

Draft Strategic Plan for Advocacy, Communication and Social Mobilization

1. Country-level strategic communication

Achievements of Global Plan 1

Insufficient focus on communication has been identified as one of the most acute weaknesses in the first Global Plan and a key reason why greater progress has not been made. Social, cultural, behavioural, epidemiological, economic, and political factors affect not only DOTS provision but also patronage. HIV/AIDS, MDR-TB, stigma and discrimination, gender inequality, public service reforms, population displacement and mobility, and changing communication environments, are among the major issues facing national TB programmes (NTPs).

Strategic communication is now recognized as an essential ingredient of national TB and HIV/AIDS initiatives. In a planned and coordinated manner, strategic communication combines: 1) **Advocacy** to raise and sustain political and financial commitment, 2) **Communication** to stimulate dialogue about behavioural and social change, and 3) **Social mobilization** to build a multi-sectoral response (**ACS**).

An Advocacy and Communications Task Force was established at the end of 2001 to support the first Global Plan. At country level, the Task Force was to contribute to:

- heightened awareness of TB-related issues among policy-makers, opinion leaders, and influential groups;
- increased action by policymakers to adopt and implement policies and programmes in support of achieving TB-control targets;
- better awareness of and training in the internationally recommended strategy for TB control on the part of public and private health-care workers, and better compliance with this strategy; and
- increased social mobilization in support of TB control and eventual elimination.

The Task Force met on an *ad hoc* basis between 2002-2004 assisted various activities to develop strategic communication in countries, including: ACS needs assessments in the 22 HBCs; several regional and national ACS training programmes; development of a range of tools for assessing needs, planning, training, research and evaluation, including the "Cough to Cure Pathway" by the Academy for Educational Development (AED); ACS technical support for GFATM Round 5 applications; and the commencement of two large-scale TB communication initiatives in Kenya and Kerala State, India, based on WHO's Communication-for-Behavioural-Impact (COMBI) approach. The Johns Hopkins University Centre for Communication Programs supported and evaluated a further two national TB communication initiatives in Peru and Viet Nam.

Based on these country level activities and experiences, strategic communication is an important means of engaging policymakers, local government officials, public and private health professionals, traditional and religious leaders, community leaders, patients and their families in bringing about behavioural and social change. Strategic communication also plays a crucial role in expanding the number and range of services for both TB and HIV/AIDS. Nevertheless, the full range of models, approaches, theories, tools, techniques and resources of Strategic Communication *have yet to be fully utilized for TB control at country-level*.

Global Plan 2 aims to establish and develop country level strategic communication as a core component of TB prevention and treatment efforts. The Working Group's country-level plan has the following objectives:

- 1) to provide strategic guidance for GP2 goals and targets as these translate to national initiatives, and examples of effective strategic communication;
- 2) to foster participatory strategic communication planning, management and evaluation capacity at regional, national and sub-national levels; and
- 3) to support and develop strategies to achieve key behavioural and social changes, depending on local context, that will contribute to sustainable increases in TB case detection and cure rates.

The country-level plan envisages that:

- By the end of 2008, at least 15 HBCs will be implementing strategic communication plans and generating qualitative and quantitative data of ACS contribution to TB control as evidenced by participatory planning and evaluation processes.
- By the end of 2012, all HBCs will be implementing participatory strategic communication plans and generating qualitative and quantitative evidence of ACS contribution to TB control.
- By the end of 2015, participatory strategic communication will be a fully developed core component of TB control programme planning.

Building and sustaining national and sub-national capacity in strategic communication is crucial. Staff at public and private health institutions, NGOs and community-based organizations (CBOs) in particular need financial and technical support in planning, implementing, monitoring and evaluating strategic communication activities.

The Working Group acknowledges the clear need for country-level strategic communication to be informed and supported by participatory research and evaluation. Human resources must be strengthened in these fields, especially at sub-national level. Furthermore, this plan takes account of the recommendations of the Community TB Care in Africa project and with similar assessments in Asia and Latin America, which emphasize the cost effectiveness of community-based DOTS programmes and associated activities in achieving TB targets.

The Working Group strongly advocates that People Living with TB (PLTB) and People Living with HIV/AIDS (PLHIV) be actively involved in all facets of NTP management and implementation to ensure more patient-centred, effective and relevant programming, and be engaged as spokespersons for TB and HIV/AIDS programmes. The Working Group also recognizes that empowering patients is among the most effective way to reduce stigma and discrimination.

The country level plan takes note of the successes in Mexico, Peru and Viet Nam and other national examples where strong connections have been forged and maintained between high-level and community initiatives, on the one hand, and mass media efforts on the other. The plan also identifies the need to maintain and foster local diversity but also recognizes the need for mechanisms to bring the many overlapping projects, tools and processes under one united framework, thereby facilitating the sharing of resources and effective practices.

The country level plan calls for rigorous studies of ACS contribution to achievement of GP2 goals and targets. The plan draws upon recent evaluation meta-analyses in other public health communication fields to propose that, at a minimum, strategic communication for TB should help to *maintain* current case detection and cure rates in most countries. In situations where DOTS services are assured, well-planned and fully-resourced, strategic communication could *increase* these rates by as much as 5-10 percentage points, although accounting for all confounding variables in the final analysis will be problematic and difficult to quantify.^{1,2,3} Few studies have calculated the cost of TB communication initiatives,

¹ Snyder, L.B., Diop-Sidibé, N., & Badiane, L. A (2003). Meta-Analysis of the Impact of Family Planning Campaigns Conducted by the Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs. Presented at the International Communication Association annual meeting, San Diego: May 2003.

especially in relation to their impact. For cost effectiveness of strategic communication to become a key criterion for NTP decision-making, research must be funded so that user-friendly assessment guidelines and tools can be developed.

The implementation of this plan will benefit from recent advancements in the art and science of strategic communication. There is an ever-growing literature on cross-cutting issues such as poverty, gender, stigma and TB-HIV/AIDS policy. There are several research tools available for ACS planning. A large number of ACS strategic planning tools and models are now available. There are various ACS field guides that provide detailed operational steps and tips to improve strategic plan implementation. Strategic communication training programmes, short courses and computer-based software have multiplied. Country level advocacy tools such as AED's PROFILES and AIDS Impact Model (AIM) from the POLICY project of the Futures Group could be adapted for TB. There are several state-of-the-art information databases on ACS including The Communication Initiative's Anthology of Health Communication Materials and The Communication for Social Change Consortium's Body of Knowledge. Finally, the range of evaluation methods, indicators and techniques has steadily improved.

Activities, timelines and milestones

Activities to strengthen country level strategic communication are divided into global, regional and national levels.

a. Global level.

The Working Group will be responsible for strategic guidance and review of regional and national ACS activities and for making recommendations to the Stop TB Partnership's Coordinating Board and to STAG on the strategic direction and resourcing of strategic communication activities. This will require at least two annual meetings for the country level subgroup of the WG. The Working Group will also commission regular technical reviews including cost-effectiveness research and tool development to assess country-level strategic communication's contribution to GP2 goals and targets.

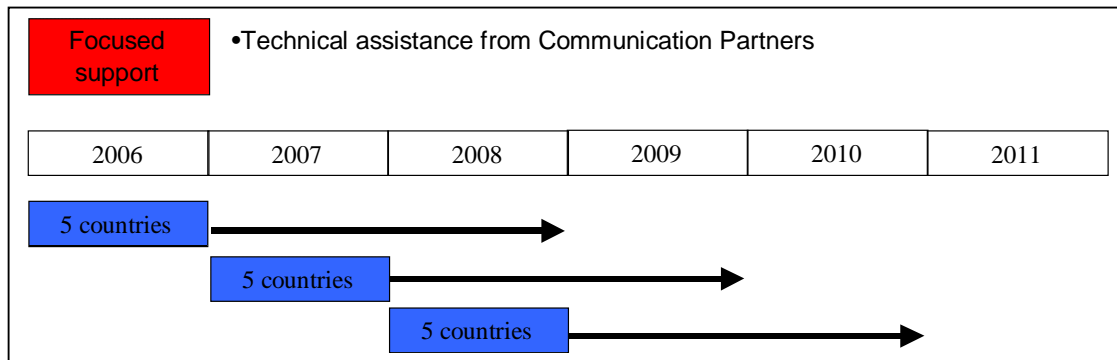
The major investment required at the global level will be in the resourcing of Technical Service Contracts (TSCs) to international and national communication partners who will be responsible for overseeing the vital task of building sustainable national and sub-national capacity in strategic communication. It is likely that these TSCs will be organized along the lines of a TBCTA-type structure. Strategic communication capacity building will be rolled out, starting with 5 countries each year between 2006-2008 (**Figure A**). NTPs not immediately in receipt of this focused technical assistance will benefit from regional support activities as described below.

International communication partners who will assist in building country-level capacity might include, *inter alia*: The Academy for Educational Development; BASICS; Communication for Social Change Consortium; Institute for Sustainable Health Education and Development; Johns Hopkins University Centre for Communication Programs; PATH; PANOS Institute; UNICEF; and WHO's Mediterranean Centre for Vulnerability Reduction (WMC). Regional and national communication partners might include: population media centres; national centres for communication programs; national social marketing organizations; advertising firms; NGOs, CBOs and patients associations with communication capacity; traditional healers; and health promotion/communication departments within ministries of health.

2 Snyder, L.B., & Hamilton, M.A. (2002). Meta-Analysis of U.S. Health Campaign Effects on Behavior: Emphasize Enforcement, Exposure, and New Information, and Beware the Secular Trend. In R. Hornik (Ed.) *Public Health Communication: Evidence for Behavior Change* pp. 357-383. Hillsdale, NJ: Lawrence Erlbaum Associates.

3 Hornik, R. (2002). *Public health communication: Evidence for behavior change*. Mahway, NJ: Lawrence Erlbaum Associates.

Figure A: Rollout of ACS capacity building activities (example)



Secretariat support for organization of international, regional and national meetings, information sharing, and coordination and brokering of technical assistance agencies will also be required. Finally, the Secretariat will need to disseminate technical review results, accumulated evidence, success stories, and lessons learnt through the web, regular publications and other communication platforms.

The budget required to accomplish these global activities over a 10-year period is estimated at US\$1.1 million per year (**Table A**).

b. Regional level

The major activities are to ensure strategic communication expertise is included in DOTS Expansion Working Group (DEWG) monitoring missions, and that strategic communication specialists and NTP communication staff participate in regional TB meetings. For NTPs yet to be reached by capacity building activities delivered through TSCs with communication partners (described above), regional communication workshops and meetings will also be held to promulgate best practices and lessons learned. Finally, funding will be required to deploy regional TB Strategic Communication Officers with the primary responsibility of coordinating regional activities and communicating constantly with NTPs to ensure effective global-to-national linkages are maintained.

Regional activities will ensure that by 2010, strategic communication support is integrated into regional TB technical assistance activities. The budget required to accomplish these regional activities over a 10-year period is estimated at US\$0.6 million per year (**Table B**).

c. National level

Among the many activities considered important, NTPs have identified the following as core:

- Establishment of a national Strategic Communication Coordinator and Task Force;
- Participatory strategic communication planning;
- Strategic communication training for national and subnational staff;
- Strategic communication plan implementation in at least 5 action areas; and
- Participatory monitoring and evaluation.

Based on experience in other public health programmes, the Working Group recommends that from 5% to 15% of national TB budgets be allocated for strategic communication to achieve the desired outcomes (**Table C**). This plan assumes that increased resources towards the upper end of that range will be required when ACS initiatives are starting up or when intensified efforts are needed in high prevalence countries or for more complex situations such as the co-existence of TB and HIV/AIDS, high levels of stigma, increasing MDR-TB, decentralized government systems, and large displaced or mobile populations.

Resource needs

(i) Budget

The budget requirements for the above activities are detailed in **Tables A-C**. Annual budget figures for NTPs (**Table C**) are shown as percentage proportions of the overall 5-15% budget allocation recommended above.

(ii) Funding

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

(iii) Financing gap

Still to be determined

Monitoring and evaluation

The monitoring and evaluation of this country-level plan occurs at several levels. At global level, annual technical reviews will be commissioned to analyze the progress being made in national strategic communication capacity building and the contribution and cost-effectiveness of strategic communication to GP2 goals and targets. The Working Group and subgroup meeting reports will also be used to track progress. Frequent international, regional and national meetings will be held to document and disseminate evidence to date, best practices, and lessons learned. Regular technical advisory missions provided under TSCs with highly experienced communication partners will offer many opportunities for NTPs to monitor and supervise national and sub-national strategic communication activities. Country-level strategic communication initiatives will develop their own participatory monitoring and evaluation processes, including appropriate indicators and reporting systems. Finally, existing information systems, methods, indicator banks, and techniques used within and beyond NTPs will be adapted where necessary to strengthen the monitoring and evaluation of this plan. Rigorously derived evidence of Strategic Communication contribution to TB control should begin to accumulate by the end of 2007.

Budget - Country level strategic communication

Table A: Strategic communication subgroup

| Input | Output | 2006 \$\$ | 2007 \$\$ | 2008 \$\$ | 2009 \$\$ | 2010 \$\$ | 2011 \$\$ | 2012 \$\$ | |
|--|--|-----------|-----------|-----------|------------|-----------|-----------|-----------|--|
| ACS-WG country-level sub-group meetings twice a year | Strategic guidance and review, recommendations to Coordinating Board and to STAG | 100000 | 100000 | 100000 | 100000 | 100000 | 100000 | 100000 | |
| Commissioned technical reviews based on country-level data and reports | Evidence-base: best practice, lessons learnt, ACS contribution to TB control | 20000 | 30000 | 40000 | 50000 | | 50000 | | |
| Technical service contracts | ACS management capacity strengthened at country-level x 5 countries | 875000 * | 875000 * | 875000 * | 1225000 ** | | | 875000 * | |
| Publications and other materials (CDs, Web, etc) | Evidence, stories, lessons learnt communicated | 20000 | 20000 | 20000 | 20000 | 20000 | 20000 | 20000 | |
| Secretariat support | Coordination, organization of meetings, information sharing, brokering of TA resources | 300000 | 300000 | 500000 | 500000 | 500000 | 500000 | 500000 | |
| TOTAL | | 1315000 | 1325000 | 1535000 | 1895000 | 620000 | 670000 | 1495000 | |

* Five countries each year. Successful Communication Partners will be awarded contract to support a specific country for 3 years. The annual sum of US\$875,000 is therefore the total of five three year contracts that, depending on the scale and initial capacity of each country requesting support, will be worth around US\$175,000 each. An appropriate proportion of this amount will be spent each year according to the country's capacity building needs. Capacity building contracts in selected countries resume again in 2012.

** Remaining 7 HBC (assuming still have 22 HBCs by 2009).

Table B: Regional level

| Input | Output | 2006 \$\$ | 2007 \$\$ | 2008 \$\$ | 2009 \$\$ |
|---|--|-----------|-----------|-----------|-----------|
| Integration with regional TB control activities | • DEWG monitoring missions | 50000 | 50000 | 50000 | 50000 |
| | • Participation in regional TB meetings | 60000 | 60000 | 60000 | 60000 |
| | • Regional Communication workshops (for countries not yet reached by technical assistance detailed in Table A) | 60000 | 60000 | 60000 | 60000 |
| | • TB Regional Strategic Communication Officer | 170000x1 | 170000x2 | 170000x3 | 170000x3 |
| TOTAL | | 340000 | 510000 | 680000 | 680000 |

Table C: Country level

| | |
|---|---|
| National Strategic Communication activities | 5%-15% of annual national TB budgets allocated to Strategic Communication, divided according to following proportions (example only): |
| Salary for Strategic Communication Coordinator | According to national salary scale |
| National Strategic Communication Task Force meetings, administration, review, etc. | 2% |
| Operational research (participatory process) | 1% |
| Strategic planning (participatory process) | 2% |
| Sub-national staff Strategic Communication management training | 5% |
| Strategic Communication monitoring and evaluation system set-up | 4% |
| Communication training for staff, volunteers, etc | 10% |
| Design and preparation of messages, events, activities, materials, etc. | 6% |
| Strategic Communication activities including but not limited to: <ul style="list-style-type: none"> ● Political advocacy, public relations, business and administrative mobilization ● Mass media – radio, TV, newspapers (as and where appropriate) ● Community mobilization – patients associations, NGOs, CBOs, schools, etc. ● Interpersonal communication – health workers, volunteers, ex-patients, etc. ● Point-of-service promotion – DOTS clinics, etc. | 65% |
| Participatory Monitoring: tracking, media analysis, etc. | 2% |
| Participatory Evaluation: pre-, post surveys, etc. | 3% |
| Total | 100% |

2. Global advocacy

Achievements of Global Plan 1

Global advocacy has helped elevate TB control higher on global agendas since 2000. This advocacy helps create the political accountability and social pressure required to attract new and more effective funding for TB control and to more effectively shape TB policy agendas. Following are the highlight achievements since 2000:

Outcomes

- TB control targets were embraced and publicized by the G8 in 2000 and Commission for Macroeconomics and Health in 2001.
- TB was included as one of the 3 diseases to be addressed by the GFATM, which has provided more than \$400 million in approved grants for TB from 2002-2004.
- Total annual aid for the HBCs (loans and grants, including GFATM) has grown from \$80 million in 2002 to \$220 million in 2005, an increase of 275%.
- More than \$80 million in total cumulative funding has been mobilized for the Global Drug Facility, as well as increasing funding support for non-GDF Secretariat activities.
- During the past year, high-level statements by Nelson Mandela, the African Union, and the Commission for Africa called for greater integration of TB and HIV/AIDS control efforts.

Partnership building

- The Partnership's outreach capacity has been expanded with information platforms, including a listserv (3,200 active subscribers), HD Net TB e-forum (7,500 members), re-designed web site (1 million visits per year), and PANOS TB media fellowships program (9 countries).
- The new Working Group for Advocacy, Communication and Social Mobilization was established by the Stop TB Coordinating Board in 2004 and is now operational.
- New international networks of TB and TB-HIV patients have emerged.

Strategic Vision

Global advocacy will support the Resource Development Plan by creating political accountability and social pressure needed in order to help attract \$15 billion in funding for GP2. Several advocacy experiences inform the estimate of advocacy resources needed to accomplish this objective:

- Since 1993 when WHO declared a "global TB emergency," WHO and the STB Partnership have been the largest funders of TB advocacy, devoting some \$15 million to this task. Roughly \$1 billion in new donor funding for global TB control efforts was mobilized over the same period.
- The cost of GFATM advocacy efforts initiated by WHO and partners in 2000 and then continued after 2002 by the GFATM secretariat and other partners can be very conservatively estimated at \$10-12 million thru 2004. Donor contributions have totaled some \$3.5 billion to the Global Fund as of end-2004.

While it is difficult to directly quantify the contribution of advocacy to resource mobilization, and while there were synergies and overlap between various TB advocacy efforts, it is estimated that an annual investment in advocacy ranging from \$.5 million - \$2 million is a prudent level to help mobilize every \$100 million in funding. This is consistent with the estimated \$5 million that the Secretariat and its partners are currently spending per year on advocacy, corresponding to an estimated \$300 million in external aid flows for the HBCs, GDF and technical agencies.

Accordingly, the GP2 strategic plan recommends that a 1% investment in advocacy should be made for every dollar to be mobilized; or \$10 million annually to help ensure \$1 billion in annual donor support. The costs of partnership building activities should be calculated in addition.

Activities

An adequately-resourced TB advocacy initiative must also be strategically sound in order to succeed. Building on experience, planning and lessons learned from TB advocacy over the past 15 years, as well as advocacy experiences from other health issues and social causes, the

following four broad strategic directions are recommended for achieving the objectives of 1) mobilizing \$1 billion annually for the control of TB; 2) ensuring these funds are put to their most effective use in accordance with GP2, and 3) increasing political and social support for TB control policies recommended by the World Health Organization.

1. Donor countries

National TB advocacy organizations and/or coalitions should be established and funded in *all* major donor countries, and regionally for smaller donor countries. Such initiatives are already well established in the US (RESULTS and American Lung Association), Canada (RESULTS and Stop TB Canada), UK (RESULTS and TB Alert), Japan (RESULTS and JATA/RIT), Norway (LHL) and the Netherlands (KNCV). NGO activist-led initiatives of a similar scale should also be established in France, Germany, Italy and Belgium/EC. On a smaller scale, NGO-led TB advocacy activities should also be established in Sweden, Denmark, Ireland, Switzerland, Austria/Luxembourg, Spain, Australia/New Zealand, Saudi Arabia/Middle East, South Korea and Singapore. These TB advocacy groups should be focused on increasing the *quantity* of donor support for TB control and research, as well as monitoring and improving the *quality* of this support.

2. Global advocacy

A number of meta-activities at global level are required to support the advocacy work of TB advocacy organizations around the world, and to command the attention of global media (eg. CNN, BBC), international organizations (e.g. World Bank and multinational corporations) and international NGOs which span the world's borders. The Partnership and WHO's STB Department are uniquely positioned to facilitate the following advocacy activities:

- Global advocacy materials / Prototype advocacy messages, materials, images and strategies – concurrent with WHO's TB control policies – are essential to align global, national and local advocacy activities. These materials play an essential part in branding and marketing TB policies, interventions and best-practices to target audiences.
- Global media coverage / Politically significant global media coverage on TB is often most effectively initiated from international organizations such as WHO and the Stop TB Partnership Secretariat.
- Celebrity, patient and policy champions / The Partnership is best positioned to identify and engage globally and nationally recognized celebrities from the music, entertainment and sports industries as champions for the control of TB, as well as global patient spokespeople and international policy champions.

3. Partnership building

The Partnership, WHO, IUATLD, Global Drug Alliance, FIND and WEF play unique roles in convening, informing and involving individuals and organizations in specific opportunities for addressing the global TB epidemic. Two main vehicles for accomplishing this include:

- Involving NGOs, business & civil society / Improve public and political support for stopping TB by increasing the involvement of new civil society actors, as well as informing, consulting with and coordinating ongoing efforts.
- Enhancing web & electronic information sharing / Increase the impact of the response to TB by increasing information exchange, discussion and transparency; increasing coordinated participation of new and existing partners; facilitating long-distance learning; encouraging cross-fertilization of ideas; and broadening the scope of decision-making.

