



Experts' **Consultation** on
Communication **and**
Social Mobilisation

June 29th – July 1st, 2003
Cancun, Mexico



A REPORT

CONTENTS

EXECUTIVE SUMMARY	3
KEY ISSUES EMERGING FROM THE CONSULTATION	6
1.1 INTRODUCTION	6
1.2 THE COMMUNICATION CHALLENGE OF TB	7
1. Characteristics and the Social Context of TB	7
2. Communication Capacities among NTPs of the High Burden Countries	8
3. The Emerging Media Environment – Implications for TB	8
1.3 MOVING THE TB COMMUNICATION AGENDA FORWARD	10
1. First Steps: A Shared Terminology	10
2. Participation, Empowerment and Mobilising Societies for TB	11
3. TB Communication Campaigns: Using Mass and Community Media	13
4. Partnering for TB Communication	14
1.4 FINDINGS AND RECOMMENDATIONS	15
ANNEXES	
Annexe – 1 Agenda	18
Annexe – 2 List of Participants	21
Annexe – 3 Suggested indicators (draft) for Communication and Social Mobilisation	24

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Executive Summary

The *Experts' Consultation on Communication and Social Mobilisation in support of the Global Plan to Stop TB* took place from 29 June – 1 July 2003, at Cancun, Mexico. The meeting was part of a series of consultations taking place towards informing the formulation of the **Report of the 2nd ad hoc Committee on the TB Epidemic**. The meeting was co-hosted by the Stop TB Partnership/Geneva, the Ministry of Health of Mexico and, the TB Working Group/Task Force-5 of the UN Millennium Development Goals Project. Twenty-five participants, including several internationally renowned communication experts, participated in the Cancun deliberations (Annex-2). The objectives of the consultation were:

- To provide input, in the area of communication and social mobilisation, to the *Report of the 2nd ad hoc Committee on the TB Epidemic*, and
- To inform the formulation of a robust and sustainable communication framework for achieving the goals of the Global Plan to Stop TB.

The focus of the consultation was on in-country communication and social mobilisation interventions, with special reference to the High-Burden Countries (HBCs). The consultation did not address issues related to global advocacy. The outcomes of the Cancun consultation are also expected to feed into the deliberations of the annual meeting of the Stop TB Advocacy and Communication Task Force, which will take place in early September 2003, in Johannesburg, South Africa.

The agenda for the experts' consultation (see Annex 1) included a series of presentations and discussions on the global TB control efforts, country case-studies of mass-media and community-based communication and social mobilisation interventions, experiences in capacity-building and, the challenges and opportunities offered by the emerging media environments. Additionally, considerable time was spent in the form of group-work to arrive at some strategic recommendations. Specifically, the consultation sought to respond to three key questions:

1. What set of communication and social mobilisation interventions can rapidly improve TB case-detection and treatment outcomes in a relatively short period of time (2003 - 2005), and then sustain these rates over a much longer period of time (2005 – 2015)?
2. What factors hamper the widespread implementation of communication and social mobilisation interventions in the TB-endemic countries, and what options are available to deal with them?
3. Aside from epidemiological data, what other key information needs to be gathered and analysed on an on-going basis by the NTPs to guide the communication and social mobilisation interventions for stopping TB?

Broadly, the group of communication experts asserted 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."

The group was of the opinion that TB communication programming was making less than optimal use of existing and tested communication strategies and methodologies. While TB had certain characteristics requiring tailored interventions and messages, much of these needs could be met by conventional and well-established communication practices.

However, the experts' group noted with concern, the serious lack, of technical capacity and a critical mass of qualified communication staff, among the High-Burden Countries (HBCs), to develop, plan and implement effective, sustained and wide-scale communication interventions.

The strategic recommendations of the experts' group are elaborated in Section 1.4 : 'Findings and Recommendations', of this document.

Corresponding to the three key questions addressed by the group, the recommendations can be broadly categorised and summarised as under:

1. Positioning and Direction of TB Communication Programming:

Advocacy, communication and empowerment must be made a central and integral part of the Stop TB Partnership mandate. Towards this, the structures within the Stop TB Partnership, dedicated to advocacy, communication and social mobilisation must be strengthened. The Advocacy and Communication Task Force of the Partnership should also be strengthened and formalised; and, representation of the Task Force must be ensured on the Strategic and Technical Advisory Group (STAG) of WHO, and on the Co-ordinating Board of the Stop TB Partnership. Additionally, in the HBCs, the Partnership should strongly advocate with ministries, NTPs and donors, to secure priority and a high level of support for TB communication programming.

As an immediate first step towards improving case detection and treatment compliance rates, TB communication programming must be directed at accelerating and scaling-up the current levels of communication activities. Much could be achieved by the wide-scale implementation of existing and tested conventional communication techniques. Country communication strategies should include an appropriate mix, of mass media interventions and community-based processes, which can facilitate rapid gains in the short-term, but also ensure sustainability and broader social commitment, in the long-term.

2. **Capacity-Building and Technical Assistance:** The Stop TB Partnership should facilitate processes within HBCs that ensure the formulation of strong TB communication programming plans, and which are supported by adequate in-country human and financial resource commitments. Additionally, the Partnership must provide on-going technical assistance to HBCs, in the form of tools, instruments, technical advisers, opportunities for information exchange, and regular, formal assessments to facilitate effective country-level programming. Specific plans must be developed and implemented to provide training opportunities and specific need-based inputs, to individuals and public sector institutions, towards rapidly strengthening in-country TB communication capacities.
3. **Information and Data:** Indicators and communication benchmarks, to monitor and measure impact and social-behavioural change, need to be established and integrated into current data-gathering mechanisms of NTPs, and reported by countries along with epidemiological data, on a regular basis. Indicators should be specially developed, to analyse political and social commitment for TB programmes, at national and sub-national levels, in the HBCs. Best practices in communication programming should be documented, based on defined criteria, and disseminated for adaptation and implementation elsewhere at regional and country levels.

As mentioned earlier, the Partnership Secretariat will be hosting the annual Stop TB Advocacy and Communication Task Force meeting in early September 2003. At the Task Force meeting, a small group of representatives from the Cancun consultation, will be invited to provide guidance in planning and operationalising the recommendations of the experts' group.

KEY ISSUES EMERGING FROM THE CONSULTATION

(A Summary of the Presentations and Discussions)

1.1 INTRODUCTION

The Global Plan to Stop TB has set itself the target of detecting 70% of all smear-positive TB cases worldwide, and to cure 85% of those detected. Additionally, for TB the UN Millenium Development Goals have been articulated as: “to have halted by 2015, and begun to reverse, the incidence of priority communicable diseases (including TB)”.

Much of the international advocacy effort so far has been directed, and perhaps rightly so, at building political commitment globally and, mobilising the necessary human and financial resources, for expanding and implementing the DOTS strategy, assuring regular supplies of high-quality drugs, strengthening overall service delivery, and maintaining intensity of research effort for developing newer and more effective drugs, diagnostic tools, and vaccines.

While progress over the years has been significant, achieving the targets for 2005 still remain a major challenge. The cases notified under DOTS programmes globally in 2001 represented only 32% of the estimated incidence, and the rate of progress in case finding between 2000 and 2001 was not significantly faster than the average since 1995. It is estimated that if DOTS expansion continues in this same linear fashion, the target for case detection will not be achieved before the year 2013. There is now a growing realisation that expansion of DOTS within countries, without additional efforts in advocacy and communication, will not be able to help achieve the targets.

While global advocacy must continue to ensure high-level political commitment and the flow of adequate resources, much more needs to be done to reach those who have remained distanced -- socially, economically and geographically, from the mainstream of development. There is urgent need for in-country communication and social mobilisation, directed at the rapid building of political commitment at the national and sub-national levels. Achieving a high order of commitment within and at all administrative levels of the health service delivery system (referred hereafter as “administrative mobilisation”), is particularly crucial in the context of TB.

There is need for processes, that will facilitate and empower communities to participate in, take ownership of, and drive the agenda for the elimination of TB. The Stop TB movement needs to mobilize whole communities, civil society groups, health sector organizations, and local leadership at the grassroots, to ensure that the poor and the vulnerable are not missed.

To catalyse and facilitate such processes, National TB Programmes need strong, sharply defined and inclusive communication strategies. However, a rapid assessment of communication capacities in the 22 high-burden countries, commissioned by the Stop TB Partnership, has revealed in-country

gaps in terms of a lack of communication staff, budgets, and well-elaborated country communication strategies.

Equally, there is need to move away from the “lack of resources” argument, and instead work towards enhancing resourcefulness. There is also a need to think strategically, and beyond defining problems in terms of existing solutions and available tools. While DOTS remains the technical strategy for TB control, critical thinking is required to identify how communication and social mobilisation can be integrated into the DOTS strategy for rapidly improving case detection and treatment compliance rates.

1.2 THE COMMUNICATION CHALLENGE OF TB

In the context of communication programming for TB control, a number of critical constraints and challenges need to be addressed. These challenges can be broadly categorised and described as under:

1. **Characteristics and the Social Context of TB:** The poor bear a high burden of TB. Those in poverty, also have poor access to information, and therefore that much more difficult to reach with TB messages. Symptom that matters most (i.e. a persistent cough), does not usually trigger the search for help. Further, the symptom (persistent cough) usually disappears within a few weeks of starting treatment, which can lead a person to stopping treatment mid-course. Those living in poverty often experience numerous episodes of persistent cough during the course of a year. More often than not, this may be due to other respiratory diseases. A person may be unwilling to return for a sputum test each time, especially if he/she had tested negative in the previous instance. Aside from the monetary costs, the social costs of stigma are high, and often act as a disincentive for seeking diagnosis and treatment.

For many people, private clinics and doctors are often the preferred choice for health services. If the service facility (especially those in low-income areas) is not covered under the DOTS strategy, chances exist for misdiagnosis, non-reporting of the case, or incomplete treatment.

Furthermore, a person could get infected with TB anytime during his/her lifetime. Which means, that ideally he/she should be taking a sputum test, each time there is an episode of persistent cough, during his/her lifetime. From a communication perspective, this is particularly challenging.

Finally, it is not enough, to meet by 2005, the case-detection targets of 70% and the cure rate of 80%. To eliminate TB, these levels will need to be maintained well beyond 2005, perhaps for a whole generation or two.

TB communication needs to be re-positioned and made an integral component of the technical (DOTS) strategy for TB control. Behaviour change communication for TB is only one component, of the larger issue of ensuring that people’s response to TB symptoms becomes ingrained,

into the culture of their everyday lives, so as to be sustained over their lifetimes.

- 2. Communication Capacities among NTPs of the High Burden Countries:** At a global level, the TB movement has been quite successful in advocating for and generating international political commitment for TB control. However, this has not been matched at country levels. Low case detection rates are a good indicator of poor levels of public awareness and commitment for TB elimination.

A rapid assessment of communication capacities within the HBCs, conducted by the Social Mobilisation and Training team of WHO, suggests an urgent need for strengthening technical capacities for communication programming among NTPs. Key issues that need to be addressed include the following:

- While most countries do have some staff assigned to TB communication activities at the national level, many of them may not be adequately qualified to plan, implement and evaluate complex, large-scale communication interventions. In many countries, there is also a lack of dedicated communication staff at provincial and district levels, where the need is perhaps stronger.
- In the area of program planning, most countries have a well-established plan for DOTS expansion, but only a few have well developed, technically sound, written plans for communication activities. Many of the countries also do not have a specific budget-line for communication and social mobilisation. Countries are seeking technical assistance in the form of communication tools, training, assistance in proposal writing, planning, and materials development.
- Nearly all the countries assessed conduct advocacy and communication activities on World TB Day, each year. However, outside of this single, annual event, most NTPs seem to lack direction in planning for on-going TB communication interventions. Additionally, the level of “administrative mobilisation” (i.e. mobilisation of the entire administrative machinery of the health service system which is directed at TB control), is less than optimal.

A more detailed situation/needs analysis is required to be urgently conducted in the priority countries, and appropriate technical assistance/tools provided on an on-going basis.

- 3. The Emerging Media Environment - Implications for TB Advocacy:** In less than a decade, two distinct and dramatic information revolutions have taken place. A revolution in technology, and a revolution in the structure, ownership, content and access to the media. The latter, in particular, has radically transformed the communication environment, and is characterised today by several contradictory trends, creating newer

challenges for moving the TB agenda ahead. New rules for engagement with media are therefore called for.

A major liberalisation and democratisation of the media in most developing countries, particularly of radio, has created both opportunities and challenges for pro-poor programming. New opportunities exist for public debate and for highlighting voices and perspectives of poor people through, for example, the explosion of radio talk shows, and the growth of community media. A more open and democratic media provide important new opportunities to place pressure on governments to more effectively and urgently address poverty related issues such as TB.

Conversely the mass media, which play a critical role in informing the public and setting political agendas, are decreasingly interested in poverty related public health issues. Cuts in budgets, coupled with the increasing need to pay for broadcast airtime, among former state broadcasters (which generally have the greatest reach to rural audiences) and the failure of most of these organisations to transform themselves from state monopolies to public service broadcasters has led to a decline in pro-poor programming, and indeed created a crisis among public service broadcasters and information providers. Even as we see an explosion in the number of titles in newspapers and channels in TV/Radio, language and outreach programming have declined.

Media content today is generally characterised by an urban-centric, entertainment and lifestyle-oriented, consumer-driven agenda. While the print media continues to play a central role in setting agendas, radio (particularly in Africa) is rapidly emerging as the preferred medium for outreach to the poor. Television too can no longer be called only a medium of the rich, though its reach remains generally more limited than radio, production costs are greater, and the new television environment is more lifestyle and consumer oriented than radio.

A decade ago, communication and media structures/systems were relatively stable, centrally controlled, top-down and vertical entities, offering only a few sources for information. However, these systems, despite being usually controlled by the governments of the day (and coloured by their respective ideologies), offered the advantage of sending out regular development information and messages, to mass audiences. Today, a more democratic and complex media and information environment has emerged, which is far more horizontal, more numerous, increasingly profit driven, fragmented, but offering information from multiple sources.

Many scholars and media professionals agree that there has been a 'reinvention', or a return, to the oral tradition in the media, as evidenced by the surge in programming using interactive formats like the talk-show, phone-ins and panel discussions. These changes have generally facilitated giving a "voice" to people, and projecting it in the mainstream.

Given these complex trends, including a general movement away from pro-poor programming, the challenges for pushing the TB agenda, both at the global as well as national levels, is going to require newer ways of engaging with the media. Putting out or disseminating 'messages', in the traditional sense, is becoming less and less effective. Asking a question, or placing an issue into a debate, is slowly emerging as a more effective method, in this complex and increasingly interactive environment. Many communication strategies are beginning to focus as much on providing a voice to people as getting a message to them – using media to empower, not just inform.

1.3 MOVING THE TB COMMUNICATION AGENDA FORWARD

At a very fundamental level, it is critical to understand as to who “produces” health. To illustrate the point: if asked as to who produces food in a country -- people or the Ministry of Agriculture ? -- there would probably be universal agreement, that it is farmers who produce food for a country. However, if asked as to who produces health -- people or the Ministry of Health? -- most would pause before giving an answer. And therein lies the crux of the matter.

A strong and emerging point of view is that families and individuals are the primary “producers” of health. Understanding a health “system” more as the inter-play between households, communities and governments on issues of health, and different from “sickness care systems” (i.e., the provision for delivery of medical services/care for the ill), is a useful way of differentiating between the two. Each of the stakeholders (households, communities, governments) have their own sets of values, resources and practices, and can be defined as their respective ‘cultures’. If these are not aligned or harmonised, chances of failure in achieving the goals of a health program are high. Good communication strategically attempts to harmonise these differences, and facilitate the building of consensus and a shared vision, to tackle a particular issue.

Communication programming that recognises families and individuals as the primary producers of health, and views them as the agents, rather than the objects of change, with the goal of building a ‘health literate’ and ‘health competent’ society, would be the first step towards bringing about sustainable change in health-seeking behaviour. For the control and elimination of TB, a strategic approach based on this thinking may become essential.

Given the complex nature of bringing about sustained social-behavioural and developmental change, it is important to appreciate that linear solutions cannot solve non-linear problems. Equally, capacity building must outpace the growth of problems. More often than not, the context of problems and the context of solutions are not always the same. While there are general principles, it needs to be recognised that there may not always be universal solutions that are replicable and predictable everywhere.

1. First Steps: A Shared Terminology

An important first step towards developing strong communication strategies, is the need for a shared understanding of some key terms used in the context of communication. However, given the extensive agenda and the task at hand, the experts' group felt that it would not be particularly productive to engage in discussions to arrive at precise definitions of terms such as communication, advocacy, and social mobilisation. Instead, some broad descriptions of the terms are offered, which are distilled from various discussions during the course of the consultation, and are useful for the purposes of understanding, structuring and categorising communication activities for TB.

- **Communication:** The overarching term 'communication' should be understood as a two-way process with 'participation' and 'dialogue' as the key elements. In the context of TB control, 'communication' may be thought of as being directed at creating an overall enabling environment, through tailored strategies and empowering discourses. All communication activities make use of some form of media and various channels/modes (e.g., mass media, community media, interpersonal communication etc.) for communicating ideas. Specific strategies, at specific moments, may call for the deployment or the emphasis, of one media-form over another.
- **Advocacy:** In the global context, advocacy for TB is to be understood as a broad set of co-ordinated interventions, directed at placing TB high on the political and development agenda, for securing international and national commitment and, mobilising the requisite resources. In country contexts, advocacy efforts broadly seek to ensure that national governments remain strongly committed to implementing national TB control/elimination policies.
- **Program Communication:** Within countries, and in the context of TB control, program communication primarily seeks to inform and create awareness among the general public about TB (e.g. its symptoms and the fact that it is curable), the services offered by the health system (for diagnosis and treatment) and, generally encourages people to seek treatment if they have the symptoms. Additionally, specific and targeted messaging may be deployed, to facilitate behaviour change or meet a particular behavioural goal.
- **Social Mobilisation:** In the national and sub-national contexts, social mobilisation is a process of generating public will, by actively securing broad consensus and social commitment, among all stakeholders, for the elimination of TB, as a public good. Community mobilisation is to be seen as a particular grassroots-level tool/process, in the context of wider social mobilisation. The logic of 'process', and 'empowerment', are the key imperatives of social mobilisation.

In the context of TB, "administrative mobilisation", which seeks to engage the entire health system machinery, at all levels, to provide sound TB control services, is a key element for building commitment. Additionally,

the mobilisation and participation of the private sector health service providers, is crucial for expanding the network of actors in TB control.

The lines between advocacy, program communication and social mobilisation, especially in national/sub-national contexts, are often blurred. Interventions under a particular category may beneficially influence or facilitate processes in the other categories.

2. Participation, Empowerment and Mobilising Societies for TB

Two country experiences, one from Peru and the other from Mexico, richly illustrated the idea of a health literate and health competent society, mentioned earlier. In the case of Peru, it was the systematic mobilisation and organising of TB patients by a civil society institution that empowered the patients to articulate their issues and demand health as a basic right. In Mexico, it was the government itself that initiated a visionary process of inviting communities to join in analysing, defining and driving the process of change towards a TB-free Mexico. Of critical importance, is the premise on which the interventions were built.

Peru: “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 organisations will show us the other side of the coin.”

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

In both cases, the centrality 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. Significantly enough, both Peru and Mexico are implementing DOTS as the technical strategy.

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 5 strategic elements: (1) Community-joined diagnosis of health issues; (2) Community-joined review and assessment of the operations of health programs; (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 organisations; (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, which 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 must be translated into knowledge, and knowledge into a permanent change in behaviour.

The patient-centred mobilisation in Peru revealed the inherent unequal power relations between health personnel and the patients. However, the process of organising the patients into groups/networks was in itself transformatory 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. Besides treatment and cure, the process empowered poor and marginalised sections of society into demanding 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.

Both the case-studies strongly demonstrate that the process of social mobilisation to fight TB can be transformatory, and bring about changes that assist the wider project of social development.

3. TB Communication Campaigns: Using Mass and Community Media

As a disease, TB (and the current strategy for controlling it -- DOTS), has several strengths: (1) TB is curable, (2) drugs are free of charge, (3) there exists a strong global organisation/mechanism for technical support, (4) a relatively simple message to convey -- "If you have a persistent cough for more than 2 weeks, come and get tested", and (5) a message that is easy to respond to, in terms of the action a person with symptoms needs to take. In essence, the "product" on offer, is very strong.

The fact that TB case-detection rates are low, could be problematized (in a marketing sense) as a simple demand-creation issue. It is in this context, that TB messaging lends itself to mass media campaigns, especially when knowledge and awareness levels about TB, among a large proportion of the population, is far below than what is desirable.

Useful evidence is available, from other health campaigns and several countries (HIV/AIDS, Leprosy and Trachoma), to suggest that both, behaviour change and stigma, could be effectively addressed by making use of mass media campaigns. The caveat however, for definitive impact, is the need for well crafted media materials which are culturally sensitive/appropriate and, the assurance of high saturation levels of these messages in the media (i.e. repetitions, appearance in multiple channels, duration of the campaign etc.). Strong media penetration is also a prerequisite for ensuring reach. Professionally crafted media-materials

offer the scope for standardisation and uniformity in the quality of message delivery.

While the extensive use of mass media for TB communication has the potential to rapidly increase the 'visibility' of TB (a much-needed input to catalyse greater debate on the issue), exclusive reliance on such strategies can be problematic. Good mass media campaigns require substantial resources. This may often lead to limiting the length or the duration of such campaigns. The danger then (and there is ample experience and evidence to suggest this) is that once the campaign is stopped, there is an almost immediate drop in progress.

On another front, while the very purpose of using mass media is to reach large numbers of the population (this can usually be evaluated and demonstrated reasonably well), what is often not emphasised enough, is the very large proportion of people who get left out -- i.e. those who could not, or cannot, be reached by the mass media.

Community media approaches, while more complex, can be very effective for facilitating participation and community empowerment. Secondly, these approaches are particularly useful for deployment in specific geographical areas ('media-dark' areas) or cultural/social contexts (poverty, special ethnic groups). Process oriented approaches also allow for flexibility and adaptation, and generally encourage/extend "conversations" within communities.

Cost-effectiveness and scale, are often cited as hurdles to the wide-scale application of community media approaches. The comparison is often problematic, as both approaches, by their very nature help address and achieve different objectives. Both approaches need to be deployed, perhaps simultaneously or during different program phases, to serve specific needs. Examples of where both approaches have been effectively integrated to work in tandem, are few and far between.

Aside from reaching large numbers, the mass media can create a supportive and enabling environment for grass-roots level participatory processes. Given the context within which TB thrives, there is much to be gained if the mass media were deployed in conjunction with community media, and directed more at creating empowering discourses than for achieving limited, short-term gains in behaviour change.

4. Partnering for TB Communication Efforts

A number of useful alliances and partnerships need to be forged, to assist the High Burden Countries, and to carry the TB communication agenda forward. Additionally, sufficient thought needs to be given for planning, to operationalise the recommendations emerging from this consultation.

Within countries, it would be useful to synergise capacity building efforts with other health programs or interventions. Closer ties with the Global

Fund to fight AIDS, TB and Malaria (GFATM) would help in developing mechanisms to assess the communication component of country proposals. Furthermore, ways to assist countries in preparing effective communication plans and proposals, need to be explored.

Inclusion of TB communication indicators in on-going research projects or surveys such as DHS and MICS would also benefit NTPs substantially.

Building alliances with organisations/agencies, which specialise in the area of communication would be useful for strengthening the Stop TB Partnership's communication efforts, at global and country levels. With the surge in TB-HIV co-infection cases, partnerships with agencies such as UNAIDS, the GFATM and others gain importance.

1.4 FINDINGS AND RECOMMENDATIONS

The experts' group on communication and social mobilisation were of the opinion, 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.

The experts asserted that many communication methodologies exist, to achieve a substantial, potentially rapid and sustained increase in case-detection and cure, and to effect significant behaviour change. The methodologies, which range from community-level mobilisation to wide-scale mass media campaigns, have been tested, used and evaluated for several health issues, including TB. However, they have been poorly exploited in the fight against TB.

Further, the experts' group noted, with concern, the serious lack, of technical capacity and a critical mass of qualified communication staff, among the high-burden countries, to develop, plan and implement effective, sustained and wide-scale communication interventions.

For sustained and systematic action in the fight against TB, the experts felt that a major advocacy campaign, particularly at national and sub-national levels, was essential to generate public pressure and strengthen political will.

There is also compelling need to understand the complex inter-play between TB, poverty and DOTS. Poverty is a critical factor that needs to be centrestaged when developing any communication strategy for TB.

As an immediate first step towards improving case detection and treatment compliance rates, TB communication programming must be directed at accelerating and scaling-up the current levels of communication activities. Much could be achieved by the wide-scale implementation of existing and tested conventional communication techniques. Country communication strategies should include an appropriate mix, of mass media interventions and

community-based processes, which can facilitate rapid gains in the short-term, but also ensure sustainability and broader social commitment, in the long-term.

Further, the group strongly recommended that while TB had certain unique characteristics requiring carefully tailored communication strategies, the overall fight against TB needs to be positioned within the context of an integrated, intensive, and urgent campaign for global public health.

In line with the above, the experts' group recommended the following:

- **Recommendation - 1:** The Stop TB Partnership must make advocacy, communication, and empowerment, a central and integral component of the Stop TB Partnership mandate. Sufficient funding should be routinely allocated by the Partnership to advocacy and communication, to reflect their growing and central importance. The structures within the Stop TB Partnership dedicated to advocacy, communication and social mobilisation must be strengthened and formalised, at the global level, by:
 1. strengthening the Stop TB Partnership Secretariat's Advocacy and Communication Team,
 2. formalising the Advocacy and Communication Task Force of the Partnership and,
 3. ensuring representation of the Advocacy and Communication Task Force on the Strategic and Technical Advisory Group (STAG) of WHO and the Coordinating Board of the Stop TB Partnership.
- **Recommendation - 2:** The Partnership needs to strongly advocate at country levels and among donors, to ensure that communication is organisationally positioned at a high level within ministries, bilaterals and NGOs, and that communication is accorded priority status within NTPs.

The Stop TB Partnership must actively facilitate the making of formal global and regional resolutions, within appropriate governing bodies related to financial support for country TB programs, to secure high-level support, especially for the following specific components:

1. adequate, sustained and specific resource commitments for country-level communication programming for TB
 2. provision of on-going communication capacity-building opportunities, for individuals at various levels, and public sector institutions
 3. reporting by NTPs, of change and impact due to communication interventions
- **Recommendation - 3:** The Stop TB Partnership should urgently facilitate the development, testing and integration of appropriate communication

indicators in country data-gathering and reporting mechanisms. Furthermore, NTPs should be encouraged to formally report on these indicators, on a regular basis, along with epidemiological data.

Specifically, to measure and document, country progress and commitment to communication programming, and the impact of communication interventions, the Stop TB partnership must facilitate the following in each of the HBCs:

1. the availability of a national TB communication strategy developed through broad participation
 2. inclusion of dedicated, qualified personnel and budgets for national TB communication programming
 3. development of indicators to analyse political and social commitment to TB programmes at national and sub-national levels
 4. development of specific monitoring indicators, benchmarks and baseline data to assess impact, progress, cost-effectiveness and social-behavioural change, as a result of communication interventions.
- **Recommendation - 4:** The Stop TB Partnership must provide on-going technical assistance to HBCs, in the form of tools, instruments, technical advisers, opportunities for information exchange, and regular, formal assessments to facilitate effective country-level programming. Plans must be developed and implemented to provide training opportunities and specific need-based inputs, to individuals and public sector institutions, towards rapidly strengthening in-country TB communication capacities.
 - **Recommendation - 5:** A major obstacle to further progress, is the lack of strong political commitment at national and local levels, to adopt and implement the DOTS strategy. Fresh, intensive and sustained advocacy efforts need to be urgently applied. While strategies will differ on a case by case basis, many existing and relatively easily applied methodologies exist to implement such strategies.
 - **Recommendation - 6:** Communities have a right to demand and receive health care. Community mobilisation and participation has an essential role to play in facilitating this process. Many successful examples exist of highly effective community based communication initiatives with proven impact, which should be used to inform and drive country programming. Patient's associations and other communities most affected by TB offer substantial untapped potential in education.
 - **Recommendation - 7:** Mass media campaigns have much to offer in generating greater awareness of TB, changing behaviour, and promoting advocacy. But their deployment should be carefully tailored to specific circumstances. Special efforts should be made to persuade the media to fulfil their social and ethical responsibility.

- **Recommendation - 8:** Tailored communication strategies should be urgently deployed within national health systems, to raise awareness of TB towards eradicating stigma and discrimination by health professionals and service providers.
- **Recommendation - 9:** Document 'best practices' on communication and social mobilisation activities for TB control, based on defined criteria, to serve as models of communication activities and community involvement, that can be adapted elsewhere at regional and country levels.

ANNEX - 1
Experts' Consultation on Communications and Social Mobilisation
in support of the Global Plan to Stop TB
29 June – 1 July 2003, Cancun, Mexico

AGENDA

Objectives of the Consultation:

- To provide input for the *Report of the 2nd ad hoc Committee on the TB Epidemic*, and
- To inform the formulation of a robust and sustainable communications framework and strategy for achieving the goals of the Global Plan to Stop TB.

Sunday 29 June, 2003

1800 – 1930 INAUGURATION

- Welcome (Dr Roberto Tapia)
- Adoption of the agenda; introduction to the key questions and expected outcomes
- Appointment of Chairperson for the consultation and, introduction to the Facilitators/Rapporteurs for Group-Work
- Keynote Address: *Emerging Trends in Communications for Behavioural and Social Change* (Dr Everett Rogers, Distinguished Professor, Univ. of New Mexico)

2000 Onwards DINNER

Monday 30 June

0900 – 1115 Critical Thinking (Chair - Dr Roberto Tapia):

- Presentation 1: DOTS Expansion, Case Detection/Cure and the Millenium Development Goals: What's the data saying? (Dr Nils Billo)
- Presentation 2: Ground-level service delivery/access and communications issues influencing community responses to TB programs. (Dr Ernesto Jaramillo)
- Presentation 3: The Stop TB Global Advocacy and Communications Strategy – An overview (Petra Heitkamp)
- Presentation 4: Communications capacity assessment of the TB-endemic Countries – Key Findings (Dr Will Parks)
- DISCUSSIONS

1115 – 1130 Tea/Coffee Break

1130 – 1315 Sharing Experiences/Lessons-1 (Chair - Dr Luis Ramiro Beltran):

- Social Mobilisation and Political Commitment, the Mexican experience (Dr Roberto Tapia, Vice-Minister for Health, Mexico)
- Grassroots-level advocacy and social mobilisation for TB – A Peruvian experience (Sr. Maria van der Linde, Peru)
- Community Mobilisation – a Mexican perspective (Dr Roberto Tapia, Mexico)
- Communications Training and Capacity Building – Dr Ben Lozare (Johns Hopkins University/CCP)

Monday 30 June (contd.,)

1315 – 1400 Lunch

1400 – 1530 Group-Work (Session-1):

- Briefing on Scope of Group-Work and Expected Outcomes
- Group-1 (Facilitator: James Deane ; Rapporteur: Dr Joan Paluzzi): What set of communications and social mobilization interventions can rapidly improve TB case-detection and treatment outcomes in a relatively short period of time (2003 - 2005), and then sustain these rates over a much longer period of time (2005 – 2015)?
- Group-2 (Facilitator: Susan Krenn; Rapporteur: Dr Will Parks): What factors hamper the widespread implementation of communications/social mobilisation interventions in the TB-endemic countries, and what options are available to deal with them?
- Group-3 (Facilitator: Lora Shimp ; Rapporteur: Dr Ernesto Jaramillo): Aside from epidemiological data, what other key information needs to be gathered and analysed on an on-going basis by the NTPs to guide the communications and social mobilisation interventions for stopping TB?

1530 – 1545 Tea

1545 – 1700 Group Work (contd):

1700 – 1830 Plenary Session (Co-Chairs – Dr Nils Billo and Dr Roberto Tapia):
Facilitators/Rapporteurs of the 3 groups to present a brief summary of their deliberations and preliminary findings/thoughts.
DISCUSSIONS

1930 Onwards EVENING RECEPTION/DINNER

Tuesday 1 July

0900 – 1115 Sharing Experiences/Lessons –2 (Chair: Alfonso Gumucio)

- The Emerging Media Environment: Challenges and Opportunities for Development Communications (James Deane, PANOS)
- Mass/Community Media Approaches to Health Campaigns (Roy Head, BBC-World Service Trust)
- DISCUSSIONS

1115 – 1130 Tea/Coffee Break

1130 – 1315 Group Work (Session-2)

- Each group to focus on arriving at 5 key recommendation/priorities for the question that they are addressing.

1315 – 1400 Lunch

Tuesday 1 July (contd)

1400 – 1530 Plenary Session (Co-Chairs: Dr Nils Billo and Prof Everett Rogers): Consolidation of group-work outcomes into a list of key recommendations/priorities for : (1) inclusion in the *Report of the 2nd ad hoc Committee on the TB Epidemic* (The Hague Vision); and, (2) informing the formulation of a *Stop TB Communications and Social Mobilisation Framework/Strategy*.

- Presentation of recommendations by the Facilitators/Rapporteurs of each of the three Work-Groups (each Group to present 5 key recommendations)
- DISCUSSIONS

1530 – 1545 Tea/Coffee Break

1545 – 1715 Plenary Discussion (Facilitator: Ms Petra Heitkamp): Defining key roles/activities for the Stop TB Partnership to operationalise the recommendations.

1715 – 1730 Break

1730 – 1830 Closure: Chair – Dr Roberto Tapia

- Adoption of Final Recommendations
 - Partner Comments and Commitments
 - Briefing on Next Steps and Vote of Thanks (Dr Nils Billo)
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Experts' Consultation on Communication and Social Mobilisation
In support of the Global Plan to Stop TB
June 29 – July 1, 2003, Cancun, Mexico

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ANNEXE – 3 : INDICATOR SET A: SOCIAL MOBILIZATION AND COMMUNICATION CAPACITY

No.	Indicator	Calculation	Level	Means of collection
1	% of districts/provinces with designated social mobilization and communication staff with appropriate experience ^λ	Numerator: # of districts/provinces with designated 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
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 <i>written</i> social mobilization and communication plan with clearly stated behavioural goals ^φ	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	<i>Written</i> 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
8	National level provides guidelines, training, supervision and funding to encourage sub-national planning/implementation of social mobilization and communication	Yes/No	NTP	Interview NTP manager

^λ *Appropriate qualifications* refers to a set of criteria such as: tertiary level health communications training, field experience in managing communications programmes, and so on.

* 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, and so on.

^φ *Behavioural goal* refers to a specific, measurable, appropriate, realistic and timebound statement such as: “To prompt, over the period of a year, approximately 500,000 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.”

INDICATOR SET A: SOCIAL MOBILIZATION AND COMMUNICATION CAPACITY (continued)

No.	Indicator	Calculation	Level	Means of collection
9	100% of all relevant levels have active inter-agency committees or teams contributing to the planning and management of social mobilization and communication ^α	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 ^π	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 ^β	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

^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.

INDICATOR SET B: SOCIAL MOBILIZATION AND COMMUNICATION ACTIVITY

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 last 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)