP stakeholders as to what is occurring for individual programme beneficiaries and groups.
- To explore and share the various values and preferences of NTP stakeholders.
- To gain a clearer understanding (as a group) of what it *is* and *is not* being achieved by ACSM and to clarify what stakeholders are *really* trying to achieve, so that the NTP can move towards what is desirable and move *away* from what is undesirable.

MSC is a valuable way of "dignifying the anecdote" – creating a legitimate space for storytelling and giving these stories validity. MSC has already been applied in developed and less developed economies, in participatory rural development projects, agricultural extension projects, educational settings, and mainstream human services delivery.

Measuring social change communication

Outcomes (81)

Indicator	Questions
Expanded public and private dialogue and debate	What increase has there been in: • Family discussion? • Discussion among friends? • Discussion in community gatherings? • Coverage and discussion in news media? • Problem solving dialogue? • Focus and discussion in entertainment media? • Debate and dialogue in the political process?
Increased accuracy of the information that people share in the dialogue/ debate	• 5 pieces of data over which there is general consensus • 4 different perspectives on the issue. Test the extent to which these are accurately reflected in the locations for dialogue and debate mentioned above among friends, within the family, etc.
Supported the people centrally affected by an issue[s] voicing their perspective in the debate and dialogue	• Which groups in relation to the issue of concern are most disadvantaged? • How were they supported to give voice to their perspective? • What happened?
Increased leadership role by people disadvantaged by the issues of concern	• Who makes the major decisions concerning the priorities and activities of the communication intervention? • How are the people centrally affected by those issues engaged in the decision making process? • What are some specific examples where the involvement of that group has influenced strategic or fine tuning decisions?
Resonates with the major issues of interest to people's everyday interests	• Which were the issues that provided the focus? • To what extent were people energized by these issues? • What actions followed?
Linked people and groups with similar interests who might otherwise not be in contact	• Which groups are involved? • What are their interests? • Have they been linked together? • How does that linking take place? • Is there an alliance? • How does the alliance work?

TB social change indicators Outcomes

Arvind Singhal and Everett Rogers in their important book "Combating AIDS: Communication Strategies in Action" suggested a range of social change indicators associated with HIV/AIDS (82). Adapted to TB, these indicators might be as follows:

- Workplaces in the community implement TB prevention programmes.
- The community initiates home-based care programmes.
- Local health services offer TB testing and counseling.
- Local health services ensure, and provide access to, a TB testing and treatment.
- Local prisons and military establishments institute TB prevention programmes.
- Local schools adopt a TB education curriculum.
- People living with TB or having suffered previously from TB are part of "mainstream" society (employed in regular jobs, working as counselors, etc.).
- Individuals living with TB or having suffered previously from TB are protected by laws designed to uphold their rights.
- The quality of life of those living with TB, and those caring for them, is enhanced.
- Community members openly discuss TB issues in public meetings.
- New community-based programmes are launched to address TB prevention, care, and support.
- New coalitions emerge among community organizations to address TB issues.
- Community members collectively make decisions or pass resolutions to combat TB.
- Grassroots leadership emerges from within the community to tackle TB issues.
- Religious organizations and spiritual leaders are involved in TB prevention and treatment programmes.
- The community engages with the local administration, service delivery organizations, NGOs, and others on TB issues.
- The community's cultural activities (sports, folk media, festivals, celebrations, songs, etc.) engage with TB issues.
- The most vulnerable groups at risk for TB in the community are empowered to take greater control of their external environment.
- Media coverage and media advocacy for TB increases.
- The community becomes TB-competent in terms of prevention and treatment.
- % of TB-free communities increases.
- Multi-sectoral involvement exists at the national level for TB control.

Monitoring and evaluating advocacy Outputs / Outcomes

According to Jennifer Chapman and Amboka Wameyo, the monitoring and evaluation of advocacy and influencing work is highly underdeveloped (83). So too is the ability to monitor or evaluate the role of civil society in bringing about sustainable change through its influencing and advocacy activities. Chapman and Wameyo recently conducted a scoping study to identify and document how various agencies and institutions have approached the assessment of advocacy. The following are two of the approaches to monitoring and evaluating advocacy examined in their study:

- USAID Conceptual Framework.
- Integrated framework on policy, civil society, and political space.

USAID conceptual framework

This framework identifies three different components of a comprehensive advocacy strategy, conceived of as loosely correlated with stages ranging along a continuum, moving from citizen empowerment (transformational), to civil society strengthening (developmental), and concluding with policy influence (instrumental). A long list of indicators for each of these stages can be found in *Advocacy Strategies for Civil Society* (84).

Stage	Questions
Transformational	To what extent are the marginalized or disadvantaged able to challenge the status quo? Are they gaining a sense of their own power, including the capacity to define and prioritize their problems and then acting to address and resolve them?
Developmental	To what extent are citizens able organize themselves collectively to alter the existing relations of power? Are they providing themselves with a lasting institutional capacity to identify, articulate and act on their concerns, interests and aspirations, including the ability to achieve specific and well-defined policy outcomes?
Instrumental	To what extent is a group or are groups able to apply a set of skills and techniques for the purposes of influencing public decision-making

Integrated framework on policy, civil society and political space

Ros David has proposed four dimensions and associated indicators of advocacy work: policy change; strengthening civil society; enlarging democratic space; and supporting people-centre policy making (85).

Dimension of work	Indicators of progress	Indicators of change and longer term impact
1. Policy change e.g. Legislative change Policy change Change in law	• Increased dialogue on an issue • Raised profile of issue • Changed opinion (whose?) • Changed rhetoric (in public/private) • Change in written publications	• Changed policy • Change in legislation • Policy/legislation change implemented • (*and in the very long term*) positive change in people's lives as a result of the policy/legislation change
2. Strengthening civil society by working with: NGOs Movements/networks Community-based organizations Popular organizations Partner organizations	• Change in individual members' skills, capacity, knowledge and effectiveness? • Change in individual civil groups' capacity, organizational skills, effectiveness? • Greater synergy of aims/activities in networks/movements • Change in collaboration, trust or unity of civil society groups	• Increased effectiveness of civil society work • Civil groups active in influencing decision-makers in ways that will benefit poor people
3. Enlarging democratic space or the space in which civil society groups can effectively operate in society	• Greater freedom of expression • Greater acceptance/recognition of civil groups • Existence of fora for civil groups to input into a wider range of decisions • Increased legitimacy of civil society groups	• Increased participation of civil society groups in influencing decisions • Change in accountability and transparency of public institutions
4. Supporting people-centered policy-making	• Greater awareness of individual rights and the power systems that withhold rights • Change in local people's skills, capacity and knowledge to mobilize and advocate on their own behalves	• Improved access to basic rights such as health, housing, water and food

ACSM budget analysis and justification

This workplan's budget has been calculated using two benchmarks:

- a careful analysis of the best developed proposals submitted and reviewed by the Global Fund for AIDS, TB and Malaria.
- extensive experience in other health issues suggesting that an overall 5–15% of total TB control programme efforts should be allocated to country level ACSM activities.

Global Fund application analysis

Applications for ACSM funding for TB that have been produced through extensive country-level consultations such as Ethiopia, Pakistan, Bangladesh, and Kenya offer insights into the specific amounts NTPs are now seeking to ensure the best outcomes for Strategic Communication. Analysis of a sample of these applications suggest that ACSM funding required from GFATM by countries represents between 5–15% of their total NTP annual budgets.

Experience with other health issues

While we should not rush to make direct comparisons between ACSM for TB and ACSM for other health problems, the first point to make is that documentation on ACSM budgets has generally been extremely weak. Referring to cost-effectiveness of ACSM in HIV/AIDS programmes, McKee *et al* (2004:40) note:

One difficulty in establishing cost-effectiveness is the dearth of rigorous research, to date, on either the cost of HIV/AIDS communication interventions or their impact in specific settings. In the absence of exact numbers, planners can, nonetheless, make rough estimates in comparing the relative return on communication through different channels. To move from cost-effectiveness as a concept to a criterion for decision-making in HIV/AIDS programming, it will be necessary for the organizations to fund such work so researchers can refine their methods for measuring cost-effectiveness in relation to communication interventions. With greater efforts in this type of research, we expect in the future to be able to more accurately respond to the question: "How can additional funds be allocated with the greatest effect to achieve and sustain healthy behaviour? (86)

The 2002 ACSM needs assessment highlighted earlier, reported the following:

Current budget breakdowns are extremely difficult to obtain. Specific budgets for advocacy and communications activities are only available for Indonesia and Kenya (Indonesia's budget is requested only and not actually committed). These budgets equate to US$1.5-2.0 allocated to [ACSM] *activities in support of each TB case (2002 estimates for each country). In other HBC, this amount is likely to be significantly less given the stated budgets are for all NTP activities (staff salaries, drugs, laboratory equipment, transport, training, etc.) not just for advocacy and communications. NTP capacity to process external funds has proved problematic in some HBC* (87).

An important point here is the need for better documentation and record-keeping of ACSM budgets – a capacity-building issue.

ACSM budget breakdowns (if available) tend to use such unit costs as US$ per patient, US$ per person at risk, or US$ per head of population reached (88). Measuring the cost-effectiveness of ACSM is especially challenging. ACSM initiatives alone – without an enabling environment of facilities, supplies and personnel – can probably not achieve lasting health behavioural and social changes. Measuring cost-effectiveness must take into account other factors besides ACSM that may have contributed to the observed results (techniques such as Contribution Analysis can help here) (89). For example, an evaluation of a Philippine media campaign to promote contraceptives in 2000-2001 showed a net effect that was about half the crude increase in contraceptive prevalence – a net adjusted increase in modern contraceptive use of 3.6% or 196141 new adopters of modern contraceptive methods after taking account of other factors. Cost-effectiveness of ACSM was calculated at US$2.79 per new acceptor of a modern method (90).

Research on the experience of ACSM initiatives in support of various health programmes (e.g. immunization, family planning, malaria control) show that the scope and intensity of activities, and therefore unit costs, vary according to local

conditions as well as the overall approach chosen for disease control. For example, campaign-intensive interventions (such as polio and measles vaccination campaigns) require short-term, nationwide social mobilization to reach all caretakers a few times per year. TB control, instead, typically requires sustainable and regular communication actions addressed to various populations (e.g. people living in prisons, seasonal migrants, workers in specific economic sectors) who are more likely to contract TB and/or are less likely to get diagnosed and adhere to full treatment.

WHO experiences with ACSM in the prevention and control of communicable diseases such as dengue fever, leprosy, malaria and lymphatic filariasis have shown that ACSM unit costs of between $US0.05 and $10.00 per targeted population per year must be invested in order to bring about and sustain behavioural results. These figures equate approximately to 5-15% of overall disease programme budgets (91, 92, 93, 94).

In sum, experience in other public health programmes suggest NTPs need to commit between 5%–15% of their national TB budget allocation to achieve the best outcomes from ACSM.

Determining ACSM budgets from within the 5–15% range

Selecting % allocation from within the recommended 5-15% range will depend on several parameters including:

- current levels of HIV transmission and associated stigma;
- current levels of TB transmission, burden and associated stigma;
- MDR-TB issues;
- the accessibility and efficiency of decentralized health systems (DOTS services);
- cultural diversity;
- factors influencing treatment-seeking behaviour including local knowledge systems, gender, and therapeutic preferences;
- socioeconomic status of affected populations;
- levels of civil unrest;
- whether TB affects in hard to reach groups (ethnic minorities, mobile populations);
- population distribution;
- population segmentation (whether the programme's focus is on vulnerable groups or the general population); and
- ACSM resource availability including skilled staff, the types of communication channels, and community networks (such as faith-based organizations and other non-government agencies), and the relative costs of mobilizing such resources.

These and other parameters, of course, vary enormously by country and data on specific issues may not be readily available.

In order to determine adequate funding, NTPs need a research-based understanding of the epidemiological, communication and social challenges that justify specific amounts. Although it is impossible to pre-determine levels of funding for all NTPs within the recommended 5%–15%, experience suggests *if* TB/HIV stigma is high, HIV/TB prevalence is high, and other factors present significant challenges to health service delivery, then NTPs should be investing at the upper end of the budget range (towards 15%) for ACSM.

Experience also suggests that if the "absorptive" is initially low (i.e. systems, human resources, infrastructure or ACSM capacity need to be built), then incremental movement should be made as quickly as possible towards 15%. Increased resources (towards the 15% end of the budget range) will also be required when ACSM initiatives are starting up or when intensified efforts are needed (e.g. when a new diagnostic or treatment tool is introduced or MDR-TB is detected).

As ACSM begins to tackle stigma, gender inequality, treatment-seeking behaviour, communication skills of health workers, and so on, so annual NTP budget proportions allocated to ACSM might decrease, but only if there is evidence to suggest Case Detection Rates and Case Cure Rates are reaching required levels and being maintained.

If TB/HIV stigma is low, TB/HIV prevalence is low, and other factors are not presenting significant challenges to health service delivery, *then* NTPs should be investing at the lower end of the budget range (towards 5%) for ACSM.

Of course, as time goes by individual programmes may fluctuate between these two margins depending on evaluation results. Improved documentation of ACSM budgets and increased emphasis on ACSM cost-effectiveness studies will assist in fine-tuning annual budgetary allocations.

Allocating ACSM budgets at country level

Obviously, calculating ACSM budgets on a percentage basis of total TB programming does not account for budget variations that may be necessary for different action areas within the "strategic mix": ACSM activities in any specific country.

Political will at the highest levels is fundamental to have a positive impact on DOTS control targets, appropriate funding for advocacy would depend on the strength of political commitment at both national and local level. For example, substantial funding for advocacy would be needed in countries where TB issues are absent in public and policy agendas, government and partners' support for TB control is low, the national programme is under-funded (compared with other health programmes nationally and other TB control programmes globally), current levels of DOTS expansion are substantially below expected goals, and serious logistical difficulties hamper the functioning of TB clinics. Conversely, less funding for advocacy may be required where political commitment and overall performance indicators are stronger.

Likewise, the level of funding for communication and social mobilization is likely to vary according to epidemiological and social conditions. Communication programmes face tougher challenges where HIV/TB co-infection and HIV rates are high, and multi-drug resistance is extended. Similarly, programmes confront more serious obstacles when high TB stigma strongly deters people from getting tested and disclosing having active TB, knowledge of TB symptoms and risk perception are low, and populations typically seek health care from non-DOTS providers and have long delays to seek assistance at TB clinics.

Also, the task of communication is substantially more difficult in countries where high TB rates are found among migrants and other hard-to-reach populations who, typically, cannot be effectively reached through conventional health systems and communication channels. Additionally, specific demographic issues may also affect the amount of funding for communication. A higher percentage of funds may be needed in countries with a large population, weak large-scale media to reach priority populations, linguistic and ethnic diversity, widespread distrust of health systems, and low quality of health services.

Under these circumstances, experience suggests that a series of regular, multi-level communication activities are needed to reach populations through specific channels and messages. Given the complexity of the issues at stake, typical informational activities that aim to raise awareness would not necessarily deliver expected results. A higher level of funding may be required to properly fund communication activities to deal with a diversity of challenges.

In contrast, less funding on communication may be needed when NTPs face different epidemiological conditions (e.g. low HIV rates concentrated in specific populations), communication indicators (e.g. high awareness about TB symptoms and cure, high risk perception), and social and demographic context (e.g. high degree of cultural homogeneity, limited cross-border population movements). In those circumstances, studies show that basic information campaigns can successfully increase TB case finding and reduce the levels of prejudice against people with TB. For example, a six-week campaign in Cali, Colombia produced an increase of 64% in the number of direct smears processed by the laboratories and an increase of 52% in the number of new cased of positive pulmonary TB with respect to the previous period (95). Unfortunately the results of the campaign were short-lived. These findings have at least two important implications. First, passive case finding is likely to be insufficient strategy to reach the operational targets of diagnostic coverage. Secondly, providing basic information about earliest symptoms of TB and the procedures of diagnosis can increase diagnostic coverage.

Besides advocacy, communication and social mobilization activities, there are other ACSM budget items that NTPs should consider, including: ACSM staff salaries; ACSM planning including formative research; staff training; message and material design, pre-testing and production; ACSM management; and participatory and conventional monitoring and evaluation. Examples of NTP applications to the GFATM provide a clear insight into some of the precise budget lines required for ACSM.

NOTES

λ "Appropriate qualifications" refers to a set of criteria such as: tertiary-level health communications training, field experience in managing communications programmes, etc.

* Definition of unit will depend on country context. Could be individual health centres, clusters of health centres, TB control teams spread out across several centres, etc.

φ Behavioural goal refers to a specific, measurable, appropriate, realistic and timebound statement such as: "To prompt, over the period of a year, approximately 500000 individuals (men, women and children of any age) throughout Bangladesh (but particularly those in rural areas) who have a cough that does not go away after three weeks to come/be taken to one of the 500 designated government health facilities for The Free TB (Sputum) Test." Statements referring to "raising awareness" or "changing knowledge" or "increasing community participation" are **not** precise behavioural goals.

α Active would need to be defined.

π Operational plans detail specific activities, responsibilities, completion/ implementation dates, and budget.

β Sufficient would need to be defined. Primary health-care workers should receive basic training in TB control such as how to recognize the symptoms of TB and refer suspected patients for accurate diagnosis and treatment. In many countries, community leaders and volunteers can also be successfully involved in TB control. Communities can encourage TB patients to go for sputum-testing and to complete treatment.

ENDNOTES

1 Jaramillo, E. (1999) 'Encompassing treatment with prevention: the path for a lasting control of tuberculosis.' Social Science and Medicine, 49: 393-404.

2 Khan, A., Walley, J., Neweel, J. and Imdad, N. (2000) 'Tuberculosis in Pakistan: socio-cultural constraints and opportunities in treatment.' Social Science and Medicine, 50: 247-254.

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