

# **Guidelines for Social Mobilization**

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## **Planning Communication-for-Behavioural-Impact (COMBI) in TB control**

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## INTRODUCTION

A continuing dilemma for TB control professionals is finding effective ways to encourage new behaviours and achieve behavioural results. Many different approaches have been useful in the past. While there have been some successes, there has also been enormous frustration at not being able to achieve more at a faster rate.

Recently, the World Health Organization's Social Mobilization and Training Team (SMT) has begun applying an approach known as COMBI (Communication-for-Behavioural-Impact) in the design and implementation of social mobilization and communication plans for the adoption of healthy behaviours. 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*.<sup>1</sup> It is a process which strategically blends a variety of communication interventions intended to engage individuals and groups in considering recommended healthy behaviours and to encourage the adoption and maintenance of those behaviours. COMBI incorporates the many lessons of the past 50 years of health education and communication in a behaviourally-focused, people-centered strategy. COMBI also draws substantially from the experience of the private sector in consumer communication. It is an approach well suited for achieving behavioural impact in TB control.

This Guide outlines the key steps for developing a COMBI plan to *increase TB case detection rates* and should only be used where well functioning Directly Observed Treatment, Short-course (DOTS) services are in place and avoided in areas where they are not well established.<sup>2</sup> Much of what is described in this Guide can of course be applied to *increasing and maintaining case cure rates* but a range of other documents describe how to deal with this second critical issue, especially through the involvement of community-based treatment supervisors in contexts where access to health facilities is limited and TB is often highly stigmatized.<sup>3</sup>

You may be a national TB control programme manager who wishes to go beyond the mundane tasks of producing pamphlets, T-shirts and posters. Maybe you have had limited exposure to social mobilization and communication work, and want to understand how it fits into your overall programme. You may be a medical officer in charge of a district health service. You may be a physician working with an NGO on a community-based TB project. You might be working with health communication, health promotion, health education or health information-education-communication (IEC) and wish to read something that will inspire you to try new ways of doing what you are already doing. This Guide will help you accomplish three essential tasks in relation to increasing case detection rates:

1. You will establish clear behavioural objectives.
2. You will determine the strategic roles of a variety of social mobilization and communication disciplines – for example, public relations, advocacy, administrative mobilization, community mobilization, advertising, interpersonal communication, and point-of-service promotion – in achieving and sustaining these objectives (**Box 1**).

3. You will combine these disciplines in a comprehensive plan that provides clarity, consistency, and maximum behavioural impact to your social mobilization and communication efforts.

#### Box 1: COMBI's integrated actions

- **Public Relations/Advocacy/Administrative Mobilization:** for putting the particular healthy behaviour on the business sector and administrative/programme management agenda via the mass media – news coverage, talk shows, soap operas, celebrity spokespersons, discussion programmes; meetings/discussions with various categories of government and community leadership, service providers, administrators, business managers; official memoranda; partnership meetings.
- **Community Mobilization:** including use of participatory research, group meetings, partnership sessions, school activities, traditional media, music, song and dance, road shows, community drama, leaflets, posters, pamphlets, videos, home visits.
- **Sustained Appropriate Advertising and Promotion:** in M-RIP fashion – Massive, Repetitive, Intense, Persistent – via radio, television, newspapers and other available media, engaging people in reviewing the merits of the recommended behaviour vis-à-vis “cost” of carrying it out.
- **Personal Selling/Interpersonal Communication/Counselling:** involving volunteers, school children, social development workers, other field staff, at the community level, in homes and particularly at service points, with appropriate informational literature and additional incentives, and allowing for careful listening to people's concerns and addressing them.
- **Point-of-Service Promotion:** emphasizing easily accessible and readily available TB diagnosis and treatment.

The key to COMBI planning is to strive for an integrated approach with a judicious blend and selection of communication actions appropriate to the behavioural outcome desired, and not to believe one single kind of communication intervention is all-powerful. The assistance of social mobilization and communication experts in the design and implementation of COMBI plans is also essential. In immunization programmes, many ministries of health are now working with private sector advertising agencies and important lessons can be learned from these experiences. A friendly chat to colleagues working on immunization can provide you with valuable information and networks for your own programme. After studying this guide, you will be able to understand more fully what to expect from social mobilization/communication specialists you may employ.

### Organization of this guide

This guide is divided into two parts.

Part One briefly examines the main factors related to TB control, noting that since the introduction of the WHO recommended control strategy – Directly Observed Treatment Short-Course or DOTS – much progress has been made yet only around 30% of people with infectious TB are currently diagnosed and treated under DOTS. Seven social mobilization and communication challenges facing the promotion of DOTS services are described. COMBI is then situated in relation to other approaches associated with

promoting healthy behaviour, the principal ones being: social mobilization; social marketing; and information-education-communication (IEC).

Part Two describes the 10 steps in developing a COMBI plan. Specific points are illustrated using extracts from a COMBI plan for TB control developed in Kerala State, India. Several tips on COMBI planning are also provided.

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# PART ONE

## 1. TUBERCULOSIS AND ITS CONTROL

### 1.1. Tuberculosis infection

Tuberculosis is a contagious bacterial disease caused by *Mycobacterium tuberculosis*. Like the common cold, TB is spread through the air. The main source of infection is a person with TB of the lungs (pulmonary TB) who coughs, sneezes or spits, and spreads infectious droplets containing bacteria in the air.

Once infected with *M.tuberculosis*, a person stays infected for many years, and often for life. The vast majority (90 percent) of people infected with *M.tuberculosis* do not develop the disease of tuberculosis. Active disease occurs in an average of 10 percent of those who are infected. Various physical or emotional stresses trigger progression from infection to disease. Any weakening of the immune system – for example, by malnutrition or HIV infection – increases the chances for disease to develop.

### 1.2. Tuberculosis treatment

Left untreated, a person with active TB will infect on average 10 to 15 persons a year. The most effective approach to TB control is the identification and cure of these infectious cases. Proper treatment of infectious cases makes them very quickly non-infectious so they can no longer spread TB to others. Because effective treatment breaks the cycle of transmission, cure is the best prevention.

This is even more important because of the emergence of drug-resistant TB. Drug-resistant TB is a human-made phenomenon caused by inconsistent or partial treatment, when TB bacilli become resistant to the most common anti-TB drugs. This happens when doctors or health workers prescribe the wrong drugs or the wrong combination of drugs, the drug supply is unreliable, or patients do not take all their medicines regularly for the required period of time. Once the bacilli become resistant to one or more anti-TB drugs, the infected person can go on to infect others with the same drug-resistant strain. Multi-drug resistant TB is more difficult and more expensive to treat, and more likely to be fatal.

### 1.3. Directly Observed Treatment, Short-Course (DOTS)

Today, however, there is a proven, cost-effective TB treatment strategy known as DOTS (Directly Observed Treatment, Short-course). *Directly observed treatment* (DOT) – watching patients taking their medications – is essential at least during the intensive phase of treatment (the first two months) to ensure the drugs are taken in the right combinations and for the appropriate duration.

With direct observation of treatment, the patient doesn't bear the sole responsibility of adhering to treatment. Health care workers, public health officials, governments, and communities must all share the responsibility and provide a range of support services patients need to continue and finish treatment. One of the aims of effective TB control is to organize TB services so that the patient has flexibility in where he or she receives

treatment, for example, in the home or at the workplace. Treatment observers can be anyone who is willing, trained, responsible, acceptable to the patient and accountable to the TB control services. 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.

*Short-course* treatment refers to a treatment regimen that lasts six to eight months and uses a combination of powerful anti-TB drugs (this compares with a long-course regimen, which lasts 12-18 months). The most common anti-TB drugs used are isoniazid, rifampicin, pyrazinamide, streptomycin, ethambutol and thioacetazone. With short-course treatment (six to eight months), patients feel better more quickly as the bacterial load decreases dramatically during an intensive initial two-month phase of treatment. Within these few weeks, patients are rendered non-infectious and are no longer able to spread the disease to family, friends and co-workers.

DOTS has five key components (**Box 2**).<sup>4</sup>

**Box 2: DOTS five point strategy**

- **Sustained political commitment** to increase human and financial resources and make TB control a nation-wide activity integral to national health system;
- **Access to quality-assured TB sputum microscopy** for case detection among persons presenting with, or found through screening to have, symptoms of TB (most importantly prolonged cough). Special attention is necessary for case detection among HIV-infected people and other high-risk groups, e.g. people in institutions.
- **Standardized short-course chemotherapy** to all cases of TB under proper case-management conditions including direct observation of treatment – proper case management conditions imply technically sound and socially supportive treatment services;
- **Uninterrupted supply of quality-assured drugs** with reliable drug procurement and distribution systems and,
- **Recording and reporting system enabling outcome assessment** of each and every patient and assessment of the overall programme performance.

Since the introduction of the DOTS strategy in the early '90s, considerable progress has been made in global tuberculosis control. 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. DOTS programmes now cover nearly half of the world's population. By 2000, 148 countries had adopted the DOTS strategy.

Although considerable, this progress has not been enough. An estimated one third of the world's population is already infected with TB. Each year, an estimated 8.4 million new cases are produced from this reservoir, and 1.9 million people die of the disease. The poor and marginalized in the developing world are the worst affected: 95% of all cases and 98% of deaths from TB occur in resource-poor countries. Only about 30% of people with infectious TB are currently diagnosed and treated under DOTS. The current targets for global TB control are to cure 85% of the infectious TB cases and to detect 70% of such cases by 2005.

Current trends indicate that by 2020 nearly one billion people will have become infected with TB, 200 million will have developed the disease and 35 million of them will have died. 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.<sup>5</sup> At the same time, we need to stimulate public demand for and use of DOTS services and ensure that TB patients complete their treatment. To achieve these behavioural goals we must overcome several social mobilization and communication challenges.

## **2. SOCIAL MOBILIZATION AND COMMUNICATION CHALLENGES OF TB CONTROL**

### **2.1. DOTS services do not sell themselves**

Case finding and diagnosis for TB control through DOTS is said to depend on a simple, cost-effective and reliable method: three sputum examinations for all infectious cases; limited use of X-ray for specific cases; tightly defined symptomatic diagnosis as a supplemental diagnosis of some cases. Case treatment is said to depend on a straightforward proven regimen: standardized for each case type; directly observed by a suitable trained person with patient counselling; drugs may be taken daily or three times a week (for at least six months); health workers can administer treatment once a week, a trained volunteer on other days; treatment can be administered at a health facility, patient's home or community centre; treatment follow-up is systematic in content at fixed times and based on inexpensive sputum smear microscopy.

But there is nothing simple about the diagnosis and treatment of TB. For most people, they would have to take two days out of their life to get to a health facility for the TB test, cough and spit for sputum once at the facility, then take a plastic cup home and cough-and-spit the next morning, come back to the facility that second day, cough-and-spit once more for sputum at the facility, and wait there for the test result. If the result is TB positive, then (under the current treatment regimen) they will need to come back to the facility or some other spot (hopefully nearer their homes) every day for two months and take a set of pills under the watchful eyes of a health worker (or some other designated responsible person), do another cough-and-spit sputum test, and then continue taking a set of pills but every other day instead for another 6 months. What's simple about this?

There is an old-fashioned view among many health professionals that all one must do is say "Folks, we have the Cure, come get it" and the mobs will show up at the clinic doors. It is not going to happen. We need to say and do a lot more.

### **2.2. Knowledge is not enough**

Evaluation researchers have noted that despite growing levels of knowledge and awareness about TB, many people are still not doing what they are supposed to be doing. Many programmes, however, still focus just on changing people's knowledge and raising awareness in the belief that behaviour will change; when it doesn't (and it usually doesn't) the standard response is to bombard people with even more clinical and epidemiological

facts, often using sophisticated advertising techniques. But more information, fancy posters, colourful T-shirts, glossy pamphlets, and snazzy TV spots rarely, in themselves, lead to behavioural responses if they are not behaviourally focused.

The foundation for having people adopt healthy behaviours is knowledge, once the behaviour and associated health services or products are within reasonable reach. Increased awareness and education about healthy behaviours have notoriously been 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. 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 50% sale on running shoes has prompted many off their couches. Communication programmes for behavioural impact will need both to engage individuals in examining recommended behaviours and also offer the incentives and tugs to action.

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 TB.

### 2.3. Behaviour changes in subtle stages

Unfortunately, people do not change behaviour all of a sudden and remain "changed" from that moment onwards. Instead, people move through subtle stages. The adoption of new or recommended behaviours can be illustrated by a simple model, known as HIC-DARM. The model, based on traditional behaviour adoption theory and practice, describes the process by which individuals accept and maintain any new behaviour, such as presenting themselves for a sputum test (**Box 3**).

First, people **Hear** about TB, its cause and its solution (presenting for a sputum test and taking the drug treatment); then, they become **Informed** about the disease, its cause and solution. Later, they become **Convinced** that the solution is worthwhile adopting and **Decide** to do something about their conviction, and take **Action** on the new behaviour. They then await **Reconfirmation** that their action was a good one and if all is well, they **Maintain** the behaviour (returning for another sputum test if the same TB-like symptoms appear again).

In this model, a line separates the HIC from the DARM, to illustrate the usual gap between informing-convincing someone (HIC) and prompting the next steps towards behavioural impact (DARM). Most programmes manage to inform and convince (HIC), but often fail to prompt people to take the steps towards adopting and maintain the new behaviour (DARM). One can easily achieve the preliminary goals of informing, awareness and educating and convincing individuals of what needs to be done. It is quite another challenge to get people to act and continue to act.

**Box 3: HIC-DARM and behaviour adoption**

First, we	<b>H</b> ear about the new behaviour
then, we become	<b>I</b> nformed about it
and later	<b>C</b> onvinced that it is worthwhile.

In time, we make the	<b>D</b> ecision to do something about our conviction
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and later we take	<b>A</b> ction on the new behaviour.
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We next await	<b>R</b> e-confirmation that our action was a good one
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and if all is well, we	<b>M</b> aintain the behaviour!
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Each dimension of HIC-DARM calls for an appropriate communication intervention, but the message to an individual that creates awareness of a healthy behaviour (regardless of the medium used) has to be different from what would prompt a decision to act and still different from what would actually trigger action. For TB control, the ultimate goal is the M or “Maintenance” of behaviour and this requires a strategic and smooth movement through the entire process of HIC-DARM.

The principles of HIC-DARM apply to audiences at all levels – the behaviours of community leaders, businesses, private physicians, and government authorities, not just the behaviours of potential TB patients and their care-givers.

#### **2.4. The cost versus value calculation**

One of the crucial equations you will need to understand that will make or break your programme is the cost versus value calculation that the people you are trying to reach will be making.

Stop for a moment and consider the cost versus value considerations Babukutty – a rice farmer living in Kuttanad, Kerala State India who has a persistent cough that he fears may be tuberculosis – will be thinking about. Assume that Babukutty wants to cure himself, as well as protect his family and community. Assume also he knows that he needs to get a sputum test. He might be asking himself: How long will it take me to reach the nearest DOTS clinic? Will I have to spend any money to reach there? If not how long will I have to walk? How many hours of work (weeding/sowing/planting) will I have to lose to get to the clinic? And therefore how much income will I lose? How long will I have to stay there? How am I going to arrange for my wife and children to get diagnosed as well? Is it important for them? In fact is it important for me? Surely these TB drugs have side effects. What could they be? How safe are the drugs? Is the treatment effective?

These cost considerations will be balanced against the “values” that Babukutty will see the diagnosis and treatment will bring to him and his family's health. If he feels that none of his family is at risk from TB and there are no benefits to getting a sputum test, the value of going to the DOTS clinic will be minimal and the costs will be greater than the value he perceives. The result is that he doesn't go to the DOTS clinic.

Behavioural responses emerge only after people are engaged in a communication process that facilitates their understanding of a recommended behaviour and allows them to weigh its merits and value in relation to the cost and effort involved in putting it into practice. The major tasks that you have are to engage with people like Babukutty in a serious reflection of the costs and values of visiting a DOTS clinic and to ensure that the perceived values outweigh the costs.

## 2.5. The complexity of communication

Communicating is something we do every day on an interpersonal or group level, automatically, without training, and there is a belief that communicating is somehow a natural phenomenon. However, there is complex process occurring which takes into account not only what is being said but also *how* it is being said. Research studies have shown that non-verbal language, for example, plays a significant part in communication.

The sum of communication theory models, developed over the last 50 years, can be described with the following acronym, **MS. CREFS**: **C**ommunication is the process in which a **M**essage from a **S**ource is sent via a **C**hannel to a **R**eceiver with a certain **E**ffect intended with opportunities for **F**eedback, all taking place in a particular **S**etting (**Box 4**).

<b>Box 4: MS.CREFS</b>	
<b>Component</b>	<b>Important considerations</b>
Message	Ensure that the language is clear, easily understandable. That it is not too technical. Giving too many messages confuses the audience. Be clear about what is the main central message.
Source	The credibility of the person who delivers the message influences the degree to which it is accepted. For example, people may pay more attention to a message if a well-known doctor rather than a local shopkeeper delivers it. In other cases, a young person may be more likely to persuade other young people to take action rather than an older person who may be seen as authoritarian. Remember that appearance makes a difference in how the source is perceived. Credibility, expertise, trustworthiness and empathy are critical.
Channel	Identifying the most appropriate channel is important, either using the mass media through radio, television and newspaper and/or interpersonal channels such as door-to-door visits, traditional theatre and community meetings. The right channel must be used for the right target audience and generally the most effective is a strategic, selective mix of channels. Note the importance of non-verbal communication, including the body language, facial expressions and posture of the person delivering the message.
Receiver	The receiver (or target audience) filters and interprets the world through the cultural lens they view the world. An understanding of this world is therefore crucial to help you to communicate effectively. The receiver filters and interprets the world through the cultural lens they view the world. An understanding of this world is crucial to effective communication. Therefore, how you would explain the sputum test to a rural farmer may be different from how one would deal with urban schoolchildren and housewives. A sound

	situation analysis is important to identify the most appropriate way, messages, timing, and location to engage different audiences in a serious reflection of what you are offering versus the cost of getting the sputum test.
Effect	The effect, the end-result of communication, is the behavioural focus through improving knowledge, and convincing beneficiaries as well as providing prompts and triggers that could have an impact on ultimate behavioural outcomes. This is an important starting point for communication planning. One must be clear about the communication effect(s) you desire that will lead to behavioural results required by the programme.
Feedback	It is important to ensure that communication interventions are appropriate, effective and engages the receiver. Feedback allows for such assurance. With it one can fine-tune communication actions.
Setting	This can facilitate or hinder communication. If there is too much noise, or the time is inappropriate, or the setting is inappropriate to the subject being discussed, or there are too many distractions, or it is too hot, or too cold, all these affect how messages are heard and interpreted. Locations such as religious venues, health centres, cafes, market places, schools, all provide their unique features which affects the dynamic of communication and must be considered in the planning of communication actions.

Each of these components requires careful consideration and attention because each impinges on how the programme is received and ultimately on the desired behavioural outcome.

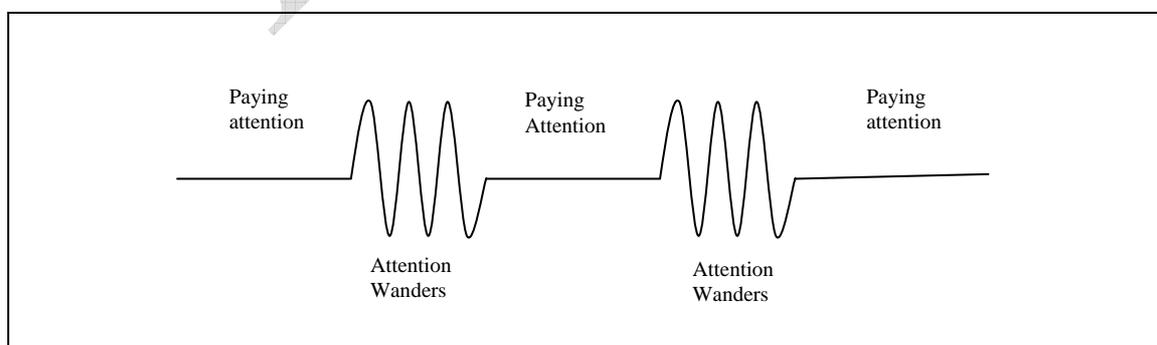
## 2.6. The three communication pains

The three most important challenges in communication, critical in the use of mass media but which still have a consequence in interpersonal communication, are:

- Selective attention
- Selective perception
- Selective retention.

Overcoming these well-documented phenomena should be built into the communication process.

**Selective Attention:** The natural attention span usually works by full engagement for about 40 seconds or so followed by the drifting of attention to other matters, returning to the message/messenger at hand, and once more drifting, and so on for the duration of a communication action.



It is usually harder to keep people's attention if it is not captured in the first seven seconds of an interaction. If they are not interested during this crucial period, it is usually too late to get them back. This is particularly the case with radio and television advertisements. Also, people choose whether to listen to someone or a message based on whether they agree with the message or whether the message would perturb them.

In other words, people will tune into what they want to hear. If they are already interested in TB by having experienced the disease or knowing someone with it, they may be more receptive to continue listening to a radio programme on the issue. People, who do not see it as a problem, however, will tend to ignore a long narrative on the subject on radio or television, unless their attention is caught immediately and they very quickly understand why they are at risk.

**Selective Perception:** This is about people perceiving issues in a certain way, selecting bits of information to support an already existing view. If an individual believes that TB is God's punishment, messages to the contrary may be interpreted to mean 'Ah, so this is how God punishes.' We all know about the phenomenon of how poster designs and messages can be interpreted in totally different ways by different people. Hence the importance of pre-testing information and education materials to ensure similar interpretation throughout a community.

**Selective Retention:** Each person remembers events that mean something to them; selective retention is about forgetting those things that they want to forget, such as unpleasant memories or points of views that do not coincide with their own. It may also occur if too much information is given, resulting in information overload. Forgetting is a frequently occurring natural phenomenon. Hence the need for the constant repetition of messages.

## 2.7. The need for an enabling environment

You might also find that an individual cannot change his or her behaviour unless the setting in which s/he lives or works is also changed. It is then up to you to discover how to make this setting an "enabling" environment, one that supports new behaviours, perhaps by making interventions more gender-sensitive and by reducing stigma and discrimination.

### *Gender*

A generalized picture describing the experiences of a poor man and a poor woman, living in a poor country and suffering from symptoms of pulmonary TB might read like this: Burdened by the demands of daily survival, both the woman and the man will effectively ignore the mild, early symptoms of TB. Poorer access to resources might make the woman live with the suffering for a longer period than the man. Knowing the time and energy they will have to spend approaching the public health centre, which anyway is not very popular, they will often borrow money and visit a nearby private practitioner of some kind. Unrelieved, the man will make a few more visits to the private practitioner before ending up in the public health centre. Sensing that her disease might be TB, however, the woman may either succeed in getting support from the family and seek care in private, mostly intermittently, where the confidentiality of her diagnosis will be maintained. If she is married she may get sent away by her in-laws to be cared for in her father's home. Yet even if she is able to approach a health care provider, she is less likely to be suspected of having TB, is less likely to be given a sputum examination, and is less likely to be found sputum positive than the man. Away from her husband's place, she may take treatment at a private or a public health centre and will generally follow the care giver's advice more assiduously than the man. If the treatment provision is regular, she is more likely to complete the

prescribed course of treatment, despite difficulties. If not, she is more likely to die of the disease than her male counterpart.<sup>6</sup>

The short-term and medium term objectives of any strategy to address TB and gender have to be focused on first making the various elements of TB programmes gender-sensitive. To enable this, the magnitude of gender-disparities in TB – from contracting the disease to obtaining cure – will have to be known and the extent to which the reasons for such disparities are biological, social or operational need to be investigated.

### ***Stigma and discrimination***

Stigma and discrimination associated with TB are among the greatest barriers to preventing further infections, providing adequate care, support, and treatment and alleviating impact. TB-related stigma and discrimination are universal, occurring in every country and region of the world.<sup>7</sup> Stigma and discrimination are triggered by many forces, including lack of understanding of the disease, myths about how TB is transmitted, prejudice, lack of access to diagnosis and treatment, irresponsible media reporting, the link between HIV/AIDS and TB, and fears relating to illness and death. Stigma is harmful, both in itself, since it can lead to feelings of shame, guilt and isolation of people living with TB, and also because negative thoughts often lead individuals to do things, or omit to do things, that harm others or deny them services or entitlements (i.e., discrimination). Discrimination can take various forms and can exist at many levels. For example, hospital or prison staff may deny health services to a person with TB. Or employers may terminate a worker's employment on the grounds of his or her actual or presumed TB-positive status. Families and communities may reject and ostracize those living, or believed to be living, with TB. Such acts constitute discrimination based on presumed or actual TB-positive status.

Lack of access to TB diagnosis and treatment is a key issue that enhances or advances TB-related stigma and discrimination in many countries. The perceived "untreatability" of TB is a key factor contributing to the stigmatization of many of those affected. As long as TB continues to be equated with serious illness and death, public attitudes towards the epidemic seem likely to be slow to change. For this reason, ***the efforts being made to expand DOTS services should help to reduce stigma and discrimination.*** Nevertheless, strengthening the legal framework to protect the human rights of people with TB (and HIV/AIDS) is also seen as paramount. A human rights framework provides avenues for people who suffer discrimination on the basis of their actual or presumed TB-positive status to have recourse through procedural, institutional and monitoring mechanisms. At national level, these include courts of law, national human rights commission, ombudsmen, law commissions and other administrative tribunals. Simultaneously, communities need to be empowered to understand and use policy and the law to obtain the care and support they require.

Policy and legal reform, however, will have limited impact unless supported by values and expectations of a society as a whole. Widespread and enduring changes in social attitudes are required if we are to make headway against TB-related stigma and discrimination. It is thus considered vital to create supportive environments to reduce TB-related stigma through national and community-based social mobilization and communication initiatives to combat fear and misinformation and to increase use of DOTS services.

### 3. SOCIAL MOBILIZATION, SOCIAL MARKETING, IEC, & COMBI

A social mobilization and communication approach is needed that simultaneously recognizes services do not sell themselves, makes a seamless connection between knowledge and behaviour, addresses the costs and values of engaging in healthy behaviours, appreciates the gradual stages of behaviour change, tackles the complexity of communication, overcomes the three communication “pains”, and creates an enabling environment. COMBI is such an approach.

Let’s pause here briefly to situate COMBI in relation to other approaches associated with promoting healthy behaviour that you might know about, the main ones being: social mobilization; social marketing; and information-education-communication (IEC).

#### 3.1. Social mobilization

Social mobilization is the process of bringing together all feasible and practical inter-sectoral social allies to raise people’s awareness of and demand for TB control, to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance. In social mobilization the concept of “community” becomes expanded to include not just householders, villagers, or urban settlements but many social allies: heads of state and other political leaders, various ministries, district and local government authorities, community and religious leaders, businesses, NGOs, service clubs, journalists, filmmakers, artists and entertainers, to name the most common examples.

Social mobilization campaigns have often been used to mobilize local resources around a proposed social or health action whether it is: a service-related activity such as drug distribution or immunization; satisfying a community identified need; or correcting societal injustice.<sup>8</sup>

COMBI differs from conventional social mobilization in at least two ways. The latter:

- is more concerned with building national consensus and carrying out a broad educational process that should energize and uplift people rather than reducing the burden of particular diseases; and
- requires analysis of societal structures but has less concern with attempting to achieve behavioural impact by researching and communicating specific messages to specific target audiences.<sup>9</sup>

COMBI 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 is thus social mobilization with a disease-oriented, behavioural focus. Adding the behavioural focus to the mobilization model ensures programmes that usually have very small budgets and human resources, get value for money in terms of actual behavioural results.

### 3.2. Social marketing

Social marketing or programme communication can be defined as the process of identifying, segmenting and targeting specific groups/audiences with particular strategies, messages, products or training programmes through various mass media and interpersonal channels, traditional and non-traditional. While careful consumer research may be carried out in social marketing programmes, there is often an absence of strategy for creating societal ownership and demand. In other words, social marketing provides no impetus for communities and other programme partners to buy into marketed innovations.

Social marketing is based on an appeal to the individual, if he or she can be reached. In many countries, however, reaching individuals with new ideas or products is the most difficult thing to do. COMBI adds the social mobilization element to the social marketing model to ensure that the products, concepts or behaviours will be widely diffused through various channels. The demand creation brought about by social mobilization ensures an accelerated process of diffusion.

Another key difference between social marketing and COMBI is the composition of the “marketing mix”. Social marketing traditionally conceptualizes the mix as the Four Ps: Product, Price, Placement and Promotion. COMBI offers a new conceptualization in the Four Cs, one more appropriate to helping to achieve and sustain healthy behavioural outcomes.

The *first C* as in “*Consumer Need/Want/Desire*” focuses on what is the consumer need being met. One does not sell a product per se; one sells a solution (e.g., sputum test and treatment) to a consumer need or want or desire, whether overt or latent, the over-riding need being the desire for good health. This need does not have to be created; it already exists. In TB control, what we offer are DOTS solutions to this need.

The *second C* as in “*Cost*” focuses on a combination of monetary costs, opportunity costs and effort costs. This forces us to ask what is the “Cost” we want the consumer/client/patient to bear for a promise of value we make with the solution offered in response to her or his need. As we noted above, this is the central decision-making point for the consumer: if the cost/value ratio is unbalanced, in that the cost seems too much for the value promised, then the consumer rejects the offer. In TB control, this has to be our constant worry.

The *third C* as in “*Convenience to Get*” raises questions about how convenient it is for the consumer to get the service or carry out the desired behaviour, in terms of service location, opening hours, service provider sensitivity, behavioural complications, among other factors. In TB control, we should strive for maximum convenience for the consumer not for the service provider.

Finally, the *4th C* as in “*Communication*” becomes integrated communication looking at a mix of communication interventions (public relations, advertising, mass media, folk media, community mobilization, personal “selling”/counselling, point-of-service promotion, etc.) rather than simply focusing on promotion of the product or service. We 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. In TB control, communication becomes the task of sharing with the consumer the information related to the other 3 Cs: “*Here is a marvellous solution to the need you have at a wonderful cost vs. value ratio and so conveniently available.*”

### **3.3. Information-Education-Communication (IEC)**

Engaged communication is clearly more than a matter of audio-visual materials production. It is more than having posters, pamphlets and T-shirts. Conventional “Information-Education-Communication” (IEC) programmes for TB have been able to increase awareness and knowledge but have not been as successful at achieving behavioural results. It is clear that informing and educating people are not sufficient bases for behavioural responses. Behavioural impact will emerge only with effective social mobilization and communication programmes, carefully planned and purposefully directed at behavioural goals, and not directed just at awareness creation, or advocacy or public education.

From the outset, the COMBI planning process requires that goals should be stated in behavioural terms and not from the perspective of increasing awareness and knowledge. With some behaviours there may be no need to increase awareness and knowledge; people may already be informed and even convinced about the recommended behaviour. A communication effort may need instead to address other factors which constrain the desired behavioural response. But to make this determination, one needs to begin with a clear statement of the desired behavioural result. COMBI therefore differs from traditional IEC approaches by moving programmes beyond awareness raising to the achievement of specific, explicit behavioural objectives.

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COMBI represents a fluid yet comprehensive step-by-step approach to planning social mobilization and communication that can be adapted and experimented with whatever the chosen set of behavioural goals. Its methodology effectively integrates health education, IEC, community mobilization, consumer communication techniques and market research, all directed sharply and smartly to precise behavioural outcomes in TB control. The “community” is intimately involved from the outset through practical, participatory research relating desired behaviours to expressed or perceived needs/wants/desires. This market research also 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 to their perception of value of the behaviour to their lives. Two principal mantras guide the process of COMBI design:

**Mantra #1: Do nothing – produce no T-shirts, no posters, no leaflets, no videos, etc....do nothing until one has set out clear, precise, specific behavioural objective/s.**

**Mantra #2: Do nothing - produce no T-shirts, no posters, no leaflets, no videos, etc....do nothing until one has done a situational “market” analysis in relation to the preliminary behavioural objective/s.**

In Part Two, we examine the ten key steps in the design of a COMBI plan of action.

# PART TWO

## THE TEN STEPS IN DESIGNING A COMBI PLAN

While the design of a COMBI Plan cannot be done in a neat linear fashion, the following 10 steps are suggested.

**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 Kerala State/India by the year 2005.*

**2. The behavioural objective/s:** a statement of specific, measurable, appropriate and time-bound behavioural objective/s. For example: *To prompt, over the period of a year, approximately 200,000 individuals (men, women and children of any age) throughout Kerala State/India who have a cough that does not go away after three weeks to come/be taken to one of the 330 designated State health facilities for The Free TB Sputum Test (and so increase the TB case detection rate to above 70%).*

**3. The situational market analysis vis-à-vis the precise behavioural objective/s:** a “consumer orientated” exploration of the factors influencing the attainment of the behavioural objective/s that will inform the strategy and the communication 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 the Behavioural Objective/s.

(b) Set out "Communication Objectives" which will need to be achieved in order to achieve the 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 Mobilization
- Community Mobilization
- Personal Selling (Interpersonal Communication)
- Advertising
- Point-of-Service Promotion.

**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 impact indicators 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.

To get an understanding of how to go about to design a COMBI Plan for achieving specific and precise behavioural results, each of the ten steps are presented in detail below. To illustrate specific points we refer to a COMBI Plan for TB control developed in Kerala State/India.

We need to emphasize that *designing a COMBI Plan is not a smooth walk from one step to the next*. It is a messy process that requires you to move back and forth between the various steps and re-think your original ideas until you are sure that you understand the problem you are dealing with and how communication can solve it.

None of these steps, of course, should be confined to an air-conditioned office at programme headquarters. You should insist upon involvement of all partners in appropriate ways and at appropriate times as your social mobilization and communication plan takes shape. The behavioural objective of this type of involvement is that stakeholders assess and contribute their perspectives on your proposed strategies and, more importantly, present their own strategies for you to advise on. The establishment of a multidisciplinary planning team or an intersectoral advisory committee (or both) who meet on regular occasions during planning and implementation presents one opportunity to engage community groups. Whether planning at district, provincial or national level, community involvement in such teams or committees is essential.

## **STEP 1: STATE THE OVERALL GOAL**

The overall long-term goal provides the context within which the COMBI Plan is to be developed. This allows one to see the connection between the COMBI Plan for a specific behavioural goal and the TB programme's overall goal. The overall long-term goal is usually related to some key health problem.

Example:

*Problem statement:* The population of Kerala State/India is about 32 million people, with about 80% living in the "rural" areas. The Kerala MOH states that they have a decent track record in curing TB, close to 90% (with the WHO goal being 85%), but a not-so-good track record in "case detection", currently around 60% (with the WHO goal being 70%). The State MOH/TB Programme sees the dominant need as one of increasing case detection throughout the state. It was estimated that there were 40,000 individuals in the State with TB in 2003. It was suggested that to identify these 40,000 TB patients one would need to test about five times that number. This figure provided authorities with a sense of the magnitude of the ideal individual behavioural responses to be prompted across the State in terms of nearly 200,000 individuals with a persistent cough seeking the TB test (the sputum test) at nearly 330 health service diagnostic points.

*Overall goal:* To contribute to the elimination of TB as a public health problem in Kerala State/India by the year 2005.

## STEP 2: STATE PRELIMINARY BEHAVIOURAL OBJECTIVE/S

**Do nothing – produce no T-shirts, no posters, no leaflets, no videos, etc....do nothing until one has set out clear, precise, specific behavioural objective/s.**

Step #2 is premised on a fundamental principle: TB control rests ultimately with the achievement of specific behavioural results. Someone has to *Do something*; it is not enough to be aware, or motivated, or persuaded. *Someone must act*. To achieve the overall goal earlier stated calls for specific behavioural responses. It is the healthy behaviours that people adopt or fail to adopt which will have an impact on their health status. The COMBI Plan must be *absolutely* informed by this behavioural imperative. Hence COMBI Mantra #1: Do nothing...make no posters, no T-shirts, no pamphlets, no video...do nothing, until one has set out specific, precise behavioural outcomes. Living by this mantra prevents the headlong rush into the production of IEC materials such as T-shirts and posters and pamphlets, without first thinking through the relevance of these materials to the behavioural outcome desired. These materials may or may not be needed; but this decision depends on how these items serve the behavioural objective/s. And that calls for a clear enunciation of behavioural objective/s at the very start.

Defining the preliminary behavioural objective/s is one of the hardest planning tasks. It requires plenty of consultation among stakeholders. *Go no further until this is done*. The entire COMBI plan depends on the delineation of expected behavioural impact. It is also central to the eventual task of evaluating impact. The more precise and specific the behavioural objective, the better the impact assessment exercise detailed later in Step #8.

Formulating the preliminary behavioural objective/s is usually based on what you already know about TB, people's behaviours, perceptions about TB, and so on. In Step 3, while carrying out the market situation analysis, you will be bombarded with information that could turn your original idea about your behavioural objective/s up-side down.

The preliminary behavioural objective as stated in the Kerala COMBI plan was:

To prompt, over the period of a year, approximately 200,000 individuals (men, women and children of any age) throughout Kerala State/India who have a cough that does not go away after three weeks to come/be taken to one of the 330 designated State health facilities for The Free TB Sputum Test (and so increase the TB case detection rate to above 70%.)

There is a temptation to attempt to tackle several behavioural objectives. In Kerala, for example:

One issue that arose had to do with the aspect of the behavioural objective which directs people to State government testing facilities. What then about those private facilities which were or would be collaborating with the State TB Programme? SMT's view was that private facilities will always attract those who can pay and for whom such a service is found appealing. No extra promotion of those services seemed warranted. On the other hand, the State and the Government of India had invested quite a bit of funds into establishing a network of government facilities which to some extent are underutilized. In Kerala, therefore, the priority was to promote the State facilities and maximize the investment in those

facilities, especially for the very poor who can not afford private care and who tend to be primarily the victims of TB. But the COMBI plan in Kerala also noted that if the State's partnership with the private facilities should rapidly expand and involve significant numbers of facilities in relation to what the State provided at the time, and if the State was willing to pay private physicians a per TB patient fee, it may be warranted to modify the behavioural objective to one of prompting individuals to go to their nearest testing site wherever the State TB flag/logo/promotional sign is located, regardless of whether it is a State or private facility. In this case private facilities partnering with the State should also be "flying" the State TB flag/logo/promotional sign.<sup>10</sup>

The overall goal we presented in Step #1 most likely would have to be achieved by a variety of behavioural results. One's "social development conscience" tempts one to tackle all or many of them. But this would be an operational error. While we feel obliged to take on every behavioural objective to get to the overall goal, we need to curtail this urge and restrict ourselves to a limited few at a time. In tackling too many desired behavioural outcomes, we may very well end up, like butterflies, flitting from one flower to the next, but not accomplishing very much by the end of a year. We would have worked hard and have been well intentioned but in attempting to do too much, we achieve little.

It would be best to limit our focus and restrict oneself to one fundamental behavioural objective at a time which would make a significant difference. At most, we urge no more than three related behavioural objectives at a time. Consumer communication research over the years have shown that people have enormous difficulty in recalling more than three themes/messages from a communication presentation. In selecting behavioural objectives, we urge a tight, limited focus.

In setting out your behavioural objectives, it is useful to review them for completeness in relation to the 5 W questions: Who, What, When, Where, and Why. A clear statement of a behavioural result expected would specify Who would do What, When, and Where. For example, *200,000 individuals (men, women and children of any age) (WHO?) who have a cough that does not go away after three weeks to come/be taken to one of the 330 designated State health facilities for The Free TB Sputum Test (WILL DO WHAT?) over the period of a year (WHEN?) throughout Kerala State/India (WHERE?)*

One should check that these essential 4 W questions are responded to in the behavioural objective. The last W (Why) reminds us to verify a substantial link between the behavioural result desired and achievement of the overall goal (e.g., *"so increase the TB case detection rate to above 70%"*). As mentioned earlier, one most likely will need to pick a limited number of desired behavioural outcomes from a longer list. In making this selection, one needs to ensure that what is selected will make a critical difference to achieving the overall goal earlier stated.

Another approach to reviewing the completeness of a stated behavioural objective is to examine it in relation to self-explanatory questions prompted by the "SMART" acronym:

- *Specific* – Does the objective clearly state what is desired in terms of behavioural result/s?
- *Measurable* – Are measurement criteria in terms of quality, quantity, timeliness and/or cost specified?

- *Appropriate* – Are objectives culturally and locally acceptable?
- *Realistic* – Are objectives within realistic control of the targeted individual or group but ambitious enough to challenge?
- *Timebound* – Is the time (and/or milestones) by which the objective is to be achieved stated?

Your first attempt at stating specific, precise behavioural outcomes will be based on your initial understanding of TB, its causes, people's behaviours and perceptions about the disease, sputum test, TB treatment, and what experts have surmised as the desired behaviours. But as you proceed to Step #3 below (conducting the Market Situational Analysis), you will be prompted to return time and again to your initial delineation of behavioural results expected for further modifications. The first shot at stating the behavioural objective/s is never the final one.

### **STEP 3: CONDUCT A MARKET SITUATION ANALYSIS**

**Do nothing - produce no T-shirts, no posters, no leaflets, no videos, etc....do nothing until one has done a situational "market" analysis in relation to the preliminary behavioural objective/s.**

The market situation analysis (MSA) is a critical step in acquiring an understanding of the desired behavioural objective/s from the perspective of the "consumer". It is only with this understanding one can proceed to engage the consumer via various communication means in considering the recommended behaviours.

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

The MSA 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.

In Kerala State, the market situation analysis involved a round of visits to health centres where TB diagnosis and treatment services are provided. Several "walk-through" exercises were conducted at these service sites to explore what an individual must go through to be tested and treated for TB. The "cost" for patients to get even a free TB test is significant. Interviews were also conducted with MOH staff at the district and village level, with patients, and several NGO partners working on TB control. These interviews included several market research techniques such as TOMA, DILO, and MILO.

Below are the main tools you can use in the MSA (but do not be limited to these). You need to understand that one tool will not provide you with a straightforward answer.

Several tools provide information not limited to one area, but give bits and pieces to several areas. You will have to go back and forth with the information you gather, letting it flavour your entire MSA. Carrying out the MSA will highlight problems that cannot be solved by communication interventions alone and that need to be addressed outside of social mobilization.

### **Positioning: Top of the mind analysis**

Top of the Mind Analysis (TOMA) allows one to explore people's perceptions and immediate associations with a particular issue. It works by asking what is the first things that comes to mind when someone says a particular word. (You can follow up with questions such as: "Ok. What's the next thing that comes to mind?") For example, a TOMA of the word 'tuberculosis' may show that people think TB is 'God's punishment'. If these are the immediate associations in a large community, they indicate the need for more substantial engagement of the community in looking at the causes of TB and how it can be prevented.

People are programmed to associate: If you are using health workers/volunteers to promote DOTS services and the general public perceives the quality of MOH services as poor, with uncaring staff, then a major worry for you is to overcome this perception and turn their experience with DOTS services into a positive one. It may be that you need to emphasize what is unique about your programme and the training that has been given to all health staff and volunteers associated with the programme. You could provide badges or a simple uniform to give more visibility and credibility. You could also design a distinctive logo that help people associate all material with that stamp with your programme. However, once you have promised a better, more caring service, you have to guarantee that the interpersonal communication from your frontline staff has indeed improved!

### **Day in the life of analysis**

A Day in the Life Of (DILO) analysis is another tool used to explore the situation and daily context in which a recommended behaviour is being urged. This most difficult and rewarding tool puts the target audience right at the centre of its analysis by looking at a day in the life of the people you are trying to reach. It lists their daily activities from the time they get up to the time they go to sleep. The DILO analysis helps to identify contact points and barriers to the behaviour being adopted. For example, a DILO analysis in one community may reveal that most adults are out of the home for most of the day, working in the rice fields. This may help answer questions such as the best time for visits by volunteers promoting DOTS services or when radio broadcasts would most likely be heard. A DILO analysis may also reveal when community-based organizations such as religious groups organize communal activities that may provide opportunities for discussion about DOTS services.

### **Moment in the life of analysis**

Moment in the Life Of (MILO) analysis is a modification of DILO and captures features of that moment when one expects a certain behaviour to be carried out. MILO takes you into the situation of the 'client group' at the exact point they are expected to carry out the recommended behaviour. It asks what exactly they may be thinking at that moment, what is motivating them at that point and what would help them in that moment to say 'Yes' to the

recommended behaviour. You can think of this in the context of a patient presenting at the clinic door to undergo a sputum test. At that moment, what goes through the mind of the patient and what can one do which would help acceptance of the offered behaviour?

### Force field analysis

Force-field analysis is another useful tool that simply refers to analysing those forces in the field, in the environment, that prevent people from acting in appropriate ways and those forces that support them in adopting new behaviours. An understanding of these forces enables you to shape appropriate messages to encourage new behaviours. For example:

Worst Perception	Drivers ("Good things")	Current Perception	Barriers ("Bad things")	Best Perception
Presenting for a sputum test will make no difference	Children's health is important  The sputum test and treatment are free  ↓	TB is an inherited disease	Only a traditional healer can cure TB  Government services are poor quality  ↓	I can prevent TB spreading from myself to other members of my family by first presenting for a sputum test
	Strategy Option:  Reinforce Drivers to prevent worst perception		Strategy Option:  Overcome barriers that will prevent achievement of best perception	

From the above, you could extrapolate a number of issues: you could tap into the need for a healthy, productive future for the children as a strong theme for the campaign; you may also reinforce the common understanding that the sputum test and treatment are free; but you also need to solve problems with the quality of government services; and you may need to encourage traditional healers to strongly endorse the programme; and so on...

### Using HIC-DARM and MS.CREFS

Use HIC-DARM (see Box 3) to segment your audiences and get an understanding of how you need to develop your messages for each group. If most people haven't heard about DOTS services and the sputum test then you should concentrate a substantial part in getting people to hear about DOTS services and the sputum test and to start talking about it. If people have information about the sputum test then you would need to concentrate on convincing them to take action (go to a DOTS clinic) perhaps through publicised endorsements of those who have already taken the test and what it did for them, or perhaps make it easier for people to access the sputum test and drugs and thus your approach and interventions will be different. In reality you will need to have a mixed strategy to deal with the spectrum of behavioural challenges.

The data for a HIC-DARM analysis is sometimes available in completed KAP (Knowledge-Attitudes-Practice) Surveys or in other similar studies. Often there is much good research lying around but unused. Sometimes a local university department or faculty member has produced some unpublished studies of relevance. In the absence of completed

studies, and provided there is adequate time, one may need to commission a specific research study (surveys, in-depth interviews, and/or focus groups) in relation to a HIC-DARM analysis. Another source of good information is health staff at the field level whose direct community experience can provide very useful HIC-DARM insights. One would urge, in any case, a HIC-DARM exploration by “walking around”: stepping into community life and chatting directly with members of the community about TB, DOTS services, the sputum test, and TB treatment and the recommended healthy behaviours, with HIC-DARM elements prompting the conversation. While conclusions from these informal sessions cannot be generalised to the larger population, they can provide fascinating HIC-DARM snapshots.

MS.CREFS is an acronym that highlights the key components of the communication process (see Box 4). A MS.CREFS Analysis involves raising a variety of questions with regard to each component. The following is a list of some of these questions – it is not intended to be exhaustive but to be more suggestive:

**Message:** What are the current messages circulating about the particular disease and related behaviours? What messages would people want? What language should be used for messages? What messages would best position the recommended behaviour in their minds? What messages would serve as triggers to action? Would different messages be necessary for different audiences? Are there particular messages (from the private or public sector) which seem to have high re-call? What about these messages which led to their being imbedded in the community’s consciousness? Are there any persistent rumours? Can one anticipate any messages which may circulate and create an implementation crisis?

**Source:** Who are currently credible, trustworthy sources of information in the community? What makes them so? Are there particular popular individuals (sports personalities, actors, politicians) who would be seen as credible, trustworthy sources of information? Are there particular characteristics of a credible, trustworthy source which the community holds dear? For the particular behaviour being urged, who might be credible, trustworthy sources of information about the particular behaviour in the community? To what extent is the health staff credible, trustworthy sources of information? To what extent are teachers and school children sources of information?

**Channel:** What are the existing channels of communication in the community? What communication channels have been used in past health communication campaigns? What channels have been used in political campaigns? Are there community meetings as part of the governance structure? Is mass media readily available? How many have and listen to radio? Television? How many read newspapers? What are the popular radio and television channels or programmes? What are the most widely read newspapers? What traditional media are used for communication? Are “houses of prayer” potential channels of communication for health messages? Are there existing places where people congregate (formally or informally) and share information? What new inexpensive channels of communication can be introduced to the community? Are there skilled advertising agencies in the community adept at using the available channels of communication?

**Receiver:** Who are the various audiences/market segments to be engaged in communication about the specific behaviour? What do we know about them from a demographic or psychographic or ethnographic point of view? What is their HIC-DARM status vis-à-vis the recommended behaviour?

**Effect:** What has been the impact/effect of other health communication efforts? What accounts for that impact/effect? What would be the intended effect of planned communication efforts with regard to the stated behavioural objective?

**Feedback:** What feedback mechanism exist in the community which would enable one to check whether messages are being heard and understood as intended? What feasible feedback system may need to be put in place for such a check if no system now exists?

**Setting:** For the various possible communication interventions envisaged, in what settings will these take place? At people's doorsteps? In their living rooms? In health centres? Under trees? In facilities with or without electricity? In the village chief's yard? In a school hall? On the roadway? How would these settings affect the design of the communication intervention? Do particular settings suggest particular convenient time periods for communication action?

#### **STEP 4: DEVELOP THE COMBI STRATEGY FOR ACHIEVING STATED BEHAVIOURAL OBJECTIVE/S**

In Step 4 you will develop an overall strategy for achieving the behavioural objective/s. A strategy is the broad approach that your programme takes to achieve its objectives. Strategies are made up of specific social mobilization and communication activities that on their own or in combination lead to achievement of objectives. The COMBI strategy should include key messages, their sequencing (if any), the overall tone for the strategy, the blend of communication actions (administrative mobilization, community mobilization, advertising, personal selling, point-of-service promotion), and relationships between these different communication actions and an overview of how the plan will be managed. We will take you through each and every one of these issues. You will also find some tips that might be useful while developing your COMBI strategy as well as the COMBI Plan of Action.

##### **Restate the behavioural objective/s if necessary**

In light of the market situation analysis carried out in Step 3, you can now state more precise and specific behavioural objective/s.

##### **Think M-RIP**

Communication interventions and actions need to be carried out in a **Massive, Repetitive, Intense and Persistent** fashion. A communication programme of minimal intensity is like throwing a mosquito at an elephant. Among many marketing communication specialists, there is the view that when one uses a particular medium, one should dominate the medium. If radio spots are to be used, then don't use only one spot per day; plan on using 6-10 spots per day.

COMBI Plans must be M-RIP...and expect that they cannot be done on the cheap. The private sector knows this; we need to grasp it in the public sector if we want behavioural impact. Expertise in getting the most cost effective use of media and promotional items such as posters, leaflets etc. can be found through private advertising agencies who usually have information about audience reach and broadcasting costs at their disposal. These agencies can usually negotiate a competitive rate based on their existing use of media for their private customers, although they may request support from you, for example in the form of a letter from the MOH if a public rate for social issues exists.

##### **Strive for engaged communication**

The foundation for having people adopt healthy behaviours is knowledge, but what is central for attaining a health impact is the application of knowledge. Applying knowledge calls for engaged communication. The main ways of overcoming these problems is to get

the message and positioning right, keeping it simple, direct, free from jargon and repetition linked with a trigger for a course of action.

The heart of the exercise of engaging people in exploring a suggested behaviour for possible adoptions is listening to them. Engaged communication starts with listening to people about their concerns, fears, anxieties, values, perceptions and preferences, and let our understanding of this inform our communication and interaction with them. If people have no voice in this exploration of new behaviours and, perhaps, re-shaping them; if there is not mechanism for a two-way information flows; if there is no opportunity for listening to community voices, there can be no engaged considerations of healthy behaviours. Failure to listen to people often lead to public rejection of suggested behaviour. When we do listen to the people, however, we can respond with appropriate communication or modifications, and with that comes readier acceptance of recommended behaviour.

### **Be creative**

Strategy development requires creativity. Oftentimes it is not a lack of money, knowledge, technology, skilled employees or motivated communities – *what programmes lack most is a stream of fresh ideas*. No effective TB control programme can exist without a creative approach to social mobilization and communication because everything must change on a regular basis. But the peculiar thing is, you won't find mention of creativity in any communicable disease programme guidelines.

Creativity is the process of developing and expressing fresh ideas that are likely to be useful. Being creative means making non-obvious connections between things or ideas. Encourage your planning team members and community groups to look at your programme with an analytical eye. Present your market situation analysis findings and ask: "What is a better way?" Because a better way *always* exists. You can design better messages, you think of a better alternative to those complex posters your programme always uses to tell people to go to clinics if they have a certain symptom, you can think of new partnerships...

### **Consider incentives and branding with a logo**

In Part One, we looked at the "Cost vs. Value" calculation of the consumer with respect to a recommended behaviour. One way of affecting this calculation in the communication strategy is by the use of incentives. For example, in encouraging people to come to a clinic to take a sputum test, one could offer the chance of winning a lottery with a modest prize (say, a bicycle) to all who come to the clinic. This incentive lowers the perceived "cost" involved in getting to the clinic.

Another way of affecting the "Cost vs. Value" calculation is by branding the behaviour (presenting for a sputum test) or a product related to the behaviour (e.g., the sputum test itself or diagnostic centres). So consider "branding" the sputum test or DOTS services in general by giving them a name associated with "effective and safe", and a logo which immediately provokes these linkages, and which is then vigorously promoted. This could increase the perceived value of what is offered in relation to the recommended behaviour.

### **Think in terms of advertising flights**

One does not broadcast a 60-sec spot every day all year long, or just three times per week just before the news. Think in terms of advertising flights, for example a three week flight, with radio posts six to eight times per day, five days per week; television spots two to three times per evening five days per week in same flight period; and full-page newspaper advertisements about three times per week during the same three week flight. Then give the public a pause; leave them alone for about another two to three weeks. Then come back again with another flight of say another three weeks.

### **Use a judicious blend**

No single activity or material (e.g., poster) will result in behaviour impact. Each strategy requires a judicious blend of different but integrated actions appropriate to the behavioural objective being sought. In COMBI, the different communications actions have been divided into five basic elements. An example of different communication actions is given below.

The heart of the COMBI Strategy for Kerala was what the private sector would call direct sale or personal selling: the door-to-door engagement of the consumer in his or her home. This was done in two ways:

Firstly, by the existing core of some 40,000 community health workers and volunteers from various community-based NGOs in all 14 districts and at the sub-centre levels: 6,000 Junior Public Health Nurses (JPHN), 6,000 Junior Health Inspectors (JHI), Anganwardi workers, members of Kudumbasree (neighbourhood volunteer group dealing with poverty issues), members of Mahala Swasth Sangh (MSS) - health volunteer group attached to Primary Health Centres (PHCs). These groups were briefed to disseminate house-to-house on their scheduled or unscheduled rounds of home visits the simple message of “if you have a cough lasting more than three weeks, please do no wait; do get to a health centre for the Free TB Sputum Test”, with supplementary information about why this was being recommended. Each of these health workers/volunteers was provided with TB Information sheets to leave with household members, regardless of literacy status. (The leaving behind of information has important psychological benefits even if the household member can not read; at some point it is likely to be given to someone who can read and explain the content. In Kerala State, this is less of a problem, given the high literacy rate.) Each of these health workers/ volunteers wore a special “TB” badge to identify them as specialized disseminators of the TB behavioural message. In addition, the health workers/volunteers continued efforts were praised via appropriate letters to them from senior MOH officials, and a small inexpensive, community organized luncheon event at the district level was held for them at which they were also thanked and encouraged to continue their promotion of the TB behavioural message. A Certificate of Appreciation signed by the Minister of Health was given to each health worker for their TB work and the luncheon or at other scheduled meetings of these workers/volunteers. The certificates and luncheon etc were small ways of expressing appreciation and motivating staff and volunteers.

Secondly, as discussed with the State Ministry of Education and agreed to, “personal selling” was carried out by all 5 million school children in all government primary and secondary schools, and also participating private schools. Each school child was given a single sheet of information on TB (a worksheet) with the behavioural message and supplementary information which was to be read aloud in each classroom by the

teacher and briefly discussed on a set date for all schools. At the back of the sheet was an exercise consisting of 5 multiple-choice TB questions based on the front page content and with some of the answer choices being purposefully funny. Students completed this quiz and the teacher took them through each correct answer. Each child was asked to take the sheet home, read it aloud to family members or have it read out aloud by someone else, have a parent or other adult sign the bottom tear-off part of the sheet indicating that the reading of the sheet was done, and the child returned the tear off part to his or her teacher. On the set date when all children were given the sheets, they were also given a coloured paper “toy” pinwheel (assembled in the classroom using the paper pinwheel sheets sent to each school to be turned into the pinwheel and attached to coconut stems brought in by the children). The pinwheel, possibly serving as the logo for TB diagnosis and cure, also carried the behavioural message, and the 5 million school children left school on the set date, waving the information sheet in the air and the pinwheel spinning in the air, and creating a community stir, with community questions being raised and answered about what this whole effort was about. The pinwheel is a common, popular toy. In this school exercise, school children became better informed about TB and the behavioural request, 5 million homes received the message in a very personal way through their children (hopefully reaching 25 million individuals) and the children’s presence on the streets with the information sheets and pinwheels provoked community curiosity and interest. (It did not matter that the very young children were not be able to read all the content of the information sheet; they acquired the basic information in the classroom and their involvement in the take-home exercise remained valuable.)

This “personal selling” was supported by an advertising campaign done in M-RIP (Massive, Repetitive, Intense, Persistent) style via radio, television and newspapers in four three-week spurts (or flights), one flight per quarter during the year, with radio advertising consisting of 60-second and 30-second spots played 6-8 times per day for 5 day per week in each flight, television spots 2-3 times per evening five day per week in each flight, and full page newspaper advertisements to start with followed by half-page advertisements three to four times in the first week of each flight in one or two of the leading newspapers. The advertising campaign in addition to pressing the behavioural trigger also lent legitimacy to the overall effort. If it is in the media, the programme acquired more credibility. Radio, television and newspapers are dominant, pervasive mass media. The high literacy rates fostered a tremendous newspaper reading public.

There were several competent advertising agencies in Kerala State/India. One of these agencies was selected. This involved issuing a creative brief, receiving strategic and budget responses and assessing these responses.

Advertising also took the form of cinema advertising, and massive promotion of TB diagnosis and treatment. Point-of-service promotion was done by having multiple flags and danglers with the TB behavioural message placed on tall metal or wood poles at the entrance points outside each health facility providing TB diagnosis (Microscopy Centres) and/or treatment services, indicating this is where one comes for diagnosis and/or treatment. Also, large printed wood or metal signs with the TB service logo were posted on the front of the various facilities.

Posters promoting the TB service logo and the behavioural message were massively pasted (in multiple numbers in the same space as now done for various campaigns such as election

campaigns) throughout the State. These were followed in 4-6 months with another round of poster placement.

In addition, there was community mobilization activities involving the local elected councils (Panchayats and Gram Panchayats) and community NGOs (e.g. Kudumbasree and Mahala Swasth Sangh) and service organizations (Rotary, Lions) in various community meetings. This was supported by extensive village-level promotional events. In communities where there were existing local drama groups, they were encouraged to have a scene or two in their current productions which raised the TB behavioural message. Each Taluk/Block Primary Health Centre was invited to form a TB Bicycle Riders Team, consisting of about 10 riders, some of them former TB patients, dressed with a colourful TB T-Shirt, and a spinning pin-wheel or the selected logo attached to their bikes, and ride through various villages in the Taluk every Sunday for the first three months and the third three months of the year of the COMBI Programme, stopping in places and explaining to people the behavioural message.

An advocacy/public relations effort (meetings and media use) at the start of this campaign put the TB challenge and communication campaign with its specific behavioural request on the public and leadership agenda of the districts and Kerala State/India as a whole. This effort also continued intermittently during the year. As part of the public relations effort, a short 8-minute video was produced in collaboration with Kerala State/Doodarshan (and involving the State's top leadership and members of the Indian Medical Association/Kerala) and used in television discussion programmes. The public relations/public advocacy effort also included a variety of feature press articles, radio/TV call-in and discussion shows focusing on TB and the behavioural message, and a weekly TB column for about 3 months in one of the major dailies in question and answer format responding to popular queries about TB diagnosis and cure. Radio-television shows were done in front of small live audience, whenever possible. This added to the "vicarious interaction" effect of these shows; listeners/viewers felt that they were involved in the discussion and this added their power to influence. This public relations/public advocacy was coupled with a special administrative mobilization effort (official memoranda/circulars and meetings) and directed at engaging all 50,000 MOH staff (TB and non-TB staff) at all levels (District, Sub-District/Block/Taluk, and Sub-Centre) in the State, all District Collectors, selected staff of other Ministries such as Social Welfare and Education, and members of the Indian Medical Association/ Kerala, and the medical teaching institutions, to actively participate in this COMBI effort. MOH staff at the field level in particular were prepared for the COMBI campaign and expected the surge in people coming in for the TB Test.

The COMBI Strategy also called for the use of minor incentives. As minor incentives to prompt the TB behavioural response, arrangements were made with the manufacturers of Horlicks to have available as a free donation at each TB testing facility small packets of Horlicks to be given to the first 100 individuals coming in at each testing site for the test, a total of 33,000 small packages. It was stressed that no one will come for the test just because of the tiny incentive but it was a small way to encourage some.

### **Achieve the 6 hits**

Consumer communication experience suggests that a consumer needs to be "hit" visually and aurally about six times per day, several days per week, over a three week period or so, in a variety of communication moments, in order for a behavioural theme to register sufficiently to prompt behavioural leaps. In Kerala, the COMBI plan ensured the six hits as follows:

An individual will get the TB behavioural message from their child coming from school, from a poster in the village, from a flag or sign or balloon atop a health centre, from a radio spot, from a television spot, from a newspaper advertisement, from someone referring to the media advertising, from a cinema screening, from a community health volunteer or community health worker, from a member of the local elected council, from the TB Riders, from a family member or neighbour who would have seen/heard the behavioural message from some source.

## **STEP 5: DRAW UP THE COMBI PLAN OF ACTION**

We come now to the production of the most important tool for managing the implementation of your social mobilization and communication strategies: the **COMBI Plan of Action**.

What should your written COMBI Plan of Action include? Ideally, there should be three basic sections:

- An **Introduction** describing the context of your programme and the behavioural challenges it faces.
- A section providing an overview of the **Strategic Approach**.
- A more detailed **Implementation Plan**, including management structures (Step 6), monitoring (Step 7) and evaluation (Step 8) methods, workplan (Step 9) and budget (Step 10). The workplan acts as a template of activity schedules and schemes for coordinating different strategies. This can be used to monitor progress and should indicate responsibilities of the various stakeholders.

Whatever format your plan takes, it should clearly and comprehensively spell out the activity steps that will be taken to implement a strategy (or set of strategies) to achieve its objective/s. The plan should include all the preparatory activities as well as what will happen once each strategy is implemented. For instance, your plan should specify how many of a particular communication material (e.g., radio spots, posters) you will need, who will produce them, and how they will be distributed (of course, all this after the pre-testing has occurred!). If, for example, training of field staff, volunteers, drama groups, and school teachers is required, then the plan should specify when and where these groups will be trained, by whom and how. If your strategy requires close collaboration from the media and press, then the plan should detail how these groups will be contracted or briefed (e.g., how often and where news conferences will occur).

The COMBI Plan of Action serves as a record of your programme's objectives and strategies which can be consulted and altered as necessary. It is a document that will and should go through various drafts – usually around three drafts – as you move backwards and forwards through all the steps outlined in this guide. The plan should be discussed and debated by your multidisciplinary planning team and other stakeholders.

Annex 1 provides a basic outline for a COMBI Plan of Action.

## **STEP 6: MANAGEMENT AND IMPLEMENTATION**

You need to think about and decide how the COMBI Plan will be managed. In Step #6, you should describe the management structure, specifying the management roles of your multidisciplinary planning team, including specific staff or collaborating agencies (e.g.,

local advertising firms, research institutions) designated to coordinate communication actions. Also included are any technical advisory groups or government bodies to which the management team receives technical support from or should report to.

### **Designate a single person as COMBI Action Plan Manager**

It is important to have one person fully responsible for COMBI implementation. If not, you risk having a wonderfully designed COMBI Plan that is only partially implemented.

### **Set up an implementation group**

Set up an implementation group of three to five individuals who will be meeting every week with the designated manager and review implementation details.

### **Designate an advisory group**

In addition to the implementation group it may be useful to have a broader advisory group which may meet every month or so to review progress. This advisory group may include various partners from the NGO and private sector, and other collaborating sectors.

### **Plan to use an advertising agency**

In countries where advertising agencies function, use them. Go through a process of briefing several, meeting with them, and having them present a strategy or respond to your COMBI Plan of Action. Pick one based on a blend of criteria (creativity but not an excess of this, cost, willingness to secure private sector sponsorship, willingness to argue over strategy). Manage them well. And argue with them from a marketing communication perspective, using their language.

## **STEP 7: MONITORING IMPLEMENTATION**

Monitoring is continuous, whereas evaluation is periodic. However, many managers tend to emphasize end-of-programme evaluations over monitoring. Heavy emphasis must be placed on regular *tracking* of strategy progress as a means to correct ineffective elements and to adjust to any changes in the environment. Monitoring helps assess how strategies are proceeding: Are you delivering understandable messages? Do people respond to your messages in the way you expected? Are the right channels being used? Is your target audience correct? Are you reaching your target audience with your communication? Are they responding in the way you planned?

Demonstrating the benefits of social mobilization and communication to government decision-makers for policy and financial support often requires monitoring to show progress and positive outcomes achieved. Continual and careful monitoring of relevant indicators also provides the data for evaluation.

Whatever monitoring and evaluation you plan to carry out, you need to consider:

- time periods (when and how frequently monitoring or evaluation should be conducted and for how long),
- what modes of data collection should be used,
- who the clients for the information should be,
- how the findings should be used,
- what decisions are needed, and
- the resources available and needed to carry out monitoring.

Although it tells you little about the effectiveness of your strategy to achieve behaviour impact, tracking implementation (often called “process evaluation”) is a fundamental aspect of managing a COMBI plan. Thorough process evaluation records actual implementation and compares it to planned implementation allowing for subsequent improvements to be made. Process evaluation typically quantifies what has been done; when, where, and how it was done; and who was reached.

Data from process evaluation can be used in at least three ways:

- Making decisions about refining the strategy’s objectives, activities, behaviours, products, services, and so on.
- Documenting and justifying how resources have been spent.
- Making a compelling case for continued or additional funding (especially if combined with behavioural impact data).

*Referring to your behavioural objective/s is a useful starting point* when you design a process evaluation and can help you avoid the common mistake of collecting data that are easy to collect but will not help you manage or improve your Plan. Process evaluation is based on such questions as:

- Is the activity reaching the people for whom it was designed?
- What do the participants think of the activity?
- Is the activity being implemented as planned?
- Are all aspects of the activity of good quality?
- What kind of participation is occurring?
- To what extent is the direction of the activity changing in response to the needs of the participants?

Process evaluation is often fragmented because data are collected separately – often using different methods – for each activity. Ideally, process evaluation should bring together implementation data from all activities, providing you with an overall picture of your COMBI plan’s achievements and recommendations for further improvement. Common process evaluation instruments and activities include:

***Bounceback cards*** – short questionnaires on the back of a stamped, addressed post card (addressed to your headquarters or the lead agency managing the social mobilization and communication – hence the name). These cards can be included with any materials (e.g., posters, videos, pamphlets) distributed to target audiences, intermediaries (e.g., clinics, schools) or partner agencies (e.g., TV stations). A few questions can be written on the back of the card to assess such issues as reactions to the materials or provide information on how to order more copies. Bounceback cards often have a low response rate but for programmes covering large geographic areas, such cards often provide the only tracking data on material distribution.

***Inventory tracking*** – apart from ensuring that an adequate stock of various materials/products is always available, inventory tracking offers the chance to learn where materials/products are going, when they were dispatched, which audiences or groups are being reached,

<p>An inventory tracking database includes:</p> <ul style="list-style-type: none"> <li>• Date of distribution</li> <li>• Name of material/product distributed</li> <li>• Quantity</li> <li>• Geographic location</li> <li>• Group, Organization distributed to</li> </ul>
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which ones are the most or least popular (which are always requested, which are never requested and why), and so on. Plotting the number of requests by date and comparing this with specific social mobilization and communication activities gives an insight into what activities generated the most requests. Less popular activities (generating fewer requests) can also be examined to determine whether they can be improved. Mapping geographic distribution of requests can also indicate areas where requests were fewer and could be targeted with more intensive social mobilization and communication.

**Service delivery** – monitoring delivery of technical services and activities (e.g., diagnosis, treatment) is essential. Specific service delivery data needed to track progress will depend on your behavioural objective/s, but in general, service delivery data includes:

- number of people presenting for sputum-testing;
- peak usage times (to assess staffing and adjust if necessary); and
- additional services of interest to clientele (to make future refinements).

**Client satisfaction** – ascertaining client satisfaction with the service/s, the facilities, and the personnel is as important as assessing DOTS service delivery. Data can be obtained through:

- unsolicited client responses (e.g., “suggestion” or “comment boxes” placed at points of service, but remember potential biases – those who leave comments may have very different views from those who don’t leave comments);
- observation and interviews (e.g., a manager visits a DOTS facility or accompanies a team of volunteers on their household visits and chats with clients about their opinions and suggestions on the service or activity); and
- meetings (not on a specific issue), focus groups (focused on specific issues) and formal, in-depth interviews with householders, neighbourhood committees, business managers, government officials, environmental groups, etc.;
- surveys of representative samples of target segments and/or programme partners using questionnaires.

**Tracking surveys** – Alongside measuring actual behavioural impact, a good monitoring system will be able to track the extent to which target segments have been reached by social mobilization and communication activities, their understanding of key messages, how their behaviour has changed and why, and if not, why not. Closely linked to client satisfaction, tracking surveys are used to assess comprehension of communication actions and to determine target audiences’ current behaviours and motivations to change.

**Media coverage analysis** – Tracking and analyzing both the amount and content of media coverage (all mentions of a topic such as “free sputum-testing” that appear as something other than an advertisement on TV, radio, or in newsprint) can help determine:

- how many opportunities there were for people to be exposed to stories or articles containing information about a particular topic;
- identify which messages are appearing in the media (with what frequency, through which media) and which are not, allowing assessment of how TB is framed from a policy perspective and offering insight into how future content of media outreach might be tailored (remembering that mass media such as TV, radio and newsprint often reach and influence key decision makers).

**Monitoring policy changes** – Monitoring policy changes depends on what type of change it is and at what level of society the power to change policy resides. For example, if businesses are asked to make changes (such as developing anti-discrimination policies) then information needs to be gathered (through interviews, letters, phone calls, etc.) from their public relations officer or relevant manager. If you are trying to gauge whether provincial governments have made legislative changes to laws forbidding discrimination against TB-positive people, then attendance at appropriate government meetings or maintaining contact with key officials will be important.

## **STEP 8: ASSESSMENT OF BEHAVIOURAL IMPACT**

Evaluation of your COMBI Plan should tell you whether it was effectively implemented in relation to its overall goal and behavioural objective/s, and if it has provided an adequate solution to the problem you wanted to address. If monitoring has been carefully planned and carried out during the life-cycle of the programme, evaluation should be easy.

A word of warning. “Knowledge” indicators such as % of population who are aware of at least 2 symptoms of TB, % of population who know that TB is a curable disease, % of population who understand the link between TB and HIV, are useful measures of the *reach* of a COMBI Plan’s messages among the general population. They are not, however, reliable or useful indicators of behavioural impact.

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

You should develop your own measures for evaluating behavioural impact. For example, you could establish a base-line measure of the current number of people coming in for the test at a random sample of “sentinel clinics” in the three month period before a COMBI programme is implemented. You could then monitor the numbers presenting at these sentinel clinics during a defined period (e.g., 1 year) and a final comparative figure can be arrived at the end of the year. You could issue interim reports at 4 months and 8 months into the COMBI programme.

## **STEP 9: WORKPLAN**

In this Step, you take the Implementation Plan you have written at Step 5 and develop a detailed workplan with time schedule for the preparation and implementation of activities required to execute each communication action. The workplan could take the form of a table with column headings: Activities, Completion Date, Responsibility (staff member, partner agency, and so on). A tabular flow-chart with weeks, months, quarters, or years as column headings along the top and specific activities as row headings down the left-hand side is also useful. Cells within the table can be shaded to indicate which weeks, months, etc., particular activities are scheduled. Such a diagram allows instant comprehension of

when different activities begin and end, whether preparatory activities have been given enough time, whether communication actions that need to be integrated are indeed integrated, and highlights periods of peak activity.

### **Develop the workplan in a group exercise**

Involve all those who will be involved in implementing the COMBI Plan in developing the workplan.

### **Remember ..... Life is not perfect!**

Recognise that life is not perfect and not everything planned will be implemented on schedule. Life is full of surprises, so build in some flexibility!

### **STEP 10: BUDGET**

Many TB programmes dedicate vast amounts of resources, both human and financial, in organizing DOTS services, but very little effort is put into getting the required behaviours. What good does it do if diagnostic tests, drugs and clinics are available, but people lack the motivation to take advantage of these solutions?

It would be a mistake to believe that promoting the use of DOTS services can be addressed with little or no investment of funds and commitment of other resources (e.g., staff and time). Everyone wants to know how to achieve and sustain behavioural results as cheaply as possible, but in general, you get what you pay for. Here we offer some final tips on optimizing your budget for COMBI.

### **Plan on planning**

Our guess is that at least half of all expenses dedicated to social mobilization and communication are unplanned in the sense that money is spent without thinking about how it fits into the big picture of TB control. Many programmes develop social mobilization and communication strategies based on ideas generated in an air-conditioned office in a capital city, on the whim of a consultant, or on previous or last year's activities and budget with just a few modifications. Programmes often reprint their four-colour flip-charts, renew their communication consultant's contracts, store large quantities of videos, or spend money on fancy posters without any idea of whether these are good investments.

If you and your programme will make a commitment to spend *nothing* on social mobilization and communication without knowing what behavioural results you are trying to achieve and why, then you will avoid wasting resources (staff, time, materials and money) on activities that don't have much impact on behaviour. Because many don't. The more time you spend developing a strategy based on a market situation analysis and organize your programme guided by this strategy, the more cost-effective and economical your programme will be.

### **Budget last**

Budgeting is best done once you have worked out what your ideal strategic plan looks like. Try not to constrain your creativity by worrying too early about budget. Be led initially by your behavioural objective/s not by budgetary obstacles. However, in the final analysis, you will probably need to prioritize activities according to their relative impact versus cost.

Questions to ask when calculating a budget include:

- What is the ideal budget you want?
- How much of the total programme budget can you put towards the social mobilization and communication plan?
- How much of the budget comes from grants or other outside funding, and how much will be paid by your organization?
- Do you need to seek additional funding before proceeding?
- Given answers to the preceding questions, can your programme develop and implement social mobilization and communication strategies at this time?

### **Use resource mobilization expertise from the non-health sector**

Public health professionals often find themselves in situations where they have to negotiate for assistance from the business sector. Few of these health professionals are skilled in the art of securing sponsorship and fund-raising. So if you don't have a staff member with the necessary skills to raise sponsorship why not consider hiring a professional fund-raiser or establishing a small fund-raising group of business professionals adept at selling ideas and winning sponsorship from fellow business people? For example, perhaps there are some retired Chief Executive Officers who would be happy to volunteer a little time or would be willing, for a small percentage of every dollar they succeed in raising, to help you muster your ideal budget. With their networks, experience, and personal influence, a skilled fund-raiser can tap into resources a non-business professional may take years to even locate.

Experience show that the private sector is very keen on supporting social development issues. They are willing to bring in fresh funds, or provide services and material needed to implement the COMBI Plan. So when planning your budget, set aside some interventions which most probably could be supported by the private sector in exchange for modest promotion of a product logo on, for example T-shirts and printed material, or presenting their name after a radio or TV show, provided it is not related to weapons, alcohol or tobacco.

You need to have a sense of which companies would be interested in supporting your programme. There has to be a win-win situation. They support your programme with resources, and you provide them with the opportunity to promote their brand. Go to the COMBI implementation area and ask yourself:

- What companies are present in the area?
- Would they like to become more visible?
- Would they want to be related to the purpose of the COMBI Plan of Action?
- Would your programme want to be related to this company/product?

Either you could contact the companies directly or use the advertising agency to contact potential partners.

Many of us might feel uncomfortable with talking with large companies as we feel that we do not speak their language. But don't let that stop you.

### **Think small!**

Be wary of the seductive charms of “production values.” Consider this story. Recently while working in South Africa, a health official and a COMBI specialist were discussing the process of selecting an advertising agency. In the conversation the health official began describing a “wonderful television advertisement” she saw. She described the scene with this car travelling through tree-lined highways, etc., etc., and coming to a stop at a cliff, and it went on. And then she said, “That was a great ad. Let's get that agency.” The COMBI specialist asked, “What was the name of the car being advertised?” She paused for several seconds, thought for a while, and then muttered, “You, know, I don't know; but it was a damn good advert.”

This is the danger of clever, creative advertising. And many of us are understandably seduced by what we call “production values,” those dimensions of an ad which would make one shout, “Wow! That's a wonderful ad.” But in due course we learn it contributes little to achieving and sustaining behavioural impact. Not all clever, creative, well-produced advertisements are losers; but we just need to be mindful of the seductive charms of “production values.”

Advertising agencies in many countries can spend significant monies on production of television spots. Some even go as far as hiring European directors to come in and shoot and edit spots. Also, vast sums can be spent hiring famous spokespersons, such as well-known actors and actresses. There is a common perception that famous talent (such as a film or sports star) can sell almost anything. This is not the case. One has to be very careful in selecting who becomes your spokesperson. The COMBI perspective would suggest that while famous talent might be helpful, it is far more important to have as a spokesperson a credible medical/health source to establish the rationale for the behavioural response being encouraged. And in turn this can be supported by famous people endorsing the behavioural request. But to rely solely on famous talent would be unwise.

Keep the advertisements simple; and engage the consumer in an earnest intimate consideration of the behavioural recommendation, using credible spokespersons. One urges simplicity in the production of radio-television spots. This is not a moment for fanciful creativity and gimmickry, or song and dance. It is a moment for intimate, credible, engaged communication with the consumer. With radio and television, despite the large audience, in the end one is chatting with just one other person.

There is always a less expensive mobilization or communication alternative. It just takes creativity and a risk-taking spirit to find it. So apply your creativity to see if there is a smaller-scale way to produce that intervention or perform that communication process. For example, consider searching for a low-cost supplier who can make the product for you in small batches. Even if the total costs are slightly higher, your fixed costs will be much lower because you won't have to advance-order in quantity, and then store extra units. Or find a distributor who can deliver the intervention for less cost than normal health service

products are distributed. How, for instance do canned drinks get to remote villages? Could the distributor help your programme?

### **Think BIG!**

Most managers are thinking, “How can we make best use of our budget?” This is the wrong question. What if you asked the following questions at your planning meetings: “What’s it going to take to have the highest level of behavioural impact? What’s it going to take to be the best programme in our Ministry of Health this year?” You don’t have to be the national programme manager to ask this question. You could ask: “What’s it going to take to be the best provincial programme this year?”

Does the following sound familiar: “We don’t have the budget to be the best.” Or “We don’t have the budget to dramatically improve our behavioural impact.” Money. The reason for not being the best programme in the Ministry of Health is always related to money. It’s never: “We don’t think big enough.” It’s never: “We don’t have enough enthusiasm.” It’s never: “We don’t have good enough ideas.”

What if you were asked: “How much money would you need to become the best?” Your answer will probably be a bit vague. You probably haven’t thought about it; you’re probably to focused on making your budget goals or improving a little. But you might also be a little afraid. What if you did have enough money to become the best, and you still didn’t make it? It’s safer to be mediocre.

Becoming the best takes more than money; it takes *thinking big* from the start. When lack of money arises, then it’s time for some creativity. A clever approach to point-of-service promotion of DOTS services, a new way to motivate volunteers – any such innovations can help you achieve widespread behavioural impact from small-scale investments.

### **Concentrate your resources**

Don’t spread yourself thin. Concentrate your staff, or your clinic points, or whatever you do in your programme into certain areas or periods of time. Of course, the epidemiological context in which your programme is operating may not allow you to concentrate on particular regions, but carefully timing interventions is usually possible. For example, it may be better to intensively promote DOTS services at the end of a harvest season when people have more cash and are more able to pay for transport to reach clinics.

### **Roll out sequentially**

Rolling out sequentially is a good way to concentrate your resources. The idea is to roll out segment by segment or region by region, rather than trying to introduce it everywhere at once. You can roll out an expensive social mobilization and communication strategy in one or two communities, and then wait for your returns from this “investment” (e.g., increased political commitment, higher levels of private sector investment, behavioural impact) before funding the programme in additional regions. If you are patient, you will be able to fund a much higher level of social mobilization and communication and achieve a far higher impact than your annual budget would seem to permit. Again, your epidemiological situation may not allow you to roll out but if and when it does, this approach is useful to demonstrate impact and increase your budget.

## ANNEX 1: A basic outline for a COMBI Plan of Action

### 1. Introduction.

**1.1. Principal findings from your formative research:** a summary of existing data and results of the formative research on the behavioural and programme environments, including issues requiring further formative research.

**1.2. Behavioural analysis:** a detailed description of the behaviours selected for attention through the analysis process described in Tool Number 4. You should also state your behavioural objective/s (make sure they are specific, measurable, appropriate, realistic, and timebound). Explain the significance of the objective/s.

**1.3. Target group segmentation:** a description of target groups (by behavioural segments, primary and secondary audiences).

### 2. The Strategic Approach (*explaining “What”, “Why” and “How”*).

**2.1. Overall goal:** For example... *To contribute to the elimination of TB as a public health problem in [location] by [date].*

**2.2. Behavioural objective/s:** Restate the specific objective/s as presented in 1.2. For example... *To prompt, over the period of a year, approximately [number] individuals (men, women and children of any age) throughout [location] who have a cough that does not go away after three weeks to come/be taken to one of the [number] designated State health facilities for The Free TB Sputum Test (and so increase the TB case detection rate to above 70%).*

**2.3. Strategy/ies:** A general overview of the social mobilization and communication strategy stating the key messages, their sequencing (if any), the overall tone for the strategy, the blend of communication actions (administrative mobilization, community mobilization, advertising, personal selling, point-of-service), and relationships between these different communication actions and an overview of how the plan will be managed.

### 3. The Implementation Plan (*explaining “What”, “When”, “Where”, “Who”, “How much”*).

**3.1. Communication actions:** Detailed specification of the communication actions outlined in the “Strategy” section including descriptions and plans for production, procurement, pricing and distribution of any technological products, services, incentives (e.g., T-shirts, prizes), and materials, as well as identifying what staff and/or partner agency training and supervision activities are required (for whom, what, when, where, why, facilitated by whom).

**3.2. Monitoring and evaluation:** Details of the behavioural monitoring and process evaluation to be used, methods for data collection and analysis, a description of the system for managing and sharing monitoring information (community feedback, programme

reports, etc.), and an explanation of how the plan will be modified as a result of monitoring. Also included here would be a description of any mid-term or final evaluations of behavioural impact (alongside other areas of interest such as entomological impact, social and organizational impact, impact on morbidity and mortality, environmental impact, cost-benefit analyses, other unintended impacts).

**3.3. Management:** A description of the management team (e.g., the multidisciplinary planning team), including specific staff or collaborating agencies (e.g., local advertising firms, research institutions) designated to coordinate communication actions and other activities (such as monitoring). Also including any technical advisory group or government body to which the management team is to receive technical support from or report to.

**3.4. Workplan:** A detailed workplan with time schedule for the preparation and implementation activities required to execute each communication action as described in Section 3.1. The workplan could take the form of a table with column headings: Activities, Completion Date, Responsibility (staff member, partner agency, and so on). A tabular flow-chart (or Gant Chart) with weeks, months, quarters, or years as column headings along the top and specific activities as row headings down the left-hand side is also useful. Cells within the table can be shaded to indicate which weeks, months, etc., particular activities are scheduled. Such a diagram allows instant comprehension of when different activities begin and end, whether preparatory activities have been given enough time, whether communication actions that need to be integrated are indeed integrated, and highlights periods of peak activity.

**3.5. Budget:** A detailed listing of costs for the various activities described in Section 3.1 (see also Step 10).

## NOTES

- <sup>1</sup> For information on COMBI see: <http://www.who.int/infectious-disease-report/2002/behaviour.html> and [http://www.cominit.com/pdf/Combi4-pager\\_Nov\\_14.pdf](http://www.cominit.com/pdf/Combi4-pager_Nov_14.pdf); World Health Organization Western Mediterranean Centre (forthcoming) *A Manual for Designing a Communication-for-Behavioural Impact (COMBI) Plan of Action*. Tunis: WHO Western Mediterranean Centre.
- <sup>2</sup> WHO (2002) *An Expanded DOTS Framework for Effective Tuberculosis Control*. WHO/CDS/TB/2002.297. <http://www.who.int/gtb/publications/dots/index.htm>
- <sup>3</sup> Harries A., Kenyon T., Maher D., Floyd K., Nyarko E., Nkhoma W. (2001) *A collaborative project coordinated by WHO. Community TB care in Africa: Report on a "lessons learned" meeting in Harare, Zimbabwe, 27-29 September 2000*. Geneva: WHO/CDS/TB/2001.29 <http://www.who.int/gtb/publications/communityTBcare/CommunityTBCare.pdf>; <http://www.who.int/gtb/policyrd/CommCare.htm>; Stop TB Partnership (2001) *Guidelines for Social Mobilization: A human rights approach to tuberculosis*. Geneva: WHO/CDS/STB/2001.9. Sharma, B.V. (2002) *Community contribution to TB care: an Asian perspective*. <http://www.who.int/gtb/publications/communityTBcare/TB-2002-302.pdf>; Jaramillo, E. *Community contribution to TB care: a Latin American perspective*. WHO/CDS/TB/2002.304. Contribución de la comunidad a la atención de la tuberculosis: una perspectiva Latino Americana. WHO/CDS/TB/2002.304(s). <http://www.who.int/gtb/publications/communityTBcare/TB-2002-304/en.pdf>, <http://www.who.int/gtb/publications/communityTBcare/TB-2002-304/sp.pdf>; <http://www.who.int/gtb/publications/training/TB-2002-300.pdf>; Stop TB Partnership (2003) *Community Contribution to TB Care: Practice and Policy*. Geneva: WHO/CDS/TB/2003.312.
- <sup>4</sup> WHO (2002) *An Expanded DOTS Framework for Effective Tuberculosis Control*. WHO/CDS/TB/2002.297. <http://www.who.int/gtb/publications/dots/index.htm>
- <sup>5</sup> WHO (1999) *What is DOTS? A guide to understanding the WHO-recommended TB Control Strategy known as DOTS*. Geneva: WHO/CDS/CPC/TB/99.270.
- <sup>6</sup> Uplekar, M., Rangan, S. and Ogden, J. (1999) *Gender and Tuberculosis Control: Towards a Strategy for Research and Action*. Geneva: WHO/CDS/TB/2000.280.
- <sup>7</sup> Stigma has been defined as “an attribute that is significantly discrediting” and “an attribute used to set the affected person or groups apart from the normalized social order, and this separation implies a devaluation.” Stigmatization therefore describes the process of devaluation within a particular culture or setting, where certain attributes are seized upon and defined as discreditable or not worthy.
- <sup>8</sup> Berjemo, A. and Bekui, A. (1993) ‘Community participation in disease control.’ *Social Science and Medicine*, **36**:9, pp.1145-1150.
- <sup>9</sup> McKee, N. (1992) *Social Mobilization and Social Marketing in Developing Countries: Lessons for Communicators*. Penang: Southbound.
- <sup>10</sup> Others have noted that: “no policies for private sector involvement can be successful unless the government can effectively provide and monitor treatment. In the initial stages of DOTS implementation the involvement of the private sector is... of secondary importance. The priority is to establish a public DOTS programme that provides free, respectful, and convenient treatment with drugs of good quality. Once this infrastructure is in place, efforts to involve the private sector are much more likely to succeed. If there is no such infrastructure, TB control is likely to fail, regardless of the level of involvement of the private sector.” Khatri and Frieden (2002) “Rapid DOTS expansion in India.” [http://www.who.int/bulletin/pdf/2002/bul-6-E-2002/80\(6\)457-463.pdf](http://www.who.int/bulletin/pdf/2002/bul-6-E-2002/80(6)457-463.pdf).