World Health Organization
Social Mobilization and Training Unit (SMT)
Department of Control-Prevention-Eradication (CPE)
Communicable Diseases Programme (CDS)

Mobilizing for Action

Communication-for-Behavioural-Impact (COMBI) in the prevention and control of TB

Background

The most fundamental challenge in confronting TB and other communicable diseases is this: having individuals (within the context of families and communities) adopt and maintain healthy behaviours. Poor recognition of symptoms, reluctance to seek or accept treatment, patchy compliance with drug regimens - all can work to undermine otherwise sound control strategies.

Considerable progress has been made in global tuberculosis control since the introduction of the WHO recommended DOTS (Directly Observed Treatment, Short-Course) strategy in the early '90s. DOTS has proven to be a successful, innovative approach to TB control in countries such as China, Bangladesh, Viet Nam, Peru, and countries of West Africa. But while DOTS programmes now cover nearly half of the world's population only about 30% of people with infectious TB are currently diagnosed and treated under DOTS.

We need to rapidly expand quality DOTS services. We need to tackle new challenges to DOTS implementation such as health sector reforms, the worsening HIV epidemic, and the emergence of drug-resistant strains of TB. At the same time, we need to stimulate public demand for and use of DOTS services and ensure that TB patients complete their treatment. There is an old-fashioned view among many health professionals that all one must do is say "Folks, we have the Cure, come and get it" and patients will show up at the clinic doors. It is not going to happen. We need to say and do a lot more.

Recently, WHO has begun applying an approach known as COMBI in the design and implementation of behaviourally-focused social mobilization and communication programmes for the elimination of leprosy in India and Mozambique, the prevention of lymphatic filariasis in Zanzibar, India, Nepal and The Philippines, and dengue prevention and control in Malaysia and Lao People's Democratic Republic.

COMBI recognizes that in TB control our ultimate goal is behavioural impact: someone doing something. One COMBI goal for TB control is to prompt individuals who have a cough that does not go away after three weeks to come/be taken to a DOTS designated health facility for the free TB (Sputum) Test. This is the first, vital behavioural step in a process leading to cure.

What is Communication-for-Behavioural-Impact?

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

Its methodology effectively integrates health education, information-education-communication (IEC), community mobilization, consumer communication techniques and market research, all directed sharply and smartly to specific, precise behavioural outcomes in health.

It recognizes that in health the ultimate goal is behavioural impact: someone doing something.

It says: we need information; we need education; we need persuasion; we need community involvement; we need an aroused society; we need a committed government; and we also need a consumer sensibility which focuses on consumer decision-making and behaviour, applied to healthy behaviours.

COMBI begins with the "people" (clients, beneficiaries, consumers – family members) and their health needs (or wants, or desires) and a precise focus on the behavioural result expected in relation to these needs, wants, desires. A COMBI mantra is: Do nothing – produce no T-shirts, no posters, no pamphlets, until one has a precise fix on the behavioural outcome desired.

COMBI is rooted in people's knowledge, understanding and perception of the recommended health behaviour. The "market/community" is intimately involved from the outset through practical, participatory community research and situational analysis relating desired behaviours to expressed or perceived needs/wants/desires. This situational analysis involves listening to people and learning about their perceptions and grasp of the offered behaviour, the factors which would constrain or facilitate adoption of the behaviour, their sense of the costs (time, effort, money) in relation their perception of value of the behaviour to their lives.

People are then engaged in a review and analysis of the suggested healthy behaviour through a strategic blend of five integrated communication actions in a variety of settings, appropriate to the "market" circumstances recognising that there is no single magical communication intervention.

COMBI is social mobilization with a behavioural bite

The five integrated communication actions

1. Public Relations/Advocacy/ Administrative Mobilization, for putting the particular healthy behaviour on the public and administrative/programme management agenda via the mass media: news coverage, talk shows, soap operas, celebrity spokespersons, discussion programmes; meetings/discussions with various categories of government and community leadership, service providers, administrators; official memoranda; partnership meetings.

2. Community Mobilization, including use of participatory research, community group meetings, partnership meetings, traditional media, music, song and dance, road shows, community drama, leaflets, posters, pamphlets, videos, home visits.

3. Sustained Appropriate Advertising, (in M-RIP fashion – Massive, Repetitive, Intense, Persistent), via radio, television, newspapers and other available media, engaging people in reviewing the merits of the recommended behaviour vis-à-vis the "cost" of carrying it out.

4. Personal Selling/Interpersonal Communication/Counseling, at the community level, in homes and particularly at service points, with appropriate informational literature and additional incentives, and allowing for careful listening to people's concerns and addressing them.

5. Point-of-Service Promotion, emphasising easily accessible and readily available solutions to health problems.

The key in planning COMBI programmes is to strive for an integrated approach with a judicious blending and selection of communication actions appropriate to the behavioural outcome desired, and not to believe that one single kind of communication intervention is all-powerful.

Why do we need COMBI?

The foundation for having people adopt healthy behaviours is knowledge, once the behaviour and associated health services or products are within reasonable reach. An awareness/educational sensibility has so far informed strategies directed at achieving behavioural results in health.

Increased awareness and education about healthy behaviours have been notoriously insufficient bases for individual or family action, though they are essential steps in the process towards healthy behaviour practice. Regrettably, an informed and educated individual is not necessarily a behaviourally responsive individual. The health field abounds with examples of how "knowledge" in itself fails to prompt desired behavioural results. The almost banal theme needs repeating: Knowing what to do is different from doing it.

The leap into behavioural responsiveness requires the application of knowledge. It calls for engaging people, through a deliberate process of behaviourally-focused social mobilization and communication, in reflecting on acquired knowledge in relation to personal benefits, societal norms and influences and prompting consideration of action on the basis of this engaged reflection. This is the key mission as we aim for the practice of healthy behaviours in controlling and preventing major infectious diseases.

Knowing what to do is different from doing it

The strategic planning and execution of social mobilization and communication programmes for healthy behaviours begins with the fundamentals: One cannot act on a suggested healthy behaviour if one is not aware of and knowledgeable about it, and if one is not engaged in a full and fair appraisal of its merits in relation to the cost and effort involved in putting it into practice. This is the essence of "applying knowledge": engaged communication, based on knowledge, in order to assess recommended actions. Strategies for achieving behavioural impact will need to offer people frequent opportunities for engaging in a deliberate review of suggested behaviours, weighing their value in relation to the "burden" of carrying them out.

This kind of engaged communication is clearly more than a matter of audio-visual materials production. It is more than having posters, pamphlets and T-shirts. It is about empowering people, families and communities to have greater control over their lives and health. It calls for strategically designed, massive education, social mobilization and communication programmes, with a consumer communication sensibility, engaging people at all levels of the society through a wide array of media and in a variety of settings (in their homes, in clinics, at work, in church, in civic groups, in school, at community events).

But these communication programmes will need to go one step beyond the fair appraisal of healthy behaviours. Despite people's conviction about a course of action, they often need prompts and triggers which move them forward to adopting and maintaining healthy behaviours. All of us often need a trivial incentive to do the right thing. The opportunity to win a prize has prompted many to immunise their children in some polio campaigns.

Communication programmes for behavioural impact will need to engage individuals in examining recommended behaviours and to offer the incentives and tugs to action. If we are to have a more profound impact on controlling, preventing and eliminating TB, we need strategically planned, behaviourally focused social mobilization and communication efforts.

COMBI plans for TB control have been designed for Kenya, Bangladesh and Kerala State (India). Each plan is a judicious blend of public relations/advocacy/ administrative mobilization, community mobilization, personal selling, sustained advertising, and point-of-service promotion. Here are some selected highlights from each plan:

- ***In Kenya:*** an ***advocacy/public relations*** effort at the start of the 2003 campaign will put the TB challenge and communication campaign with its specific behavioural request on the public and leadership agenda of the districts and Kenya as a whole. This effort will continue intermittently during the year. As part of the public relations effort, a short 8-minute video will be produced in collaboration with Kenya TV (and involving the country's top leadership) and used in television discussion programmes and also shown via the system of mobile cinema which goes from district to district on a fixed schedule. The public relations/public advocacy effort will also include a variety of feature press articles and radio/TV call-in and discussion shows focusing on TB and the behavioural message.
- ***In Bangladesh: community mobilization*** will include each Upazilla forming a TB Bicycle Riders Team, consisting of about 10 riders, dressed with colourful TB T-Shirt, and chorkis attached to their bikes, and will ride through various villages in the Upazilla every Friday for the first three months and last three months of the COMBI Programme, stopping in places and explaining to people why the behavioural message. The riders will attend Friday prayer service at whatever mosque they arrive at, and after prayer mingle with people and explain the TB behavioural message.
- ***In Kerala: personal selling*** will involve 40,000 Junior Public Health Nurses, Junior Public Health Inspectors, Anganwardi workers, members of MSS and Kudumbasree-with badges and TB worksheets - conducting door-to-door home visits; and 3-5 million school children taking home paper pin-wheels with the TB behavioural message and information worksheets (private sector co-sponsored).

THE KEY STEPS IN DESIGNING A COMBI PLAN

SMT's technical staff and consultants trained in COMBI planning apply a process in developing a COMBI plan. The building blocks of a COMBI plan are outlined below. It assumes a prior understanding of a few basic communication and marketing principles.

Identifying the behavioural objectives

1. The overall goal: a statement of the overall programme goal that COMBI will help achieve. For example… To contribute to the elimination of TB as a public health problem in [location] by the year 2005.

2. The behavioural objective/s: a statement of specific, measurable, appropriate and timebound behavioural objectives. For example… To prompt, over a period of a year, approximately 400,000 individuals (men, women and children of any age) in [location] who have a cough that does not go away after three weeks to come/be taken to one of the 320 designated government health facilities for The Free TB Sputum Test.

3. The situational market analysis vis-à-vis the precise behavioural goal: a "consumer oriented" exploration of the factors influencing the attainment of the behavioural objectives that will inform the strategy and the communication mix.

The situational market analysis

COMBI uses state-of-the-art participatory research techniques adapted from marketing, communications, anthropology, and sociology to identify behavioural issues amenable to communication solutions.

The situational market analysis involves listening to people and learning about their perceptions and grasp of the offered behaviour(s) through tools such as TOMA (Top of the Mind Analysis), and DILO (Day in the Life Of). Their sense of the costs (time, effort, money) in relation to their perception of value of the behaviour to their lives is explored through a Cost vs Value calculation.

Other tools such as the Force Field Analysis helps community members, field staff, local experts, and the COMBI specialist to analyse the social, political, ecological, moral, legal, and cultural factors that could constrain or facilitate adoption of the behaviour.

The situational market analysis also examines where and from whom people seek information and advice on the particular health problem and why they use these information sources. The concept of positioning (used extensively in the advertising world), also helps the development of appropriate messages and communication approaches. Areas that require further investigation are also highlighted.

Finally, issues not substantially amenable to communication solutions, such as the ready availability of services, are documented so that appropriate organizational change or political action can be taken.

The communication strategy and mix

4. The overall strategy for achieving the stated behavioural result: a description of the general communication approach and actions which need to be taken to achieve the behavioural results in light of #3 above and the communication issues identified that includes (a), (b) and (c) below.
(a) Re-state Behavioural Objective.
(b) Set out "Communication Objectives" which will need to be achieved in order to achieve behavioural result (s).
(c) Outline Communication Strategy: a broad outline of the proposed communication actions for achieving communication and behavioural results in terms of the five communication actions listed in #5 below.

5. The COMBI Plan of Action: a description of the integrated communication actions to be undertaken with specific communication details in relation (but not exclusive) to:

Public Relations/Public Advocacy/Administrative Mobilisation
Community Mobilisation
Personal Selling (Interpersonal Communication)
Advertising
Point-of-Service Promotion

Implementation, monitoring and evaluation, budgeting

6. Management and implementation of COMBI: a description of how COMBI will be managed specifying the multidisciplinary planning team, including specific staff or collaborating agencies (e.g., local advertising firms and research institutions), designated to coordinate communication actions and other activities such as monitoring. Also included are any technical advisory groups or government body to which the management team receives technical support from or should report to.

7. Monitoring implementation: the process indicators to be used in tracking the effect and penetration of the communication actions. A description of the decision-making process and how data will be gathered, shared and used.

8. Assessment of behavioural impact: details of the behavioural to be used, methods for data collection, analysis and reporting.

9. Calendar/Time-line/Implementation Plan: a detailed workplan with time schedule for the preparation and implementation activities required to execute each communication action as described in #5.

10. The budget: A detailed listing of costs for the various activities described in #5, 6, 7 and 8.

What are the key steps in designing a COMBI plan?

The first mantra:

Do nothing- produce no T-shirts, no posters, no leaflets until you have a clear specific behavioural goal.

The second mantra:

Do nothing until an appropriate situational market analysis uncovers the specific behavioural outcomes required.

Is this different from Health Education and Promotion?

Yes and no. COMBI integrates principles and techniques of health education and promotion. While health education and promotion may be dedicated to behavioural outcomes stated implicitly, COMBI focuses on and is informed by behavioural outcomes that are made explicit. While health education and promotion emerges from an "educational" sensibility, COMBI springs from a consumer communication sensibility, recognising that behavioural results call for an educational and information base coupled with a marketing orientation. COMBI also begins from "zero-based planning", with the underlying principle that nothing is to be assumed. Instead, through appropriate participatory research, the real barriers and constraints that prevent people from choosing to adopt healthy behaviours are discovered.

Where has it been applied?

COMBI Programmes have already been implemented in Zanzibar (covering the entire population), India (covering two states) and Sri Lanka (covering two provinces) for lymphatic filariasis (LF) prevention, and for dengue control in the state of Johor Bahru, Malaysia.

COMBI programmes are currently being implemented in India and Mozambique for leprosy and planned for Bangladesh, India and Kenya for TB.

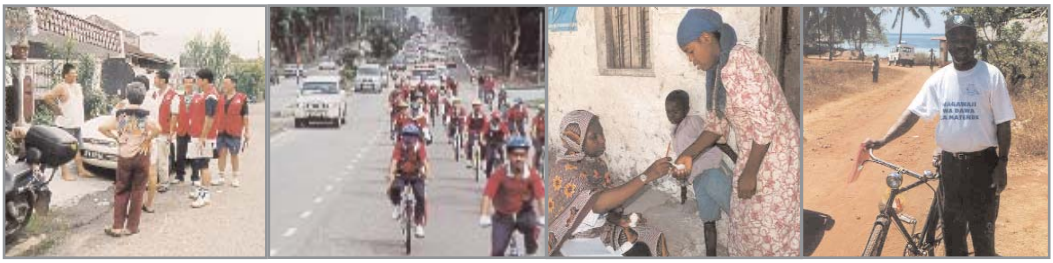
The COMBI Progress Report 2001-2002 provides a case study analysis of the COMBI programmes carried out so far.

How can one tell if COMBI works?

COMBI's impact is defined by the behavioural results specified from the very outset. Once these have been established, the social science research methods of tracking surveys, sample surveys, field observation and in-depth interviewing allow for measuring the achievement of specific behavioural results. The essential pre-requisite, however, for measuring impact is having clear behavioural outcomes as programme goals.

Suffice it is to say that in Zanzibar, despite implementation hurdles, the mass drug administration for LF prevention on October 27th, 2001, supported by a vigorous COMBI Programme, resulted in an almost 90% "drug compliance" among the eligible population, with an 80% threshold set out as the desired behavioural result. And in Sri Lanka 80% of the eligible population complied.

In Johor Bahru, Malaysia, a three-month COMBI Programme resulted in 85 % of households in sampled areas carrying out the desired behavioural task of inspecting the inside and outside of their homes for mosquito breeding sites and taking appropriate action every Sunday for the 12-week duration of the programme.



Is COMBI a good investment?

There is no precise way to indicate likely investment costs for a COMBI Programme. So much depends on the scope of the programme, whether it is a national effort or covers only one district. There is a tendency to see communication work as relatively inexpensive. It is not. While we have a sense of the massive marketing communication investment in developing countries for promoting the sale of consumer products, such as toothpaste or detergents, there still lurks the view that health communication requires minimal funding. If COMBI is to be done well for achieving the essential behavioural goals in confronting communicable diseases, it will require reasonable funding.

Huge investments are made in finding effective cures and treatments such as developing vaccines and establishing the efficacy of drug regimens. Imagine the waste of human and financial resources, as well as the escalating cost of disease burdens, in having such superb solutions to major public health problems being ineffective - precisely because the necessary investments in engaging people in considering new behaviours are not being made.

COMBI will have several effects: social mobilization will be more strategically targeted from the outset; existing resources will be utilised better; the true constraints and problems will be pinpointed; relevant experts will be used much more appropriately; monitoring and evaluation will be simpler and there will be greater understanding and co-operation on the social mobilization outcomes between partners.

COMBI certainly gives value for money and more. It draws in diverse individuals and groups from communication specialists, researchers, volunteers, and businesses to name just a few, thereby, encouraging public-private sector partnerships and invigorating existing health programmes. Because it delivers the expected behavioural outcomes, COMBI is well suited for acheiving behavioural impact in the control of TB.

How can one find out more?

For more information on how COMBI may be applied to behavioural goals in confronting communicable diseases, please contact:

Dr. Elil Renganathan, Coordinator,
Social Mobilization and Training, CDS/CPE,
The World Health Organization,
20, Avenue Appia,
1221 Geneva, 27
Switzerland

Tel: +41 (0) 22 - 791 3828 Fax: +41 (0) 22 791 3154
E-mail: renganathane@who.int