

DRAFT

Stop TB Partnership

**Advocacy and Communications Assessment
of the 22 High Burden Countries**

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Acronyms

ACS	Advocacy and Communications Strategy
ALA	American Lung Association
BCC	Behaviour Change Communications
CDC	Centers for Disease Control and Prevention
CDR	Case Detection Rate
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment Short-course
GATB	Global Alliance for TB Drug Development
GDF	Global Drugs Facility
GFATM	Global Fund for AIDS, TB and Malaria
HBC	High Burden Countries (the 22 high-burden countries accounting for approximately 80% of all new TB cases arising each year)
IEC	Information-Education-Communication
IUATLD	International Union Against Tuberculosis & Lung Disease
MDR-TB	Multidrug-resistant Tuberculosis
NGO	Non-Government Organization
NTP	National Tuberculosis Control Program
STB	Stop TB Partnership
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBCTA	?????
TFCSD	?????

Executive Summary

Background and aims

Tuberculosis (TB) rates are increasing dramatically in many regions of the world due to poverty, rapid population growth, ineffective TB programs and the HIV pandemic. A Global Plan to stop TB was laid out in 2001. The first phase of this plan (2001-2005) aims to: (1) expand the currently available anti-TB strategy – DOTS – so that all people with TB have access to effective diagnosis and treatment; (2) adapt this current strategy to meet emerging challenges of HIV and drug resistance; (3) improve existing tools by developing new diagnostics, new drugs, and new vaccines; and (4) strengthen the Stop TB Partnership (STB) so that proven TB-control strategies are effectively applied.

A cross-cutting Advocacy and Communications Strategy (ACS) has been prepared by STB to help achieve these first phase objectives. A STB Task Force for Advocacy and Communications was established in January 2002 [correct?] to oversee implementation of the ACS. At a Task Force meeting in April 2002, it was recommended that a comprehensive baseline assessment of advocacy and communications for TB control in the 22 high-burden countries (HBC) be undertaken to better inform subsequent activities. The assessment is ongoing but this report summarizes the findings to date.

The aims of this report are to:

1. better inform STB's ACS by assessing current National Tuberculosis Programme (NTP) advocacy and communications capacities and activities in the 22 HBC, and by providing a baseline against which subsequent impact of this Strategy can be progressively measured;
2. begin documentation of national and sub-national advocacy and communications activities leading to identification of best practices;
3. propose a second group of HBC for which STB support for advocacy and communications should be provided (following on from activities initiated in Bangladesh, Kerala State (India), and Kenya); and
4. provide feedback on an assessment tool pilot-tested during a series of key informant interviews with NTP managers and staff.

Methods

Three methods were used in this assessment:

- Rapid desk analysis of HBC TB Control Plans and relevant documents.
- In-depth review of HBC TB Control Plans.
- Key Informant Interviews with National TB Program Teams (from Kenya, South Africa, Cambodia, Indonesia, Philippines, Uganda, United Republic of Tanzania, Myanmar, India, China) as well as regional WHO staff.

Main findings

Written descriptions of advocacy and communications activities and opportunities reported by interviewees and stated in available HBC strategic plans for TB control are provided in Annexes 4-8. The main findings of the 10 in-depth country reviews together with pertinent issues for all 22 HBC are as follows:

1. Current advocacy activities

Six out of the 10 HBC included in the in-depth assessment have established reasonably strong national advocacy mechanisms. Advocacy for TB in Myanmar

UR Tanzania, Uganda and China, are either limited to urban centres or extremely weak, especially at the district level. All 10 HBC program teams 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.

2. Current communications activities

The 10 HBC included in the in-depth assessment varied in terms of the intensity and reach of communications activities currently taking place. All countries, apart from Uganda, celebrated World TB Day 2002 at various levels of society. World TB Day 2002 produced the following reported results: new alliances between government departments and between government and NGOs (Philippines and Myanmar); an increase in awareness amongst the general public (Cambodia and UR Tanzania); and an anecdotal increase in the number of new TB patients presenting for treatment (Kenya). Other countries reported no specific impact resulting from World TB Day 2002. Only Philippines, India, UR Tanzania, and Cambodia reported any communications activities outside World TB Day (that is, of course, excluding the ongoing work of health staff in their consultations with suspected TB patients and patients currently on treatment).

3. NTP capacity to conduct advocacy and communications

Capacity to conduct advocacy and communications activities depends upon a variety of interrelated factors including: (a) having designated managerial staff with appropriate qualifications and experience; (b) having access to appropriate agencies from which technical advice can be regularly sought and to which specialized work can sub-contracted; (c) having a well-researched, strategic plan with a precise behavioural goal by which activities can be properly coordinated, monitored and evaluated; and (d) sufficient financial resources to implement planned activities.

Managerial staff: Of the 10 HBC assessed in-depth, three (Kenya, South Africa and UR Tanzania) report having a designated advocacy and communications manager. Philippines and Myanmar utilize existing institutional capacity. In India, each state has an Information-Education-Communication (IEC) director and at national level has hired an external communications consultant. Uganda has a staff member working part-time on advocacy and communications. Cambodia, Indonesia, and China do not have a designated NTP staff member managing and coordinating advocacy and communications activities. This assessment did not explore the capabilities of designated staff or appointed institutions.

Technical assistance: All 10 HBC included in this assessment had access to Ministry of Health and WHO Regional Public Relations Officers. Only India and South Africa reported contracting private sector agencies to assist with their advocacy and communications activities. Indonesia, Uganda, and UR Tanzania are considering contracts with private sector expertise. Kenya benefits from expertise within the University of Nairobi (though this is not specifically advocacy and communications expertise). Cambodia receives technical advice from Family Health International and the United States Agency for International Development. Philippines, Myanmar, and China report no formal association with private sector expertise in public relations, advocacy, or communications.

Strategic planning: All 22 HBC have prepared a plan to address barriers to expansion of the Directly Observed Treatment Short-course (DOTS) strategy. Few of these plans detail any comprehensive approach to advocacy and communications activities. Of the 10 HBC countries assessed in this baseline, **only** UR Tanzania reported having developed a definitive plan to manage,

monitor and evaluate advocacy and communications activities. Several countries (South Africa, Cambodia, Philippines, Uganda, India, China) reported a plan was being drafted. Of these, only the Philippines' draft plan appeared to contain behavioural goals ("decrease delays in consultation with a health provider" and "increase treatment compliance among patients"). No available plans (draft or otherwise) contain detailed sections on how activities will be monitored and evaluated. Myanmar and Indonesia currently have no written strategic plan (draft or otherwise) for advocacy and communications.

Financial resources: A few HBC have been successful in securing financial support through the Global Fund for AIDS, TB and Malaria (GFATM). Others receive support through the Global Drugs Facility (GDF). A range of donors are actively supporting several NTPs. 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 advocacy and communications 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.

4. Advocacy and communications training and materials development needs

Representatives of each NTP from the 10 HBC selected for this assessment stated they would welcome training on a range of advocacy and communications issues including:

- Planning IEC campaigns
- Generating media coverage
- Spokesperson media training
- Communicating to public officials
- Creating coalitions and partnerships with community groups to impact elected officials
- Production of brochures for general distribution, press kits/press releases, and briefing papers for elected officials.

5. How STB may best help NTP advocacy and communications

Interviews with representatives of each NTP from the 10 HBC selected for this assessment generated a list of seven basic areas for support:

- Technical assistance in strategic advocacy and communications planning
- Technical assistance in strategy development (e.g., message and materials design, target group segmentation, monitoring and evaluation indicators)
- Technical assistance in advocacy and communications training, especially to improve district level capacity
- Technical assistance in proposal writing (e.g., GFATM and GDF applications)
- Assistance in developing in-country media networks
- Ensuring senior government officials are invited to important global meetings
- Financial assistance.

6. Comments on the data collection tool pilot-tested during the baseline assessment

This assessment used a basic set of questions in the form of an interview checklist to determine current NTP advocacy and communications capacity and

activity in the 10 selected HBC (see Annex 3). The checklist is divided into five key areas:

- Current Information-Education-Communication (IEC) activity within the NTP
- NTP capacity to conduct Advocacy and Communications activities
- Advocacy activity within the NTP
- IEC and Advocacy Training and Materials Development
- How the Stop TB Partnership may best help NTP IEC and Advocacy activities.

The key target audiences of the checklist are NTP programme staff and staff within the Ministry of Health identified as having advocacy and communications responsibilities. This 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. An external consultant may use the checklist during a program review or program assessment.

Many times, NTP staff and external consultants using the checklist will have no formal communications training. With this in mind, the checklist contains language that is easy to understand, is as brief as possible, and is similar in format to other checklists used during a standard NTP review.

Recommendations

- IUATLD/TBCTA **[SECOND ACRONYM?]** have been invited to develop tools for conducting an advocacy training needs assessment. **[NEXT PHRASE DEPENDANT ON CURRENT STATUS OF THIS EXERCISE?]** This exercise should proceed as quickly as possible. As part of this activity, specific material/tools will be developed to increase the capacity of TB staff and managers on policy change, budget analysis, general and political advocacy. Findings from this exercise would compliment the baseline established in this report.
- More effort must be made to assess the impact of World TB Day (in terms of specific indicators such as increased case detection rates, increased funding, etc.) given so many resources are dedicated to this exercise.
- NTPs should ensure that the complex, multi-level advocacy and communications activities required to support DOTS expansion is managed by a designated, full-time, well-qualified staff member or team. If required, further in-country assessment should take place of the capabilities of designated staff and institutions.
- More in-country advocacy is required to ensure adequate resources are available to support social mobilization and communication for behavioural impact, especially at sub-national level. NTP's should use local resources as *thoroughly as possible*, and only afterwards seek external resources – first elsewhere in the country, and finally internationally. Capacity building in financial management may be required for managers or teams responsible for implementing TB control at national and especially at sub-national levels.
- NTPs should be actively encouraged to seek support from multinational and national corporations, not just in cash or other resources but in terms of *skills*. These linkages may result in substantial benefits to NTPs as well as serve as a useful public relations exercise for the corporations concerned. Resource groups that are available within country to help plan, develop and implement

advocacy and communication activities need to be identified. These would include media professional, production agencies and other patient organizations, NGOs and professional bodies that could be utilized for advocacy and communication activities. The IUATLD/GATB/TFCSD [LAST ACRONYM?] were invited to identify regional, country level organizations, groups, consultants, resources for developing, planning and implementing advocacy and communications activities. [NEXT PHRASE DEPENDANT ON CURRENT STATUS OF THIS EXERCISE?] This exercise should proceed as quickly as possible. Findings from this activity would compliment the baseline established in this report.

- Comprehensive training programs to build capacity in strategic social mobilization and communications planning, implementation, and monitoring are urgently required. Training should also emphasize evaluation of advocacy and communications strategies:
 - Pre-testing interventions (products, behaviours, messages, and materials) developed for implementation with relevant target audiences.
 - Process evaluation to determine actual level of implementation of interventions.
 - Outcome evaluation to determine immediate effects of interventions.
 - Impact evaluation to assess long-term benefits and sustainability of interventions.

Training programs 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, but may take longer to implement than on-the-job technical assistance.

- More detailed assessment of the current and potential advocacy and communications linkages between NTPs and HIV/AIDS programs in the 22 HBC is required.
- Based on this present assessment, the following HBCs are recommended for STB support to strengthen their advocacy and communications capacities and activities: Cambodia, Indonesia, Myanmar, South Africa, Uganda, and Tanzania.

Immediate next steps for STB

- Establish in-country focal points to keep abreast of advocacy and communications progress, and obtain written plans for advocacy and communications activity from NTP managers.
- Determine ways to provide access to already created TB resource materials.
- Determine ways to coordinate efforts between Stop TB and the NTP, as well as the education departments and media offices within country’s Ministry of Health.
- Develop internal communications protocols so that all work groups can easily exchange information and begin to use the Advocacy and Communications Task Force as a resource.
- Determine ways to provide technical assistance to the partnership in developing evaluation methods for advocacy and communication strategies.
- Assist in planning, conducting, and reporting the field testing of the Advocacy and Communications Assessment Checklist with NTPs.

- Provide technical assistance and consultation on how to use the Advocacy and Communications Assessment Checklist to individuals making country visits.
- Plan and conduct more detailed in-country assessments of advocacy and communications capacity and activity in Cambodia, Indonesia, Myanmar, South Africa, Uganda, and Tanzania as a precursor to further STB support.
- Write a project proposal to support NTP capacity building in advocacy, social mobilization and communication planning, implementation, monitoring and evaluation to be funded by a yet to be determined source.

1. Introduction

Tuberculosis (TB) rates are increasing dramatically in many regions of the world due to poverty, rapid population growth, ineffective TB programs and the HIV pandemic. TB will remain one of the main health concerns in the world for at least the next ten years.

A Global Plan to stop TB was laid out in 2001. The first phase of this plan (2001-2005) aims to: (1) expand the currently available anti-TB strategy – DOTS – so that all people with TB have access to effective diagnosis and treatment;¹ (2) adapt this current strategy to meet emerging challenges of HIV and drug resistance; (3) improve existing tools by developing new diagnostics, new drugs, and new vaccines; and (4) strengthen the Stop TB Partnership (STB) so that proven TB-control strategies are effectively applied.²

The 2005 targets for global TB control ratified by the World Health Assembly are to:

1. Successfully treat 85% of smear-positive TB cases.
2. Detect 70% of all smear-positive cases.

The rate of case finding between 1999 and 2000 was no faster than the average since 1994, with a mean annual increase of 133,000 smear-positive cases. At this rate of progress, the target of 70% case detection under the Directly Observed Treatment Short-course regimen (DOTS) will not be reached until 2013.³ This means that globally, national TB programs using the DOTS strategy must recruit an extra 330,000 smear-positive patients each year to reach 70% case detection by 2005.

A cross-cutting **Advocacy and Communications Strategy** (ACS) has been prepared by STB to help achieve the first phase objectives of the Global Plan. A Task Force for Advocacy and Communications was established in January 2002 **[correct??]** to oversee implementation of the ACS. The ACS consists of three main components:

- **Community mobilization**, required to detect 70% of all infectious TB cases' (nearly three times as many as currently detected). This mobilization will reduce stigma associated with the disease and promote healthy behaviour.
- **Private sector partnerships** to provide a means of building greater and more sustainable support for the eventual global elimination of TB. These partnerships will expand and diversify capacities for research, service delivery, community mobilization and advocacy, and are of vital importance in developing new tools and meeting the challenges of TB/HIV co-infection and multidrug-resistant TB (MDR-TB).
- **Global advocacy**, required to ensure significant increases in political commitment and financial support for achieving the global targets for DOTS expansion. Global advocacy is also needed to increase commitment for the development of improved TB diagnostics, drugs and vaccines. Global advocacy will create the political accountability and social pressure required to help attract over \$4 billion in new funding for TB control by 2005.

¹ The DOTS strategy comprises five elements: political commitment and resources, microscopy, treatment, medicines, and monitoring.

² WHO (2001) *The Global Plan to Stop Tuberculosis*. Geneva: World Health Organization, WHO/CDS/STB/2001.16.

³ WHO (2002) *Global Tuberculosis Control: Surveillance, Planning, Financing*. Geneva: World Health Organization. WHO/CDS/TB/2002.295

Four priority advocacy and communications activities within the **community mobilization component** of the ACS were discussed at the second Task Force for Advocacy and Communications meeting held in Newark, New Jersey (USA) on 25-26 April, 2002 (Annex 1). The activities are as follows:

1. Mobilizing local communities
2. Promoting healthy behaviour
3. Mobilizing patients
4. Providing training to health officials.

Specific objectives and targets related to these activities are listed in Table 1. The budget to achieve these targets has been estimated at US\$6,010,000.

Table 1: Objectives and targets for Stop TB Community Mobilization in the 22 high-burden countries

Objectives	Targets
<ul style="list-style-type: none"> • Develop health promotion and health behaviour best practices in each of the 22 high burden countries (HBC) to permit the detection of 70% of symptomatic TB cases in DOTS by 2005. • Encourage community ownership and people's participation in demanding, developing and providing DOTS services where currently none are offered. • Enable TB patients and health care workers to be influential voices in promoting TB control in each high burden country, helping to reduce stigma associated with the disease. 	<p>2002 Develop Communications for Behavioural Impact (COMBI) plans for each high burden country.</p> <p>2004 Create TB patient organizations (PROFIT Networks) in each HBC by 2004, involving them in national TB control planning in most HBCs.</p> <p>2005 Establish Community TB Watch groups in 100 districts not currently providing DOTS services.</p> <p>2005 Equip 700 leading health officials with advocacy and communications skills.</p>

2. Aims of this report

At the Newark meeting, it was recommended that a comprehensive baseline assessment of advocacy and communications for TB control in the 22 high-burden countries (HBC) be undertaken to better inform subsequent activities. The assessment is ongoing but this report summarizes the findings to date. This report concentrates on issues relevant to the advancement of national TB advocacy and communications in HBC. It does not comment on specific technical issues relating to DOTS planning, management, and delivery (e.g., drug supplies, training, supervision, record keeping, microscopy, use of community-based workers, etc.).

The aims of the report are:

1. better inform STB's ACS by assessing current National Tuberculosis Programme (NTP) advocacy and communications capacities and activities in the 22 HBC, and by providing a baseline against which subsequent impact of this Strategy can be progressively measured;
2. begin documentation of national and sub-national advocacy and communication activities leading to identification of best practices;
3. propose a second group of HBC for which STB support for advocacy and communications should be provided (following on from Bangladesh, Kerala State (India), and Kenya); and
4. provide feedback on an assessment tool pilot-tested during a series of key informant interviews with NTP managers and staff.

3. Methods

Three main methods were used in this baseline assessment:

3.1. Rapid Analysis of HBC TB Control Plans

Completed before the Newark meeting, a matrix profiling the 22 HBCs was developed looking at the parameters of political environment, partnerships, TB program planning, community health education, case detection rates, DOTS coverage, budget, and significant comments from the country profiles in WHO (2002).⁴ Parameters and criteria for success included:

- potential for demonstration of rapid success
- DOTS Expansion Working Group involvement at all stages
- good services infrastructure but low Case Detection Rates
- medium to high political support
- external and national partners identified during the country missions
- opportunity for added funding
- infrastructure for communication activities at country level (see Annex 2).

Based on this rapid desk analysis, a decision was made to conduct in-depth assessments of advocacy and communication activities in line with the DOTS expansion plans of three countries through country visits. The countries were Bangladesh; some states of India; and Kenya. STB-supported advocacy and communications activities in these three countries began in August 2002.

3.2. In-depth review of 22 HBC TB Control Plans

All available country plans were analyzed for content in terms of evidence of relevant research, stated advocacy and communications objectives, strategies, implementation plans, monitoring and evaluation mechanisms, outcomes, budgets, and partnerships. Additional information was also drawn from evaluation reports of World TB Day 2002 and the WHO (2002).⁵

3.3. Key Informant Interviews With 10 National TB Program Teams

Phone interviews with HBC national TB control program managers, staff and advisers were conducted using a standardized checklist (Annex 3). Eleven countries were selected based on the information in the country plans and suggestions from the DOTS expansion team at WHO. These countries included Kenya, South Africa, Cambodia, Indonesia, Philippines, Uganda, United Republic of Tanzania, Myanmar, India, China, and Thailand. Contacts in Thailand were unavailable due to a typhoon. Additional telephone interviews were also conducted with regional WHO staff to give them information on the project and to gather background information.

⁴ WHO (2002) *Global Tuberculosis Control: Surveillance, Planning, Financing*. Geneva: World Health Organization. WHO/CDS/TB/2002.295

⁵ WHO (2002) *Global Tuberculosis Control: Surveillance, Planning, Financing*. Geneva: World Health Organization. WHO/CDS/TB/2002.295

4. Main findings and discussion

Written descriptions of advocacy and communications activities and opportunities reported by interviewees and stated in each HBC strategic plan for TB control are included in Annexes 4-8. This section summarizes the main findings of the 10 in-depth country reviews together with pertinent issues for all 22 HBC. The findings are grouped into the following categories (with some best practices identified):

1. Current advocacy activities.
2. Current communications activities.
3. NTP capacity to conduct advocacy and communications.
4. Advocacy and communications training and materials development needs.
5. How the Stop TB Partnership may best help NTP advocacy and communications.
6. Comments on the data collection tool pilot-tested during the baseline assessment.

4.1. Current advocacy activities

The 10 HBC included in the in-depth assessment varied in terms of the intensity and reach of advocacy activities currently taking place (see Annexes 4-5). Advocacy mechanisms for TB in India, Kenya, Philippines, Cambodia, and Indonesia appear to be well established with core groups managing fund-raising and partnership building (India, Kenya, Philippines) and inter-sectoral planning (Cambodia, Indonesia). In India, for example, national efforts to build technical partnerships have been established with NGOs, community health volunteers, the private sector, government employees' health services, armed forces, and the railway companies. More than 300 NGOs have entered into structured agreements to provide DOTS services as part of the NTP.

In South Africa, the NTP is currently conducting pilot projects in which core services for TB, HIV/AIDS and Sexually Transmitted Infections (STIs) are being combined in an effort to provide evidence for an integrated approach to TB and HIV/AIDS prevention and control.

In the other countries included in this assessment, concerted advocacy is relatively weak. No organized advocacy is reported in Myanmar although the central government has supported procurement of new drugs. Advocacy for TB in UR Tanzania appears to be limited to urban centres. In Uganda and China, advocacy activities are extremely weak, especially at the district level.

While strong advocacy at national level is important, each program manager interviewed during this assessment emphasized the need for capacity building in TB advocacy at district level. Administrative reforms in many countries have decentralized managerial and budgetary decisions to district governments. Finding ways to ensure sufficient human and financial resources for TB control are secured or retained within district government budgets and plans must be a priority activity for NTPs (see Section 4.4).

4.2. Current communications activities

The 10 HBC included in the in-depth assessment varied in terms of the intensity and reach of communications activities currently taking place.

4.2.1. Communications activities for World TB Day 2002

Kenya, United Republic (UR) of Tanzania, India, and Myanmar reported a variety of communication actions at several levels of society (Annex 6). Philippines focused on extending intra-government partnerships while China used the occasion to announce the signing of a new loan from the World Bank. World TB Day in South Africa focused on the connection between TB and HIV/AIDS. The assessment did not document what activities took place in Cambodia. There was no celebration of World TB Day 2002 in Uganda.

While description of communications activities during World TB Day is useful, it is more important to document the specific impact these activities achieved. In Philippines and Myanmar, World TB Day 2002 created new alliances between government departments and between government and NGOs. Some countries (e.g., Cambodia and UR Tanzania) reported an increase in awareness amongst the general public. Other countries reported no specific impact. Only Kenya reported an anecdotal increase in the number of new TB patients presenting for treatment.

4.2.2. Communications activities beyond World TB Day

World TB Day is a time-limited set of coordinated advocacy, mobilization and communication activities (each activity should be linked to an overall behavioural goal or have a precise behavioural objective) that contribute directly or indirectly to the overall program goal (e.g., reducing morbidity and mortality associated with TB). Ideally, World TB Day is part of a broader NTP approach with other elements such as management, training, and ongoing advocacy, mobilization and communication activities between World TB Days building sustained behaviour change by all concerned. World TB Day should be viewed as a peak in a continuous process rather than a discrete, one-time event.

Of the 10 HBC included in this initial baseline assessment, only Philippines, India, UR Tanzania, and Cambodia reported any communications activities outside World TB Day (that is, of course, excluding the ongoing work of health staff in their consultations with suspected TB patients and patients currently on treatment). Kenya, South Africa, Uganda and China appear to have annual communications plans under development (see Section 4.3 for further information). There appear to be no organized communications activities beyond World TB Day in Myanmar.

4.3. NTP capacity to conduct advocacy and communications

Capacity to conduct advocacy and communications activities depends upon a variety of interrelated factors including: (a) having designated managerial staff with appropriate qualifications and experience; (b) having access to appropriate agencies from which technical advice can be regularly sought and to which specialized work can sub-contracted; (c) having a well-researched, strategic plan with a precise behavioural goal by which activities can be properly coordinated, monitored and evaluated; and (d) sufficient financial resources to implement planned activities. While this list is not comprehensive, it provides a basic framework against which current NTP advocacy and communications capacity in the 10 selected HBC can be directly assessed, thereby providing some insight into the general state of advocacy and communications capacity in all 22 HBC.

4.3.1. Designated staff with appropriate experience and qualifications

Of the 10 HBC assessed in-depth, three do not yet have a designated NTP staff member managing and coordinating advocacy and communications activities (Cambodia, Indonesia, China). Uganda has a staff member working part-time on advocacy and communications.

Kenya, South Africa and UR Tanzania reported having a designated advocacy and communications manager. The NTP in Philippines and Myanmar utilize existing institutional capacity in the form of a National Centre for Health Promotion (Philippines) and the Central Health Education Department (Myanmar). In India, each state has an Information-Education-Communication (IEC) director and at national level has hired an external communications consultant to oversee implementation of the national advocacy and communications strategic plan (still in draft form).

This assessment did not explore the capabilities of designated staff or appointed institutions. Previous international evaluations, however, have reported that many national “Health Promotion and Education” (Communications) Centres, Units, Branches or Sections have: *poorly trained staff who, if they are active at all, are involved in designing posters, calendars, and booklets and arranging special ceremonies for senior civil servants and political leaders. They often lack strategy and focus and are seldom involved with communication research or synchronization of educational activities with service delivery.*⁶

Achieving behavioural results at all levels of society calls for a completely new breed of senior manager trained in all communication and mobilization disciplines. It is of utmost importance that the complex, multi-level advocacy and communications activities required to support DOTS expansion are managed by a well-qualified staff member or team.

4.3.2. Access to technical agencies

In addition to or in the absence of suitably qualified advocacy and communications staff, do NTPs have access to technical experts or agencies? This assessment asked whether each NTP had access to: (a) Ministry of Health Public Relations Officer (or equivalent); (b) WHO Regional Public Relations Officer (or equivalent); and (c) Public Relations contract agency (from the public or private sector).

All 10 HBC included in this assessment had access to Ministry of Health and WHO Regional Public Relations Officers. Only India and South Africa reported contracting private sector agencies to assist with their advocacy and communications activities. Indonesia, Uganda, and UR Tanzania are considering contracts with private sector expertise. Kenya benefits from expertise within the University of Nairobi (though this is not specifically advocacy and communications expertise). Cambodia receives technical advice from Family Health International and the United States Agency for International Development. Philippines, Myanmar, and China report no formal association with private sector expertise in public relations, advocacy, or communications.

4.3.3. Well-researched, strategic plans with precise behavioural goals

⁶ McKee, N. (1992). *Social Mobilisation and Social Marketing in Developing Countries: Lessons for Communicators*. Penang: Southbound. P.24.

The purpose of strategic planning for advocacy, social mobilization and communication is to devise a plan that is appropriate to the health problem and target groups identified, within the resources available, and which will have the best chance of bringing about sustainable behavioural impact. It is perhaps the most important tool for managing the implementation of advocacy, social mobilization and communication strategies. A Strategic Plan serves as a record of an NTP's objectives and strategies which can be consulted and altered as necessary. During its development, the plan should be discussed and debated by NTP staff and stakeholders.

A strategic plan should be based on a thorough situation analysis of the behavioural and programmatic challenges facing implementation and expansion of DOTS. The plan should be focused on the achievement of a precise and feasible behavioural goal. For example, *“to prompt, over the period of a year, approximately [number] individuals (men, women and children of any age) throughout [geographic region] who have a cough that does not go away after three weeks to come/be taken to one of the designated government health facilities for The Free TB Sputum Test (and so increase the TB case detection rate to above 70%).”*

The plan should clearly and comprehensively spell out the activity steps that will be taken to implement a strategy (or set of strategies) to achieve its behavioural goal. The plan should include all the preparatory activities as well as what will happen once each strategy is implemented. For instance, a plan should specify how many of a particular product (e.g., TB treatment tablets) or communication material (e.g., radio spots, posters) the NTP will need, who will produce them, and how they will be distributed. If, for example, training of field staff, volunteers, drama groups, and school teachers is required, then the plan should specify when and where these groups will be trained, by whom and how. If a particular strategy requires close collaboration from the media and press, then the plan should detail how these groups will be contracted or briefed (e.g., how often and where news conferences will occur). The plan should also specify relevant monitoring and evaluation procedures.

All 22 high burden countries (HBC) have prepared a plan to address barriers to DOTS expansion.⁷ **Few** of these plans detail any comprehensive approach to advocacy and communications activities. Of the 10 HBC countries assessed in-depth, **only** UR Tanzania reported having written a definitive plan to manage, monitor and evaluate advocacy and communications activities. Several countries (South Africa, Cambodia, Philippines, Uganda, India, China) reported a plan was being drafted. Of these, only the Philippines' draft plan appeared to contain behavioural goals (“decrease delays in consultation with a health provider” and “increase treatment compliance among patients”). No available plans (draft or otherwise) contain detailed sections on how activities will be monitored and evaluated. Myanmar and Indonesia currently have no written strategic plan (draft or otherwise) for advocacy and communications.

Lessons from countries with detailed advocacy and communications plans are also insightful. In Bangladesh, for example, Behaviour Change Communication (BCC) is accepted as a priority area to focus on in order to increase case detection rates. Much work has already gone into the development of a National BCC strategy to support the NTP. The strategy was finalized in October 2001.

⁷ WHO (2002) *Global Tuberculosis Control: Surveillance, Planning, Financing*. Geneva: World Health Organization. WHO/CDS/TB/2002.295

The strategy currently lacks any explicit, precise behavioural goals (such as motivating patients with a cough that has lasted for 3 or more weeks to get to a DOTS service centre for a free diagnosis) nor any explicit means by which activities will be monitored or evaluated. Unfortunately, no activities specified in the BCC strategy document have been undertaken due in part to funding deficiencies and delays, and in part because no technically proficient managing agency has been identified or appointed to operationalize the strategy.

4.3.4. Sufficient financial resources

A few HBC have been successful in securing financial support through the Global Fund for AIDS, TB and Malaria (GFATM). Others receive support through the Global Drugs Facility (GDF). A range of donors are actively supporting several NTPs. More information on financial resources and sources is provided in Annex 7. Table 2 presents available financial data for 2002 across the 22 HBC.

Table 2: Estimated financial resources for NTPs in 22 HBC and specific budgets for advocacy and communications activities for 2002.

Country	Population (1000s)	Cases (1000s) ^a	Rate per 100,000 pop ^a	2002 Budget (US\$) ^b	2002 Budget per case (US\$) ^c
Afghanistan	21765	70	321	None so far	-
Bangladesh	137439	332	242	2500000	7.53
Brazil	170406	116	68	None so far	-
Cambodia	13104	75	572	500000	6.67
China	1275133	1365	197	6000000	4.40
DR Congo	50948	163	320	300000	1.84
Ethiopia	62908	249	330	None so far	-
India	1008937	1856	184	2600000 ^d	4.20
Indonesia	212092	595	280	1000000	1.68
Kenya	30669	149	484	20000	2.01
Mozambique	18292	79	433	None so far	-
Myanmar	47749	80	168	100000	1.25
Nigeria	113862	347	305	200000	0.58
Pakistan	114256	247	175	200000	0.81
Philippines	75653	249	330	2900000	11.65
Russian Federation	145491	193	132	None so far	-
South Africa	43309	228	526	15000000 ^e	-
Thailand	62806	88	140	None so far	-
Uganda	23300	82	351	100000	1.22
UR Tanzania	35119	126	359	100000	0.79
Viet Nam	78137	148	189	600000	4.05
Zimbabwe	12627	74	321	None so far	-

^a Estimated number of cases in 2000 (from WHO 2002, p.6)

^b Unless highlighted in bold, the stated budget is not exclusively for advocacy and communication activities. Where "None so far" is indicated, this means either no 2002 budget has been created or no information on the actual budget is currently available.

^c This calculation is done to compare the level of budgetary commitment between countries. Again it should be noted that the stated budget is not exclusively for advocacy and communications.

^d US\$78000000 reported for NTP from 2002-2004. The figure in Table 2 is an estimated annual budget.

^e Earmarked at the Mandela Foundation but not yet transferred to the NTP.

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). One should note that these figures equate to US\$1.5-2.0 allocated to advocacy and communications 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. In some HBC, NTP capacity to process external funds has proved problematic. In

India, for example, only US\$200,000 of the US\$7.8 million allocated by the World Bank and Government sources for the NTP was spent in 2001.

4.4. Advocacy & Communications Training & Materials Development needs

Representatives of each NTP from the 10 HBC selected for this assessment stated they would welcome training in a range of advocacy and communications skills including:

- Planning IEC campaigns
- Generating media coverage
- Spokesperson media training
- Communicating to public officials
- Creating coalitions and partnerships with community groups to impact elected officials
- Production of brochures for general distribution, press kits/press releases, and briefing papers for elected officials.

4.5. How STB may best help NTP advocacy and communications

This report has outlined some of the current strengths, weaknesses, opportunities and threats faced by NTPs in planning, implementing, monitoring and evaluating advocacy and communications. How can the Stop TB Partnership best provide support to NTPs in these crucial managerial activities?

Interviews with representatives of each NTP from the 10 HBC selected for this assessment generated a list of seven basic areas for support (see Annex 8):

- Technical assistance in strategic advocacy and communications planning
- Technical assistance in strategy development (e.g., message and materials design, target group segmentation, monitoring and evaluation indicators)
- Technical assistance in advocacy and communications training, especially to improve district level capacity
- Technical assistance in proposal writing (e.g., GFATM and GDF applications)
- Assistance in developing in-country media networks
- Ensuring senior government officials are invited to important global meetings
- Financial assistance.

4.6. The assessment tool

This assessment used a basic checklist of questions to determine current NTP advocacy and communications capacity in the 10 selected HBC (see Annex 3).

The key target audiences of this checklist are NTP staff and staff within the Ministry of Health identified as having advocacy and communications responsibilities. This 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. An external consultant may use the checklist during a programme review or programme assessment.

Many times, NTP staff and external consultants using the checklist will have no formal communications training. With this in mind, the checklist contains language that is easy to understand, is as brief as possible, and is similar in

format to other checklists used during a standard NTP review.⁸ It is also important to keep in mind the many ways in which communications and advocacy activities are “labeled” or commonly referred to by NTP staff. Among the NTP managers interviewed, the terms with which they were most familiar were “Information and Education Campaign” and “social mobilization.”

⁸ WHO (1998) *Guidelines for conducting a review of a National Tuberculosis Programme*. Geneva: World Health Organization. WHO/TB/98.240

5. Recommendations

The aims of this report were to:

1. better inform STB's ACS by assessing current National Tuberculosis Programme (NTP) advocacy and communications capacities and activities in the 22 HBC, and by providing a baseline against which subsequent impact of this Strategy can be progressively measured;
2. begin documentation of national and sub-national advocacy and communication activities leading to identification of best practices;
3. propose a second group of HBC for which STB support for advocacy and communications should be provided (following on from Bangladesh, Kerala State (India), and Kenya); and
4. provide feedback on an assessment tool pilot-tested during a series of key informant interviews with NTP managers and staff.

Recommendations arising from this initial assessment are as follows:

5.1. Advocacy activities

Advocacy mechanisms for TB in some HBC appear to be well established with core groups managing fund-raising and partnership building (India, Kenya, Philippines) and inter-sectoral planning (Cambodia, Indonesia). In other countries, advocacy mechanisms require support.

Recommendation: IUATLD/TBCTA [SECOND ACRONYM?] have been invited to develop tools for conducting an advocacy training needs assessment. [NEXT PHRASE DEPENDANT ON CURRENT STATUS OF THIS EXERCISE?] This exercise should proceed as quickly as possible. As part of this activity, specific material/tools will be developed to increase the capacity of TB staff and managers on policy change, budget analysis, general and political advocacy. Findings from this exercise would compliment the baseline established in this report.

5.2. Communications activities

The 10 HBC included in the in-depth assessment varied in terms of the intensity and reach of communications activities currently taking place. World TB Day has provided many HBC with a critical focus and created opportunities to build new alliances and secure additional support. However, no HBC involved in this assessment had conducted any formal evaluation of the impact of World TB Day 2002.

Recommendation: More effort must be made to assess the impact of World TB Day (in terms of specific indicators such as increased case detection rates, increased funding, etc.) given so many resources are dedicated to this exercise.

Ideally, World TB Day is part of a broader NTP approach with other elements such as management, training, and ongoing advocacy, mobilization and communication activities between World TB Days building sustained behavioural impact. Of the 10 HBC included in this initial baseline assessment, six countries had no advocacy and communications activities outside of World TB Day. Recommendations for capacity building in strategic planning (see below) should improve this situation.

5.3. NTP human resources for advocacy and communications

Of the 10 HBC assessed in-depth, three countries (Cambodia, Indonesia, China) do not yet have a NTP staff member or national institute designated as the TB advocacy and communications manager. This assessment did not explore the capabilities of designated staff or appointed institutions.

Recommendation: NTPs should ensure that the complex, multi-level advocacy and communications activities required to support DOTS expansion is managed by a designated, full-time, well-qualified staff member or team. If required, further in-country assessment should take place of the capabilities of designated staff and institutions.

5.4. Financial resources

It is highly likely that additional financial resources will be required to reach the 2005 targets of the Global Plan to Stop TB, especially through social mobilization and communication for behavioural impact. Global advocacy is a key part of the STB's work and over time, should ensure increased funds become available. At country-level, however, commitment to funding social mobilization and communication is generally weak. Capacity to process external funds has proved problematic for some NTP.

Recommendation: More in-country advocacy is required to ensure adequate resources are available to support social mobilization and communication for behavioural impact, especially at sub-national level. NTP's should use local resources *as thoroughly as possible*, and only afterwards seek external resources – first elsewhere in the country, and finally internationally. Capacity building in financial management may be required for managers or teams responsible for implementing TB control at national and especially at sub-national levels.

5.5. Use of in-country private sector expertise

In-country linkages between HBC NTPs and private sector expertise are generally weak. In recent years, many national and multi-national corporations have become champions of health issues. In addition to employing a significant percentage of urban populations potentially at risk of contracting TB, corporations also can influence government decisions, the activities of small and medium enterprises, and popular behaviour. Many businesses (even those not specializing in public relations and communications) have extensive communications, advertising, financial, distribution, and marketing networks. They also have in-house expertise in a wealth of areas valuable for increasing the effectiveness of advocacy, social mobilization and communication for behavioural impact, including strategic planning, target setting, implementation management, and procurement.

Recommendation: NTPs should be actively encouraged to seek support from multinational and national corporations, not just in cash or other resources but in terms of *skills*. These linkages may result in substantial benefits to NTPs as well as serve as a useful public relations exercise for the corporations concerned. Resource groups that are available within country to help plan, develop and implement advocacy and communication activities need to be identified. These would include media professional, production agencies and other patient organizations, NGOs and professional bodies that could be utilized for advocacy and communication activities. The IUATLD/GATB/TFCS [LAST ACRONYM?] were invited to identify regional, country level organizations, groups, consultants, resources for developing, planning and implementing advocacy and communications activities. [NEXT PHRASE DEPENDANT ON CURRENT STATUS OF THIS EXERCISE?] This exercise should proceed as quickly as possible. Findings from this activity would compliment the baseline established in this report.

5.6. Capacity building in strategic planning

Based on the findings of this assessment, the skills needed to develop social mobilization and communication plans based upon participation and informed by thorough social and behavioural analyses are generally lacking in NTPs. It is highly probable that the lack of comprehensive advocacy, social mobilization and communication planning seriously undermines many HBC NTP efforts.

Recommendation: Comprehensive training programs to build capacity in strategic social mobilization and communications planning, implementation, and monitoring are urgently required. Training should also emphasize evaluation of advocacy and communications strategies:

- Pre-testing interventions (products, behaviours, messages, and materials) developed for implementation with relevant target audiences.
- Process evaluation to determine actual level of implementation of interventions.
- Outcome evaluation to determine immediate effects of interventions.
- Impact evaluation to assess long-term benefits and sustainability of interventions.

Training programs 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, but may take longer to implement than on-the-job technical assistance.

Training activities, however, are likely to have little long-term effect unless they are supported by changes in program environment that reinforce new practices. Evidence from many capacity building programs suggests that training activities are more successful if they are combined with policy, procedural and legislative changes that support the new practices being proposed.⁹ Any proposed capacity building exercises would require comprehensive monitoring and evaluation.

5.7. Coordination between TB and AIDS

⁹ <http://www.changeproject.org/reports/c-b%20paperfinal.pdf>

The association between TB and HIV/AIDS is profound. Innovative approaches of treatment supervision are required to increase cure rates and hence reduce transmission of both diseases. Although this assessment did not explore current in-country collaboration between NTPs and HIV/AIDS programs, South Africa's NTP is currently conducting pilot projects in which core services for TB, HIV/AIDS and STIs are being combined in an effort to provide evidence for an integrated approach to TB and HIV/AIDS prevention and control. This is a good example of how solutions to these two major epidemics can be combined at the operational level of district services. NTPs need to be co-ordinated with HIV/AIDS programs and supported by national advocacy groups.

Recommendation: More detailed assessment of the current and potential advocacy and communications linkages between NTPs and HIV/AIDS programs in the 22 HBC is required.

5.8. Second round of HBC in which STB support should be offered

In August 2002, in line with STB's ACS and based on rapid field and desk analysis, Bangladesh, Kerala State (India), and Kenya began to receive STB-support to strengthen their advocacy and communications capacities and activities.

Recommendation: Based on this present assessment, the following HBCs are recommended for STB support to strengthen their advocacy and communications capacities and activities: Cambodia, Indonesia, Myanmar, South Africa, Uganda, and Tanzania.

These six countries were selected based on a combination of parameters (Annex 9), the most important being:

- *Potential to demonstrate rapid increase in case detection rates.* Surrogate markers that would indicate this potential include the HBC's history of success in expanding DOTS coverage, detecting cases, successfully treating cases, and readiness to further expand its DOTS coverage.
- *Current advocacy, communications, and education activities occurring in the HBC and capacity to conduct a larger-scale activity.*
- *Evidence of actual or potential budget allocated to advocacy and communication activities.* Although current NTP budget breakdowns are difficult to obtain, findings from this assessment suggest that most of these countries have allocated some financial resources to advocacy and communication activities.

Globally, NTPs using the DOTS strategy must recruit an extra 330,000 smear-positive patients each year to reach 70% case detection by 2005. If a target of 70% case detection and 90% DOTS coverage within a year of implementing a coordinated advocacy and communications plan was set and reached, these six countries combined may be able to contribute roughly 55,420 additional smear positive cases detected under DOTS programs every year.



6. Immediate next steps for STB

- Establish in-country focal points to keep abreast of advocacy and communications progress, and obtain written plans for advocacy and communications activity from NTP managers.
- Determine ways to provide access to already created TB resource materials.
- Determine ways to coordinate efforts between Stop TB and the NTP, as well as the education departments and media offices within country's Ministry of Health.
- Develop internal communications protocols so that all work groups can easily exchange information and begin to use the Advocacy and Communications Task Force as a resource.
- Determine ways to provide technical assistance to the partnership in developing evaluation methods for advocacy and communication strategies.
- Assist in planning, conducting, and reporting the field testing of the Advocacy and Communications Assessment Checklist with NTPs.
- Provide technical assistance and consultation on how to use the Advocacy and Communications Assessment Checklist to individuals making country visits.
- Plan and conduct more detailed in-country assessments of advocacy and communications capacity and activity in Cambodia, Indonesia, Myanmar, South Africa, Uganda, and Tanzania as a precursor to further STB support.
- Write a project proposal to support NTP capacity building in advocacy, social mobilization and communication planning, implementation, monitoring and evaluation to be funded by a yet to be determined source.