Section 2

Use this section of the workbook together with the corresponding Action in the Guide, *Action 2: Know the TB situation in your country*

Tool 2.1: Organisation of TB service delivery

Tool 2.2: Epidemiology of TB

Tool 2.3: National policies and guidelines

Tool 2.4: National TB objectives, targets and activities

Tool 2.5: Successes and challenges

Tool 2.6: The Cough-to-Cure Pathway

Tool 2.7: Logical linkages between challenges and activities

Tool 2.8: Advocacy planning

Tool 2.9: Communication planning

Tool 2.10: Social mobilisation planning

Tool 2.11: Service delivery planning

Tool 2.1:
Organisation of TB service delivery

This tool can help you understand how your national TB control programme is organised and who your national TB programme (NTP) points of contact are at national and local levels.

Step 1: Use this space to draw a picture of how the programme is organised from the central level to the local level, starting with the ministry of health and ending with the smallest unit of service where people with TB are treated (such as the primary health centre or health post, or in the community). Include laboratory services as well. If your programme has developed a graphic already, you can copy it and paste it here.

What are possible issues?

Major challenges related to programme organisation may include:

- TB services may not be delivered at the same level or in the same location as HIV services. This increases the burden on clients in terms of time, inconvenience and cost of transportation, which in turn increases the likelihood that they will not go for services.
- The TB programme (NTP) may be understaffed at some or all levels due to a lack of adequate funding, or poor distribution of the existing resources. This may have an impact on the speed, quality or availability of services.
- The TB and HIV control programmes may not be well coordinated, leading to gaps in care or duplication of effort.

These are only examples of some common challenges. Your programme may function well, or it may face different problems.

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Tool 2.1:
Organisation of TB service delivery

Questions about the organisation of TB services (write answers on this sheet)

National TB programme organisation

1. How many positions does the NTP have in its central unit? Are they all filled?
2. Does the NTP have a line in the national or ministry of health budget to fund its activities? What percentage of the TB budget is covered by the national government?
3. Does the TB programme have grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) or other donor money for TB or TB/HIV? What percentage of the TB budget is covered by outside donors?
4. Where are national-level data on TB kept, and is it possible to access that information?
5. When does the NTP plan its work for the following year? Are civil society organisations (CSOs) invited to participate?
6. When does the NTP hold review meetings? Are CSOs invited to participate?
7. Do the NTP and national AIDS control programme (NACP) have a formal coordinating mechanism? Are CSOs invited to participate? When are meetings held?
8. For what time period is the current national TB strategy valid? When will the NTP start planning the next strategy

Service delivery

1. Where does someone with TB symptoms go for diagnosis of TB?
2. Where does someone with TB go for HIV counselling and testing? HIV treatment?
3. Where does a person with TB go for treatment?
4. If drug-resistance is suspected, where does the programme send the sputum specimen for testing
5. If a person must be treated for drug-resistant TB, where is the treatment given?
6. Does the TB programme provide any incentives and enablers to support people on treatment, such as transportation vouchers or food packages?
7. Does the NTP work with CSOs to find and deliver care to people with TB? Does the NTP provide any budget for CSOs?
8. Are there any major issues you know about that affect programme performance, such as drug stockouts, lack of human resources, lack of laboratory supplies, or others?

Tool 2.1:
Organisation of TB service delivery

Step 2: Use the template to fill in the names and contact information for key people working within the NTP at the national level and at the other levels where you will interact with the programme. Contacts may include the NTP manager and lower-level managers (provincial and district levels); data managers or monitoring and evaluation (M&E) managers; focal people for TB/HIV, community-based care, advocacy, communication and social mobilisation (ACSM), or CSOs if they exist in your programme; and nurse supervisors or outreach workers at the local level. You can add or subtract rows or change this table to fit your own needs. This is an example – a blank template is provided on the following pages.

Example of National TB programme contact list

Location	Position	Name	Phone	**Email**	Notes
NTP Central Unit	NTP manager	Dr Rose Mbwala	075-22-3467	drrose@ntp.org	Prefers meetings on Thursdays
	TB/HIV focal point	Mr Simon Shrestha	075-21-5678	mrsimon@ntp.org	Newly appointed
	M&E/data manager	Mrs Hsieh Wang	075-22-9876	mrsevelyn@ntp.org	Updated data available on the 15th of the month
Western Province Unit	Provincial TB manager	Dr D. Phiri	087-32-0987	phiri@ntp.org	On medical leave until June 2013
Western Province Lungta District Unit	District medical officer	Dr Sara Farai	087-34-3847	sillons@ntp.org	
Lungta District Yiasu Health Centre	DOTS nurse	Mrs Hassan Tembe	087-34-5123	none	
Lungta District Yiasu Health Centre	Community health worker	Mr John Bikindu	087-34-1122	none	

Tool 2.1:
Organisation of TB service delivery

National TB programme contact list

Location	Position	Name	Phone	Email	Notes

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Tool 2.1:
Organisation of TB service delivery

Location	Position	Name	Phone	Email	Notes

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Tool 2.2: Epidemiology of TB

Use this tool to review the basic information about the burden of TB in your country and the area where you work. First, we will go through an example of what you can find in the World Health Organization (WHO) *Global Tuberculosis Report* and other WHO resources, which summarise data for each country, and then you can fill out a template for your own country.

Imagine you have a meeting with your country's NTP to discuss priorities for community-based support. You will need to be well prepared for the meeting! To do so, you need to be familiar with the TB situation in your country and to understand what the numbers mean.

The first place to go to find this information will be the WHO *Tuberculosis country profiles* website available at: www.who.int/tb/country/data/profiles/en/index.html. This provides the most up-to-date data available for every country in the world that reports on TB. (If you live in one of the 22 high-burden countries for TB, you can also find a similar one-page summary of key TB data for your country in one of the annexes of the WHO *Global tuberculosis report*.) An example from Kenya appears on the next page. We discuss what each of the key sections circled in red means on the following pages. The discussion is quite detailed, and so you may decide to use this only as a reference when reviewing your own country data. Regardless of how you approach it, this is essential information for you to understand as a CSO working on TB.

***TIP**: Remember that data available in the global reports lag behind real time. This is because it takes a long time to treat TB and report final treatment outcomes for every person diagnosed during a calendar year. So for many indicators used on the one-page summary, they will be referring to data for people with TB who were diagnosed one or two years ago. You may be able to get more recent data directly from the NTP, but the data in the global reports are easily accessible to everyone.*

Key resources

Reviewing TB data can be confusing, even for people working in the NTP. It may be useful to review data as a group, and to have some references handy that provide definitions of TB terms if you need reminders. This reference includes definitions and discussions about TB indicators:

World Health Organization (2004), *Compendium of indicators for monitoring and evaluating national tuberculosis programs.* Available at: www.who.int/tb/publications/tb_compendium_of_indicators/en/index.html

If you are working on Global Fund-related HIV and TB projects, you will also want to be familiar with its monitoring and evaluation guidance. You can also access the Global Fund Monitoring and Evaluation Toolkit at: http://www.theglobalfund.org/en/me/documents/toolkit/

Tool 2.2: Epidemiology of TB

Kenya

World Health Organization

Tuberculosis profile

| High TB burden | High HIV burden |

Population 2011 — **42 million**

Estimates of TB burden * 2011	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	9.2 (4.7–15)	22 (11–36)
Prevalence (includes HIV+TB)	120 (63–200)	291 (152–475)
Incidence (includes HIV+TB)	120 (110–120)	288 (276–300)
Incidence (HIV+TB only)	47 (45–49)	113 (109–118)
Case detection, all forms (%)	81 (78–85)	

TB case notifications 2011

New cases		(%)	Retreatment cases		(%)
Smear-positive	37 085	(39)	Relapse	3 356	(34)
Smear-negative	30 394	(32)	Treatment after failure	263	(3)
Smear-unknown / not done	9 416	(10)	Treatment after default		
Extrapulmonary	17 069	(18)	Other	6 398	(64)
Other	0	(0)			
Total new	**93 964**		**Total retreatment**	**10 017**	
Other (history unknown)	0				
Total new and relapse	**97 320**		**Total cases notified**	**103 981**	

New cases	Smear-positive	Smear-negative/ unknown/ not done	Extrapulmonary
M:F ratio	1.6	1.2	1.2
Age < 15	985	2 008	2 795

Laboratories	2011
Smear (per 100 000 population)	3.8
Culture (per 5 million population)	0.7
Drug susceptibility testing (per 5 million population)	0.1
Is second-line drug susceptibility testing available?	Yes, outside country
Is there a national reference laboratory?	Yes

Treatment success rate 2010 (%)

New smear-positive and/or culture-positive	87
New smear-negative/extrapulmonary	85
Retreatment	79

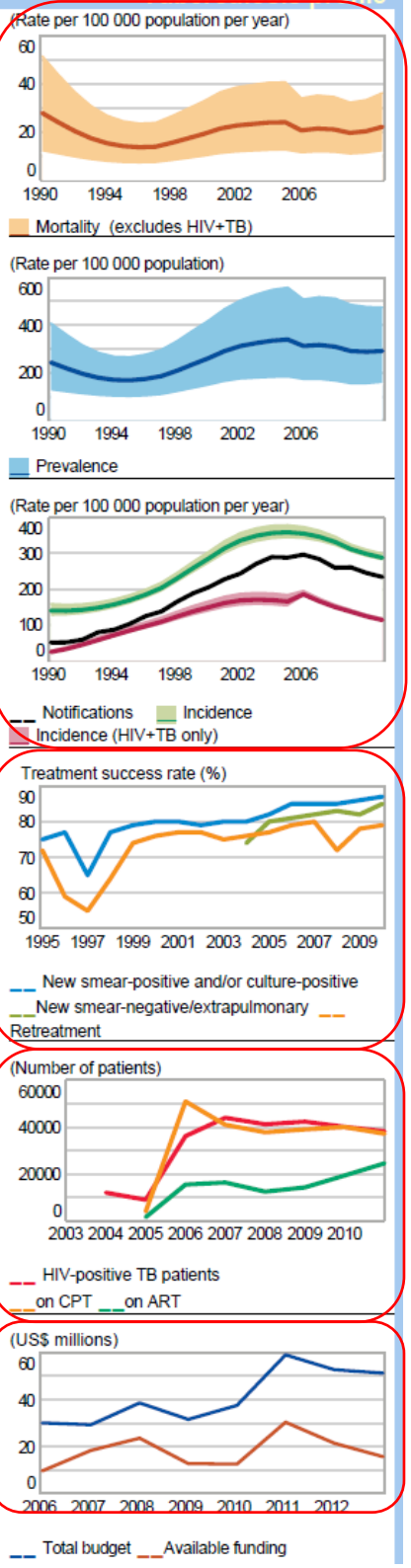
Is rifampicin used throughout treatment for new patients? Yes

TB/HIV 2011	Number	(%)
TB patients with known HIV status	97 136	(93)
HIV-positive TB patients	38 172	(39)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	37 147	(97)
HIV-positive TB patients on antiretroviral therapy (ART)	24 497	(64)
HIV-positive people screened for TB		
HIV-positive people provided with IPT		

Estimates of MDR-TB burden 2011*	New	Retreatment
% of TB cases with MDR-TB	3.1 (0.1–7.1)	10 (2.1–18)
MDR-TB cases among notified pulmonary TB cases	2 400 (77–5 500)	1 000 (210–1 800)

Reported cases of MDR-TB 2011	New	Retreatment	Total
Cases tested for MDR-TB	92 (<1%)	1 195 (12%)	1 393
Laboratory-confirmed MDR-TB cases	17	149	166
Patients started on MDR-TB treatment			156

Financing TB control	2012	2013
Total budget (US$ millions)	53	51
Available funding (US$ millions)	21	16
% of budget funded	41	31
% available funding from domestic sources	46	55
% available funding from the Global Fund	51	23



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Tool 2.2: Epidemiology of TB

How to look at the country profile

1 At the top of the page, you will find whether your country has been designated as a high-burden country for TB and/or HIV. This will give you an idea of how important TB/HIV co-infection is in determining the progress toward TB elimination in your country. In the case of Kenya, it has a high burden of both diseases, and so TB/HIV is a big concern for stopping TB.

| High TB burden | High HIV burden |

2 The first box on the profile provides scientists' *estimates* (best guess) about how much TB exists in a country, based on prevalence survey information or mathematical models. These numbers are important for you to understand, but are not the most important numbers for you to track as they are only estimates. The first column of numbers provides the total estimated *number* for each category, and the second column provides the estimated *rate*, or number of people with TB per every 100,000 people living in the country. The numbers in parentheses represent a range of values that the real number is likely to fall within. In this example from Kenya, we see the number 9.2 in the first column for mortality. We see from the column heading that this number represents thousands of people, so we multiply 9.2 x 1,000 and understand that WHO thinks that about 9,200 people died with TB in Kenya in 2011. The TB mortality rate for Kenya in 2011 was estimated at 22 deaths per 100,000 people in the country per year.

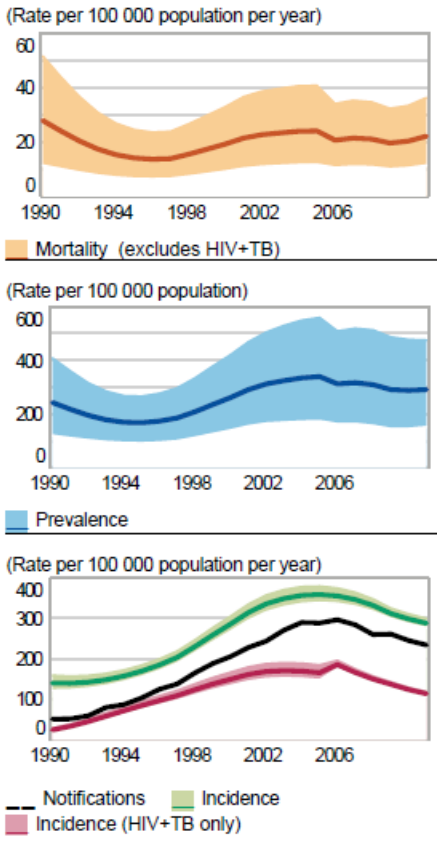
It is important to note that in the table it says that the estimate of mortality excludes people with TB/HIV. This means that anyone who was known to be HIV positive and may have died with TB is not counted in the numbers. That is because HIV-associated TB deaths are counted by the HIV programme as AIDS deaths rather than TB deaths, and WHO does not want to double-count them. What this means in a country like Kenya, with a high burden of HIV, is that the estimates for mortality are probably low – they underestimate the real TB death toll because people with HIV are not included in the mortality calculation.

Estimates of TB burden * 2011	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	9.2 (4.7–15)	22 (11–36)
Prevalence (includes HIV+TB)	120 (63–200)	291 (152–475)
Incidence (includes HIV+TB)	120 (110–120)	288 (276–300)
Incidence (HIV+TB only)	47 (45–49)	113 (109–118)
Case detection, all forms (%)	81 (78–85)	

The other numbers *do* include people with TB/HIV. In this example, WHO estimates that prevalence and incidence were about the same in 2011, at 120,000 people. Prevalence counts all the people with TB that exist during the year, even if they became ill before the year started, while incidence counts only the people who became ill in the current year. The prevalence rate is 291/100,000 and incidence rate is 288/100,000. When compared with other high-burden countries, Kenya is somewhere in the low–middle in terms of the burden of disease. South Africa's estimated incidence was 993/100,000 in 2011, while Brazil's was 42/100,000.

Tool 2.2:
Epidemiology of TB

It is important to know what is happening in any one year, but it is also important to know how things have changed over time. Are they getting better or worse? In the case of mortality, prevalence and incidence, we want to see these numbers going *down* over time. You can look at the graphs to the right of the table to see what has happened in Kenya since 1990.



What we see is that mortality (first graph) has gone down and then up again, and has not changed much since 2006. Prevalence (middle graph) went down and then up, and is now steady. Incidence (lower graph) is coming down slowly. All of these graphs point to the fact that Kenya is making gains in TB, but that more needs to be done to accelerate progress. To decrease mortality, we may need to advocate with the government to increase funding for new TB diagnostic tools, so people with TB can be diagnosed earlier in their disease when they have a better chance of being cured. We may also need to make sure everyone with TB receives HIV counselling and testing so that appropriate treatment can be provided as early as possible. To decrease prevalence and incidence, we may need to put more people with TB/HIV co-infection on isoniazid preventive therapy (IPT). These are just examples of how looking at the data can help you think of interventions to stop TB. To decide in real life, you will gather more information about why these numbers are not decreasing faster before you develop interventions. (This is how you will use the Cough-to-Cure Pathway and your project cycle in Tool 2.6).

3 The next table on the page is one of the most important to understand how your national TB programme is performing in finding and recording people with TB. The table below reports the actual data from Kenya's NTP for the year 2011. It is divided into new cases and retreatment cases. Here, we can see that a total of 93,964 new cases of TB were reported in Kenya in 2011. Of these, 37,085 were smear-positive, representing 39% of all new cases. Of note, we see that 10% of new cases did not have a smear result recorded – there is room for improvement, since everyone should have a result. There were 10,017 retreatment cases reported in 2011. The good news is that very few of them (3%) were people who had failed treatment. Relapses

TB case notifications 2011					
New cases		(%)	Retreatment cases		(%)
Smear-positive	37 085	(39)	Relapse	3 356	(34)
Smear-negative	30 394	(32)	Treatment after failure	263	(3)
Smear-unknown / not done	9 416	(10)	Treatment after default		
Extrapulmonary	17 069	(18)	Other	6 398	(64)
Other	0	(0)			
Total new	**93 964**		**Total retreatment**	**10 017**	
Other (history unknown)	0				
Total new and relapse	**97 320**		**Total cases notified**	**103 981**	

(people who became sick again after treatment) were 34% of retreatment cases. Most of the retreatment cases fell into the "Other" category, meaning that we don't know what happened to these people before they were treated again. There is room for improvement here as well, either in making sure health care providers know how to interview clients and categorise them properly, or how to fill in the reporting forms.

One thing we can do with this table is to compare the total number of cases notified with what WHO estimated as the total number of cases that existed in the first table (diagnosed or undiagnosed). We see that Kenya actually notified 97,320 new and relapse cases of TB in 2011 (this is the sum of the people who are registered during the year as a new episode of TB). WHO estimated the incidence of these cases to be 120,000. Dividing the actual number of cases notified by the estimated cases, we get the percentage of existing cases that Kenya detected – in this case, 97,320/120,000 x 100% = 81%. This percentage is called the *case detection rate*. If the WHO estimate is correct, then Kenya did not find and report about 19% of existing cases, or 22,680 cases of TB. These are cases we would need to continue looking for using interventions such as new diagnostic tools, new community-based approaches, and stigma reduction activities. The case detection rate is a tricky number, though, and depends on a very good estimate. Sometimes it is not possible to make one very accurately. For this reason, WHO no longer favours using this measure and instead relies on the case notification rate as a measure of performance. Even if your country still uses and reports on this measure, as many countries do, it is a measure that should only be estimated at the national level, not at provincial or district level.

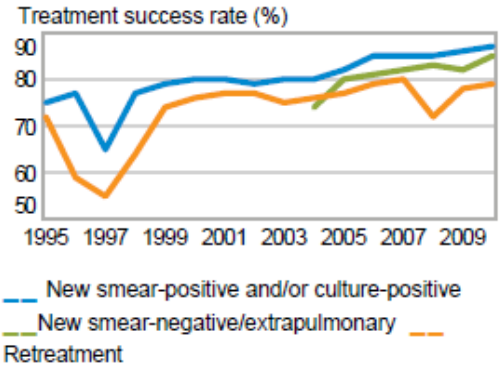
4 The next table shows how well your NTP is performing in treating people diagnosed with TB. The treatment success rate shows what percentage of the people started on TB treatment during a one-year period completed their treatment. Remember, this percentage includes those whose cure was confirmed by a laboratory test (usually a sputum smear) plus the people who completed their treatment but did not have a test at the end.

In Kenya, for the people who were notified as having TB in the year 2010, we see three separate success rates that vary from a high of 87% for smear- or culture-positive TB to a low of 79% for retreatment. How good is this? The current global target for treatment success by the year 2015 is 90% for all categories, so Kenya is getting close except in the category of retreatment. This may be because some of the people being retreated for TB have drug-resistant TB that has not been diagnosed, or because they are often more likely to become lost to follow-up (since some of them did not complete treatment the first time around).

Treatment success rate 2010 (%)	
New smear-positive and/or culture-positive	87
New smear-negative/extrapulmonary	85
Retreatment	79

Tool 2.2:
Epidemiology of TB

We also want to look at how Kenya has done over time on treatment success. The graph to the right of the table shows us the same breakdown as the table, but for the years since 1995. We see steady improvements for people with smear- or culture-positive TB (blue line) and those with smear-negative or extrapulmonary TB since 1997. However, for people being retreated for TB, there is a noticeable dip in 2008 that we might want to investigate. And overall, it seems that the difference in success rates for the first two categories versus retreatment is growing larger. So Kenya may need to redouble its efforts to retreat people with TB successfully. One potential intervention would be more intensive community-based support for these clients.



5 The TB/HIV data table is also critically important for your work as a CSO. It gives you the key information about how your NTP is performing in addressing the issue of TB/HIV co-infection. In our example from Kenya, we see that in 2011 there were 97,136 people with TB who knew their HIV status, equal to 93% of all people with TB. This is very good performance, but still a little less than the 100% target.

Next, we see that of all the people diagnosed with TB in 2011, a high percentage was co-infected with HIV: 39%, or 38,172 people. This reflects the very large impact the HIV epidemic in Kenya has had on TB, and the synergy between the two diseases. Next, we see that 37,147 people (97%) with both diseases have been placed on co-trimoxazole preventive therapy (CPT), a life-saving intervention. This is also a very encouraging result. However, only 64% of HIV-positive people with TB were started on antiretroviral therapy (ART). The current global recommendation is that all (100%) of them should be placed on ART, so there may be some work to do here. However, that recommendation was given in 2012, after the group of people (cohort) reported below. We will have to wait to see what happens with the cohort for 2013 to see the real performance. In the meantime, we can advocate at the national level for rapid adoption of the new recommendation.

The next two indicators, people screened for TB and provided with IPT, are blank in this table. This is another area for investigation to find out why these are not reported. We know that TB is a leading killer of people with HIV, so it is important for them to be screened at each visit. The global recommendation also calls for all HIV-positive people who do not have active TB to be put on IPT. We do not know the reason why these figures are not reported for Kenya. We have to investigate further and ask “Why?” before we decide this is a problem that needs to be addressed.

TB/HIV 2011	Number	(%)
TB patients with known HIV status	97 136	(93)
HIV-positive TB patients	38 172	(39)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	37 147	(97)
HIV-positive TB patients on antiretroviral therapy (ART)	24 497	(64)
HIV-positive people screened for TB		
HIV-positive people provided with IPT		

Tool 2.2: Epidemiology of TB

6 The two tables on multidrug-resistant TB (MDR-TB) help you understand how the country is doing in expanding the accessibility of diagnosis and treatment for MDR-TB. The first table estimates the burden of MDR-TB, and the second table reports on what is actually happening in the country. Estimates are often based on a survey of all or part of the TB cases to see what percentage is MDR-TB. In Kenya, the percentage of new cases with MDR-TB is estimated at 3.1%. MDR-TB in newly diagnosed people always represents transmission of MDR-TB from someone else. The higher the number, the more people with MDR-TB who are going undiagnosed and untreated in the community, thereby infecting other people.

Estimates of MDR-TB burden 2011*	New	Retreatment
% of TB cases with MDR-TB	3.1 (0.1–7.1)	10 (2.1–18)
MDR-TB cases among notified pulmonary TB cases	2 400 (77–5 500)	1 000 (210–1 800)

Reported cases of MDR-TB 2011	New	Retreatment	Total
Cases tested for MDR-TB	92 (<1%)	1 195 (12%)	1 393
Laboratory-confirmed MDR-TB cases	17	149	166
Patients started on MDR-TB treatment			156

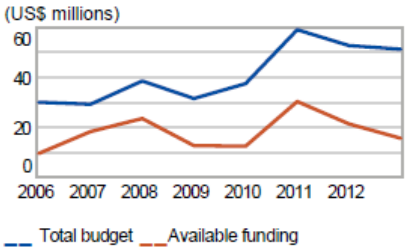
WHO estimates that 10% of people being retreated for TB have MDR-TB. This is a higher number than among people with new TB because all of these people have been treated before, and the TB in their bodies has had a chance to develop resistance to the medications they were given. That is one of the reasons why it is important to provide anyone who is being retreated for TB with a drug susceptibility test to see if the TB bacteria are resistant to first-line drugs.

What we see in Kenya is that WHO estimates that in 2011 there were about 3,400 people with MDR-TB out of new and retreatment cases reported. The next table of reported MDR-TB cases will tell us how well the programme is doing in finding them. Here, we see that Kenya tested 1,393 people for MDR-TB in 2011. Kenya found only 17 cases among people with newly diagnosed TB, and 149 among people being retreated, for a total of 166 cases of MDR-TB reported. This number is only 5% of the expected total number of MDR-TB cases. As with most countries, Kenya will need to expand these services rapidly to find and treat people with MDR-TB appropriately. CSOs could play a role in expansion, for instance, through advocacy efforts aimed at government decision-makers, who can increase funding for diagnostic tools and purchase of second-line drugs for treatment, or by providing community treatment support for people diagnosed with MDR-TB.

7 The last table and graph on the page provide information on the level of funding for TB activities and where that funding comes from. The first line in the table gives the total budget if all desired TB activities were fully funded. In Kenya, the total budget was $53 million in 2012 and has dropped to $51 million in 2013. However, the funding available is less than half of that required: for 2013, available funding is only $16 million, or about 31% of what is needed. Clearly more financial resources are needed, and advocacy may support efforts to fund the NTP. The last two lines in the table tell us what percentage of the available funding comes from which sources. In Kenya, 55% of the available funding for 2013 comes from the government, an increase over 2012. Only 23% of the funding is

coming from Global Fund, a sharp drop from the 51% contribution in 2012. The graph on the right shows us the trend in total budget (blue line) and available funding (brown line) since 2006. The worrying message from looking at this graph is that the gap between the two lines is getting larger, meaning that a smaller proportion of the total budget needed for TB activities is being met. This means that many activities the NTP needs or wants to do to reduce the burden of TB cannot be done.

Financing TB control	2012	2013
Total budget (US$ millions)	53	51
Available funding (US$ millions)	21	16
% of budget funded	41	31
% available funding from domestic sources	46	55
% available funding from the Global Fund	51	23



This completes our review of the country profile information. Now you can use the following pages in the workbook to do this analysis for your own country. The analysis will help you identify some of the potential issues that your NTP will face in trying to stop TB.

Tool 2.2: Epidemiology of TB

Country profile analysis

Use the form below to help you analyse your country's TB data.

Location (numbers from our example above)	Question	Answer	Questions to help with your analysis
1	Is your country a high-burden country for TB?	☐ Yes ☐ No	• How important is TB as a health issue in our country? • How important is TB/HIV co-infection as a health issue in our country?
	A high-burden country for HIV?	☐ Yes ☐ No	
2	What is the estimated TB mortality and mortality rate?	_____total _____/100,000	• Do the graphs to the right show decreases, increases or no change over time? Is this good or bad? • Are these numbers and rates high, medium or low when compared with other countries?
	What is the estimated TB prevalence and prevalence rate?	_____total _____/100,000	
	What is the estimated TB incidence and incidence rate?	_____ total _____/100,000	
3	How many total cases were notified in the year?	_____	
	How many new cases were notified?	_____	
	What percentage of the new cases notified were smear-positive?	_____%	• Is this percentage well above the percentage of other new cases diagnosed? • Does this suggest that non-smear-positive cases are being under-diagnosed?

Tool 2.2:
Epidemiology of TB

Location (numbers from our example above)	Question	Answer	Questions to help with your analysis
3 (cont.)	What percentage of the new cases notified were smear-negative?	_____%	• Is this percentage similar to the percentage of smear-positive cases? • Does this suggest that new diagnostic tools such as Xpert could help improve diagnosis?
	What percentage of the new cases notified were smear unknown?	_____%	• Is this percentage more than 2–3%? • What does this show about programme performance?
	What percentage of the new cases notified were extrapulmonary?	_____%	• Is this percentage high? Does this suggest that there may be many HIV-positive people with TB?
	How many retreatment cases were notified?	_____	• Is this a high percentage of the total cases reported in the year? • Does this make sense when compared to treatment success among new cases? • What does this mean about how well our country is performing in treating people with TB the first time around?
	What percentage of retreatment cases notified were relapses?	_____%	• Is this percentage relatively high? • Does this make sense when compared to treatment success among new cases?
	What percentage of retreatment cases notified were treatment after failure?	_____%	• Is this percentage relatively high? • What does this suggest about the possibility of higher rates of MDR-TB among new cases?
	What percentage of retreatment cases notified were treatment after default?”	_____%	• What does this suggest about treatment support efforts?

Tool 2.2:
Epidemiology of TB

3 (cont.)	What percentage of retreatment cases notified were classified as "other?"	_____%	• Is this a relatively high percentage? • What does this suggest about recording and reporting?
	How many new + relapse cases were notified?	_____	• How does this compare with the estimated number of incident TB cases from the first table? • What does this suggest about how well the programme is performing in finding people with TB?
4	What was the treatment success rate for new smear- and/or culture-positive cases?	_____%	• Have we reached our national target for treatment success? • Does treatment success vary significantly for these three categories of TB cases? • What do these percentages suggest about the performance of the programme in treating people with TB? • Looking at the graph to the right, what has the trend been for treatment success—are we doing better, worse, or about the same?
	What was the treatment success rate for new smear- negative and extrapulmonary cases?	_____%	
	What was the treatment success rate for retreatment cases?	_____%	
5	What percentage of people with TB knows their HIV status?	_____%	• Have we met our national targets for HIV counselling and testing in people with TB? • Is the HIV co-infection rate high among people with TB? What might this mean for TB case-finding activities? • Does our country have a policy related to CPT for people with TB/HIV? Have we met our targets? • Does our country have an updated policy on ART for people with TB/HIV? Have we met our targets? • How close are we to screening all people living with HIV for TB? • Does our country have a policy that supports providing IPT for people living with HIV? Have we met our targets?
	What percentage of people with TB is co-infected with HIV?	_____%	
	What percentage is on CPT?	_____%	
	What percentage is on ART?	_____%	
	What percentage of people living with HIV is screened for TB?	_____%	

Tool 2.2:
Epidemiology of TB

5 (cont.)	What percentage of people living with HIV is provided with IPT?	_____%	
6	How many cases of MDR-TB does WHO estimate among people with new TB?	_____total _____%	• Are these relatively high percentages, especially among those with newly diagnosed TB? • What does this suggest about our country's approach to treating TB in people with newly diagnosed TB and in people with retreatment TB?
	How many cases of MDR-TB does WHO estimate among people with retreatment TB?	_____total _____%	
	How many laboratory-confirmed cases of MDR-TB were reported among people with new TB in the year?	_____	• How do these numbers compare with the estimated number of existing cases of MDR-TB? • Are these numbers in line with any targets set for treatment of people with MDR-TB (in Global Fund grants or the national strategy)? • What does this suggest about our country's efforts to make treatment of MDR-TB accessible to everyone who needs it?
	How many laboratory-confirmed cases of MDR-TB were reported among people with retreatment TB in the year?	_____	
7	What is the total TB budget for the most recent year?	_____	• Does our country have sufficient funds available to stop TB? • Does the percentage of available funds provided by the government indicate a strong commitment to TB? • Are outside donors providing the majority of support for our TB programme? What are the implications for the future? • Looking at the graph, does the trend show improvement in the funding situation, or is the funding gap becoming larger?
	What percentage of the total TB budget is actually available to the programme?	_____%	
	What percentage of the available funds is provided by the government?	_____%	
	What percentage of the available funds is provided by Global Fund?	_____%	

Tool 2.2: Epidemiology of TB

Now that you have looked at your country's TB profile, write down the top three to five concerns or questions that you have about progress on stopping TB and TB/HIV based on your analysis. You can then use these as a starting point to do some further investigation, start discussions with the NTP about areas to support, or plan your own activities. Refer back to this list when you fill out **Tool 2.5**: **Successes and challenges.**

1.

2.

3.

4.

5.

Tool 2.3:
National policies & guidelines

Use this tool as a checklist to make sure you have copies of all the current national policies, guidelines and other important documents that will ensure your TB work is in line with the NTP's policies. Some of these documents may not be available in your programme.

Document	Questions to consider
☐ Current national TB strategy	• What time period does it cover? _____ • Was it developed in consultation with partners, including CSOs? • Does it include the goal, objectives and targets? • Does it discuss the role of CSOs? • Does it include a budget estimate?
☐ NTP annual work plan	• Was the work plan developed in consultation with partners? • Was it available at the beginning of the annual cycle? • Are CSO activities included in the work plan? • Do CSO activities have budget allocated to them?
☐ TB treatment guidelines *(combined or separate documents)*	• When were the guidelines last updated? _____ • Do they address TB treatment for children? • Do they discuss TB/HIV treatment? • Do they address drug-resistant TB treatment?
☐ TB/HIV guidelines	• Do the guidelines include information on the country's policy on IPT? • Do the guidelines describe how the country will achieve intensified case-finding?
☐ Infection control policy and guidelines	• Are there guidelines that describe how to implement infection control? • Do the guidelines cover community infection control?
☐ Community-based TB care guidelines	• Do the guidelines describe a standard referral process? • Do they describe how CSOs should interact with local health facilities? • Is there a specific position named in the guidelines responsible for supervising CSO activities?
☐ TB reporting guidelines	• Are the definitions in the reporting guidelines clear and consistent? • Are the lines and methods of reporting clear? • Are the timelines for reporting clear?
☐ TB forms (for recording and reporting)	• Are the same forms used throughout the country? • Do the forms include a place for reporting of HIV status? • Is training or support available to help you fill in the forms correctly?

Fill in the template below by referring to your country's national TB strategy and any work plans for the current year. Add more rows as needed.

National TB programme goal:			
	National TB control objectives	Targets	Planned activities
1			
2			
3			
4			
5			
6			
7			

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Now take your country's objectives and targets, and do an analysis of where it stands in reaching those targets. Below is an example. On the next page, you can use the blank template to do the analysis for each objective in your country. One problem you may encounter in doing this exercise is that the NTP does not have easily measurable objectives, or its targets are unclear. Do the best you can with the information available.

	National TB programme objective (from your national strategy document)	**Target** (from the national strategy, Global Fund plans, etc.)	**Current performance** (from the annual TB report of the country or WHO)	**Analysis: success or challenge?**
EXAMPLE	Increase treatment success to 90% by 2015.	90% treatment success for new smear-positive pulmonary TB.	Since 2005, treatment success has been steadily increasing. For 2011 (the latest year with complete data available), treatment success = 80% nationally, but varied among individual districts from a low of 62% to a high of 87%.	Challenge. Although treatment success continues to improve and some districts have almost reached the target, we are still below the national target of 90%, and some districts are doing poorly. May need to focus improvement efforts on lowest-performing districts.

Tool 2.5:
Successes & challenges

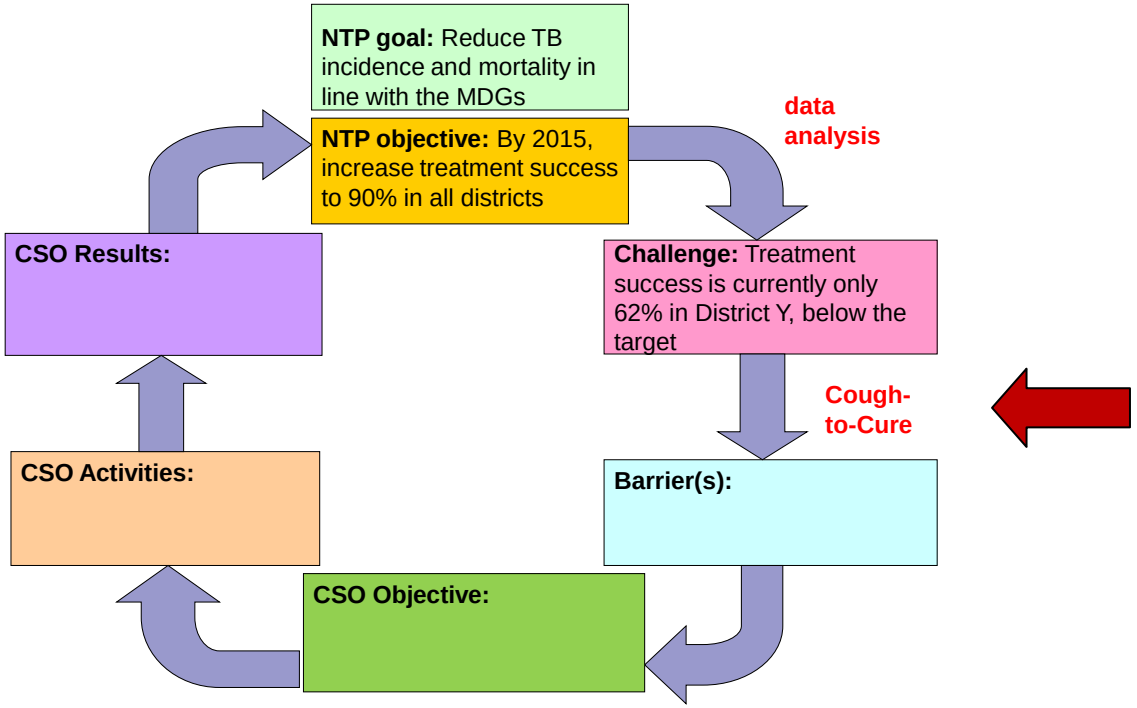
	National TB programme objective (from your national strategy document)	**Target** (from the national strategy, Global Fund plans, etc.)	**Current performance** (from the annual TB report of the country or WHO)	**Analysis: success or challenge?**
1				
2				
3				
4				

Tool 2.5:
Successes & challenges

	National TB programme objective (from your national strategy document)	**Target** (from the national strategy, Global Fund plans, etc.)	**Current performance** (from the annual TB report of the country or WHO)	**Analysis: success or challenge?**
5				
6				
7				

Tool 2.6:
The Cough-to-Cure Pathway

In Tool 2.4 you listed the NTP goal, objectives and activities. In Tool 2.5 you assessed the performance of the NTP in reaching its targets and accomplishing its objectives. You did so by analysing programme data. Then you identified the places where the NTP faces challenges in reaching its targets. Now that you have identified the challenge areas, you will use the Cough-to-Cure Pathway as a framework to identify the potential reasons (barriers) for each of the challenges that the NTP faces, using a client-centred perspective. Taking the example used in the previous tool, here is where you are in the project planning, implementation and evaluation cycle:



Now go to the next page to see an example of how to use the Cough-to-Cure Pathway to 1) identify which step in the Pathway is linked to your challenge, and 2) what the barriers might be in reaching your target. Then you can do this for your own identified challenge on the blank Pathway form provided. You can go through this process for each challenge you would like to address.

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Tool 2.6:
The Cough-to-Cure Pathway

Continuing with our example of low treatment success, we go through the following steps:
Step 1: What challenge are we trying to address? Treatment success is currently only 62% in District Y, below the target of 90%.
Step 2: Which step in the Cough-to-Cure Pathway is our challenge most closely linked with? Continue and complete treatment.
Step 3: What are the likely individual, community and system barriers that contribute to our challenge? (filled in below for this example)

Ideal	• Community members have knowledge of TB symptoms. • Community members know when, where and how to seek care. • The community supports care-seeking behaviour for people with TB symptoms. • Health facilities provide the community with information about TB symptoms and where to seek care for free.	• Community members know the facility to visit for TB evaluation. • Community members trust the facility to provide quality services. • The community encourages care-seeking behaviour. • Health facility is available nearby, with trained staff and client-friendly services.	• People with TB symptoms have the correct information about where to go for evaluation and how to produce sputum. • People with TB symptoms trust the facility to give them an accurate diagnosis. • Laboratory equipment and supplies are available to diagnose TB and test for HIV. • Staff are trained to diagnose TB. • Staff are trained to provide HIV counselling and testing. • Services are provided in a timely manner for free.	• People with TB receive thorough client education, and understand the importance of treatment. • A treatment supporter is identified for each person with TB. • Quality drugs are available for treatment. • Treatment support is provided, and DOT is done at a place and time convenient for the person with TB. • People with TB do not face stigma or discrimination.	• People with TB receive ongoing encouragement and education from health care providers and community volunteers. • Regular monitoring of treatment is done, including a final sputum. • Side effects are identified quickly and addressed. • Treatment supporters help people with TB cope with ongoing treatment. • Quality drugs are available.
Cough-to-Cure Pathway	**Recognise illness and the need to seek care**	**Seek care at a health facility that can diagnose TB**	**Complete diagnosis for TB, including HIV counselling and testing**	**Begin treatment for TB**	**Continue and complete treatment**
Individual barriers					• **DOT conflicts with work schedules** • **No money for transportation** • **Poor understanding of the need to complete treatment** • **Side effects of medications**
Community barriers					• **Stigma prevents people from continuing treatment** • **Community members are not engaged as treatment supporters**
System barriers					• **Drug stockouts** • **Inconvenient times for DOT at clinic, and no community-based DOT provided** • **No transportation subsidy**

Tool 2.6:
The Cough-to-Cure Pathway

Use the blank Pathway below to go through the steps for your identified challenge. Repeat for each challenge you would like to address.

Step 1: What challenge are we trying to address? _____

Step 2: Which step in the Cough-to-Cure Pathway is our challenge most closely linked with? _____

Step 3: What are the likely individual, community and system barriers that contribute to our challenge? (fill in below)

Ideal	• Community members have knowledge of TB symptoms. • Community members know when, where and how to seek care. • The community supports care-seeking behaviour for people with TB symptoms. • Health facilities provide the community with information about TB symptoms and where to seek care for free.	• Community members know the facility to visit for TB evaluation. • Community members trust the facility to provide quality services. • The community encourages care-seeking behaviour. • Health facility is available nearby, with trained staff and client-friendly services.	• People with TB symptoms have the correct information about where to go for evaluation and how to produce sputum. • People with TB symptoms trust the facility to give them an accurate diagnosis. • Laboratory equipment and supplies are available to diagnose TB and test for HIV. • Staff are trained to diagnose TB. • Staff are trained to provide HIV counselling and testing. • Services are provided in a timely manner for free.	• People with TB receive thorough client education and understand the importance of treatment. • A treatment supporter is identified for each person with TB. • Quality drugs are available for treatment. • Treatment support is provided, and DOT is done at a place and time convenient for the person with TB. • People with TB do not face stigma or discrimination.	• People with TB receive ongoing encouragement and education from health care providers and community volunteers. • Regular monitoring of treatment is done, including a final sputum. • Side effects are identified quickly and addressed. • Treatment supporters help people with TB cope with ongoing treatment. • Quality drugs are available.
Cough-to-Cure Pathway	**Recognise illness and the need to seek care**	**Seek care at a health facility that can diagnose TB**	**Complete diagnosis for TB, including HIV counselling and testing**	**Begin treatment for TB**	**Continue and complete treatment**
Individual barriers					
Community barriers					
System barriers					

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Tool 2.7:
Logical linkages between challenges and activities

Once you have identified a list of potential barriers, you will need to decide which of the barriers are real issues, and of these, which barriers your organisation can help remove. It is not enough to guess at what the problems might be. You have to have evidence that they are the real problems. Otherwise, you may be developing solutions for the wrong problems, and wasting time and resources without seeing improvements. To gather the information you need to confirm your ideas about the barriers, you can do several things. You can hold focus groups or individual interviews with people with TB in the community to understand their views of the barriers they face. You can do the same with the TB programme manager, TB clinic staff or outreach workers. You can review data from the programme. However you go about it, be sure to confirm your identified barriers with evidence. Once you have a list of the real barriers, you may need to prioritise them further because of limited resources, time or expertise. To do so, you can use a simple template like the one below to help sort out which barriers you want to address, or which ones you want to address first. These are generally the ones that would fall into the green boxes, although there are many exceptions to this rule. Use your own judgment about the situation to decide which are most important for your organisation.

	Less important (removing this barrier would benefit only a few of our target group, or only improve outcomes a little)	**Somewhat important** (removing this barrier would benefit at least 50% of our target group or make a moderate improvement in outcomes)	**Most important** (removing this barrier would benefit most of our target population or make a significant improvement in outcomes)
Very feasible to succeed (our organisation has existing capacity to address this barrier and it is politically feasible to do so)			Most desirable box for a barrier to fall in
Somewhat feasible to succeed (our organisation needs only a little help to succeed, there is some political opposition that can be overcome, or success will take a long time)			
Difficult to succeed (our organisation does not have this expertise, there is strong political opposition that is difficult to overcome, or there are other factors that work against success, such as geography)	Least desirable box for a barrier to fall in		

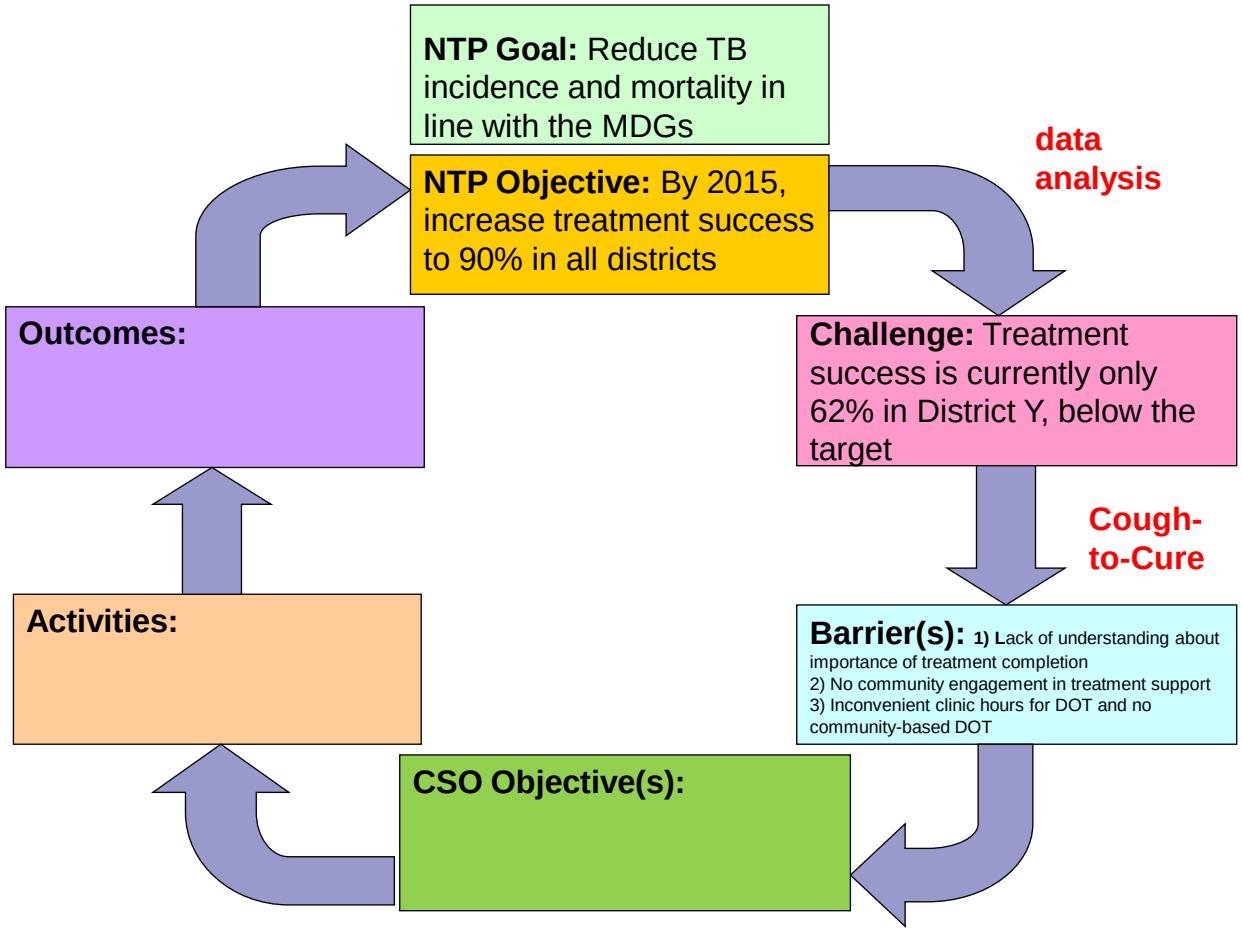
Tool 2.7:
Logical linkages between challenges and activities

Assume we have gone through the process of verifying the real barriers when it comes to low treatment success in our example. We have discovered that the main problems include all of the barriers we originally listed. Now we need to prioritise them, and we do so using this template.

	Less important (removing this barrier would benefit only a few of our target group, or only improve outcomes a little)	**Somewhat important** (removing this barrier would benefit at least 50% of our target group or make a moderate improvement in outcomes)	**Most important** (removing this barrier would benefit most of our target population or make a significant improvement in outcomes)
Very feasible to succeed (our organisation has existing capacity to address this barrier and it is politically feasible to do so)		Poor understanding of need to complete treatment	Lack of community engagement in treatment support
Somewhat feasible to succeed (our organisation needs only a little help to succeed, there is some political opposition that can be overcome, or success will take a long time)		Clinical hours conflict with work	Stigma
Difficult to succeed (our organisation does not have this expertise, there is strong political opposition that is difficult to overcome, or there are other factors that work against success, such as geography)	Side effects of medication	Drug stockouts No transportation subsidy	No money for transport

From our prioritisation exercise, we choose three of the barriers that we feel our organisation can address. We know stigma is important, but it will take a longer time to address, and our organisation has decided to concentrate on successes we can accomplish within one year. We choose to address the poor understanding of the need to complete treatment, lack of community engagement in treatment support, and conflicting clinic hours as three barriers that are appropriate for us to tackle this year.

Tool 2.7:
Logical linkages between challenges and activities



Now we have completed the **Barriers** identification step in our planning cycle, we are ready to write our objectives and choose the activities we will do to accomplish those objectives.

As you can see, there is a logical connection between each step we take in the process. When we get to the next steps, we will easily be able to explain what problems our activities are trying to address, and the results we hope to see as an outcome of those activities.

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Tool 2.7:
Logical linkages between challenges and activities

Developing objectives is one of the most challenging parts of project planning for many people, whether you work in a CSO or in a government department. Here is a brief tutorial to make writing objectives easier.

Make your objectives **SMART**:

Specific	• Single focus or result. • No overlap with other objectives. • What do I want to accomplish? • For whom? • Where? • When?
Measurable	• Can it be quantified or measured? • How much? • How many? • How will I know when it is accomplished?
Attainable	• Can we really do this? • Is this achievable and easy to put into action? • Considers limits, such as resources, personnel, cost and time frame.
Relevant	• Does this connect to the larger goal? • Does this seem worthwhile? • How important is this objective to our desired result?
Time-bound	• This is the objective's "due date". • When do we expect the change to happen or the activity to be completed? • Keeps activities on track and moving.

Examples of well-written objectives:

- By December 2015, increase the case notification rate in District X from 200/100,000 to 225/100,000.
- Recruit and train 25 home-based care volunteers to provide TB/HIV services to 250 clients in District Z by April 2014.
- Implement a national advocacy campaign to ensure that TB is declared an emergency in our country by March 2014.
- By May 2015, increase the percentage of people with TB in Province B who are counselled and tested for HIV and receive their results from 60% to 85%.

The general format of an objective that you can use to develop your own is as follows:

By (a certain time), we will (do a specific activity) in (a specific place) to achieve (this measurable result).

We will continue to build our example on the next page, and then you can practise developing your own objectives and activities to address your identified barriers.

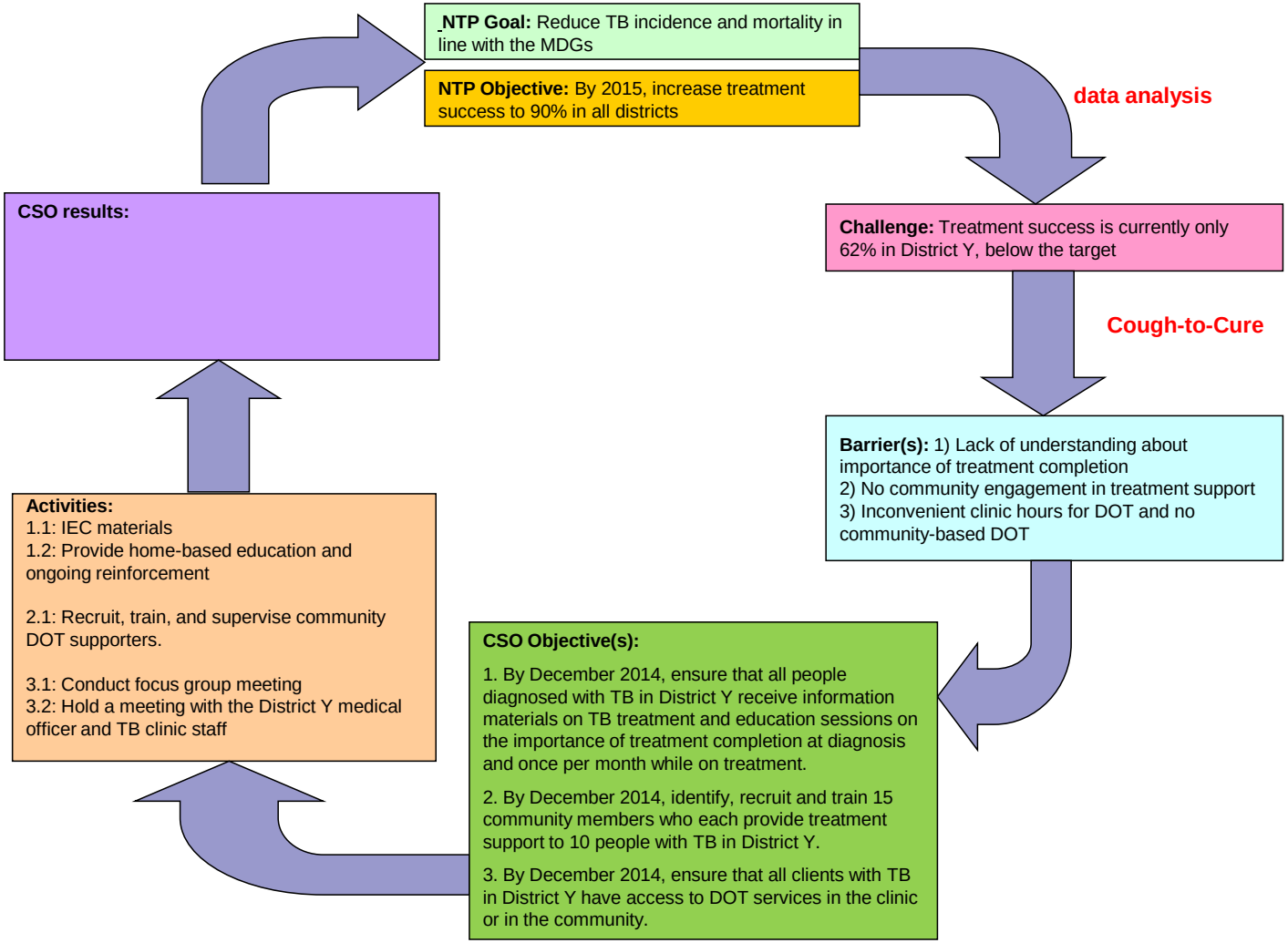
Tool 2.7:
Logical linkages between challenges and activities

Developing a logical plan is a key element of success for your TB/HIV activities. It allows you to communicate clearly with the NTP, NACP, partners and donors about how your activities relate to the country's TB strategy. It gives them confidence that your activities will support their objectives and help reach the targets. The information here is the same as in the project cycle diagram on the next page. However, with multiple barriers and objectives, you can put more information in a table format. Now practise this for your own barriers on the blank page that follows. You can add tables if you are addressing more than one objective or challenge. **NOTE: To help you develop the details of activities that can be put into this table, you can use Tools 2.8–2.11 before you complete the table.**

Example of *TB/HIV* barriers, objectives *and* activities matrix

TB control objective: By 2015, increase TB treatment success to 90% in all districts		
Challenge: Treatment success is currently only 62% in District Y, well below the target of 90%.		
Key barriers (from Cough-to-Cure analysis)	**Objectives to address barriers**	**Activities to address barriers**
1. People with TB have a poor understanding of the need to complete treatment (individual).	By December 2014, ensure that all people diagnosed with TB in District Y receive information materials on TB treatment, and education sessions on the importance of treatment completion, at diagnosis and once per month while on treatment.	1.1: Develop and distribute a simple flyer or other appropriate information, education and communication (IEC) materials for District Y community members diagnosed with TB. 1.2: Provide home-based education and ongoing reinforcement of the importance of treatment completion to District Y community members with TB, using our existing home-based care staff.
2. Community members are not engaged as treatment supporters (community).	By December 2014, identify, recruit and train 15 community members who each provide treatment support to 10 people with TB in District Y.	2.1: Recruit, train and supervise community DOT supporters.
3. Clinic hours are inconvenient for clients who need DOT, and no community-based DOT is provided (system).	By December 2014, ensure that all clients with TB in District Y have access to DOT services in the clinic or in the community.	3.1: Conduct focus group meeting with community members with TB to understand how clinic hours can be changed to better meet their needs. 3.2: Hold a meeting with the District Y medical officer and TB clinic staff to present findings of the focus group discussion, advocate for a change in clinic hours, and offer to provide community-based DOT in collaboration with the clinic.

Tool 2.7:
Logical linkages between challenges and activities



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Tool 2.7:
Logical linkages between challenges and activities

Organisation: _____

TB/HIV barriers, objectives and activities matrix for (dates): _____ **to** _____

TB control objective:		
Challenge:		
Key barriers (from Cough-to-Cure analysis)	**Objectives to address barriers**	**Activities to address barriers**

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Tool 2.8: Advocacy planning

What is advocacy?

Advocacy is defined by the Stop TB Partnership as a set of coordinated activities that are designed to:

- place TB higher on the political agenda
- strengthen government commitment to implement or improve TB control policies
- increase and sustain financial and other resources for stopping TB.

Advocacy **changes** policies, laws, funding, media coverage and/or practices. It **targets** decision-makers, community leaders, policymakers and other people in positions of influence. Advocacy activities may occur at the local, provincial, national or international level. Indicators of the success of advocacy include: new or improved policies, laws, programmes or practices that enable positive changes (for example, access to TB care and treatment for HIV-positive people); more funding, more human resources, more material resources; or better coverage in the media.

There are three specific types of advocacy in which you may engage:

- **Policy advocacy** informs politicians and administrators how TB and TB/HIV affect the country, and requests specific actions to improve laws and policies.
- **Programme advocacy** targets decision-makers/opinion leaders to make decisions and take action to implement specific improvements at a programme level (such as the NTP).
- **Media advocacy** prompts the media to cover TB-related topics regularly and in a responsible manner to raise awareness of problems and possible solutions.

Your advocacy objectives, activities, target audiences and methods will depend on what the problem is and who can make the changes needed to address it. The next pages will guide you through a process of analysing what the issue is, what change you want to see, and how you will go about making that change. You can then translate that information into a CSO objective and related activities.

Key resources

For detailed information and training on advocacy, see the resources below.

You can access a number of useful TB advocacy documents on the ACTION website at: http://www.action.org/resources/ending-tb/publications

PATH (2012). Advocacy to improve global health: a training course for advocacy strategy development. Available at: http://www.path.org/publications/detail.php?i=2165

PATH (2013). Policy advocacy for health. Available at: http://www.path.org/publications/files/ER_app_workshop_curric.pdf

USAID and Stop TB Partnership (2011). Overcoming barriers to TB control: the role of advocacy, communication, and social mobilization. Available at: http://www.path.org/publications/detail.php?i=2030

Tool 2.8:
Advocacy planning

Key resources

Advocacy Partnership (2011). TB/MDR-TB advocacy toolkit. Available at: http://www.stoptb.org/assets/documents/global/awards/cfcs/TB_MDR%20Advocacy%20Tool%20Kit.pdf

PATH (2007). Ten steps to developing a strategic advocacy agenda. Available at:http://www.path.org/publications/files/ER_advocacy_ten_steps.pdf

International HIV/AIDS Alliance (2002). Advocacy in action – A toolkit to support NGOs and CBOs. Available at: http://www.aidsalliance.org/publicationsdetails.aspx?id=142

OSI, TAG (2006), 'Civil society perspectives on TB/HIV: highlights from a joint initiative to promote community-led advocacy'. Available at: www.soros.org/initiatives/health/focus/phw/articles_publications/publications/highlights_20060811

You can access many additional advocacy, communication and social mobilisation resources through the ACSM community of practice. Available at: http://www.aidsportal.org/web/acsm/resources;jsessionid=D17DB2489EB1524E2DBE69158284EDD5.node1

Tool 2.8:
Advocacy planning

Advocacy planning matrix example

Advocacy activities may be able to address some of the challenges and barriers you have identified by using the Cough-to-Cure Pathway (Tool 2.6). You can use the step-by-step process below to develop the details of how you will implement advocacy activities to make the desired change you would like to see. An example is provided, and then you have a blank template you can use for each barrier you would like to address with advocacy activities. Make as many copies as you need to develop activities for each barrier. Remember, advocacy seeks to influence decision-makers who have the power to change a situation for a large number of people (a nation, a community). If you are working to influence individual behaviour or small groups of people, you are probably doing communication work instead. You can use the communication planning tool (2.9) to develop the details of those activities.

Question	Answer
What TB control challenge would we like to address with advocacy activities?	Despite a high burden of HIV in our country, only 50% of people diagnosed with TB are receiving HIV counselling and testing.
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with advocacy?	There is no national TB/HIV policy that supports universal access to HIV counselling and testing for people diagnosed with TB.
What specific change (outcome) do we want to see as a result of our advocacy activities?	Development, approval and dissemination of a national policy on TB/HIV that includes a specific requirement for universal access to HIV counselling and testing for all people diagnosed with TB.
What activities will we do to see?	1. Joint meeting with the NTP and NACP managers and CSO representatives to discuss the issue and offer support to them to approach the minister of health. 2. Group meeting with the NTP and NACP managers, CSO representatives and the minister of health to ask for his or her support in rapid policy development and dissemination. 3. Meeting with journalists to brief them on the issue and invite them to a community event with affected people's organisations. 4. Develop and publicly issue an annual "report card" on TB/HIV for the ministry of health to track its progress in resolving the concerns we have raised. Specifically include the percentage of people with TB receiving HIV counselling and testing as part of the report card.

Question	Answer
How will we measure the success of this advocacy work?	Interim measures of advocacy success (outputs): 1. Minister of health agrees to achieve universal HIV counselling and testing for people with TB. 2. Journalists produce five articles on TB/HIV that include information about the lack of HIV counselling and testing for all people with TB. 3. Community event held that is covered by the media and demands universal access to HIV counselling and testing for people with TB. 4. Report card issued with media coverage that reports on ministry of health progress and any continuing concerns. Final measure of advocacy success (outcome): 1. National policy on TB/HIV is developed and approved by the ministry of health and disseminated to all providers. It includes a requirement for universal access to HIV counselling and testing for all people diagnosed with TB. The ultimate impact we would like to see is that 100% of people diagnosed with TB receive HIV counselling and testing and know their results. This can be measured through the annual data generated by the NTP.

Now try this on the next page for a TB challenge and related barriers you have identified in your country or region.

Tool 2.8: Advocacy planning

Advocacy planning matrix

Organisation:_____ **Time period:**_____

Question	Answer
What TB control challenge would we like to address with advocacy activities?	
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with advocacy?	
What specific change (outcome) do we want to see as a result of our advocacy activities?	
What person or group has the ability to make the change we want to see?	
What messages do we need to deliver to this person or group to convince them to make the change?	
What activities will we do to deliver these messages?	
Who is best suited to deliver the messages?	
When will we deliver these messages?	
How will we measure the success of this advocacy work?	

Tool 2.9: Communication planning

What is communication?

In TB, communication is often defined as activities designed to:

- create and improve knowledge about TB/HIV (symptoms, curability) and TB services (diagnosis, treatment)
- change attitudes and behaviours of people with TB, family members and the community, health care providers, and the general public.

Communication is a two-way process of sharing information and experience. It **changes** knowledge, attitudes and behaviours related to TB and HIV. Communication may **target** people with TB, community members, the general public, health care providers, decision-makers, donors or the media. The ultimate goal of communication is to change behaviour by improving knowledge or understanding, changing attitudes and reducing stigma, or changing priorities.

There are many different forms of communication. In TB/HIV, we think of written communication such as flyers or posters, verbal communication such as one-on-one counselling or group trainings, and mass media communication such as radio or TV broadcasts. The methods you use will depend on the audiences you are trying to reach and the messages you want to give to them.

The following pages will provide you with an example of communication planning and a step-by-step process to work through to plan your own communication activities.

Key resources

For detailed information and training on communication, see the resources below.

USAID and Stop TB Partnership (2011). Overcoming barriers to TB control: the role of advocacy, communication, and social mobilization. Available at: http://www.path.org/publications/detail.php?i=2030

Health Communication Partnership (2004). The role of communication in achieving global TB control goals. Available at: http://www.stoptb.org/assets/documents/countries/acsm/Summary.pdf

You can access many additional advocacy, communication and social mobilisation resources through the ACSM community of practice. Available at: http://www.aidsportal.org/web/acsm/resources;jsessionid=D17DB2489EB1524E2DBE69158284EDD5.node1

Tool 2.9: Communication planning

Communication planning matrix example

Communication activities may be able to address some of the challenges and barriers you have identified by using the Cough-to-Cure Pathway (Tool 2.6). You can use the step-by-step process below to develop the details of how you will implement communication activities to make the desired change you would like to see. An example is provided, and then you have a blank template you can use for each barrier you would like to address with communication activities. Make as many copies as you need to develop activities for each barrier.

Question	Answer
What TB control challenge would we like to address with communication activities?	Treatment adherence among people with TB is low, and as a result the treatment success rate is only 72% in District Y.
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with communication?	Health care providers do not provide adequate information about anti-TB drugs and the length of treatment, and do not have the skills to establish a trusting relationship with their clients.
What specific change (outcome) do we want to see as a result of our communication activities?	Health care providers in District Y strengthen their skills in interpersonal communication and counselling, and use those skills to better support treatment completion for their clients with TB.
What audience are we trying to reach with our **communication** activities?	Doctors and nurses in District Y TB facilities.
What messages do we need to deliver to our audience?	1. Treatment success in District Y is below our national target. One of the barriers identified is that clients with TB do not have a good understanding of the need to continue through a full course of treatment. 2. Client education and ongoing counselling are an important part of TB treatment success, and doctors and nurses play a critical role in this process. 3. Using the skills they learn in a one-day training on client communication and counselling can improve the District's TB indicators, increase their client's satisfaction with services, and increase their own job satisfaction.
What activities will we do to deliver these messages and by what methods?	One-day trainings on interpersonal communication and counselling, TB education for clients, and techniques for ongoing treatment support.

Tool 2.9:
Communication planning

Question	Answer
How will we measure the success of this communication work?	Interim measures of communication success (output): 1. All doctors and nurses who serve people with TB receive training in interpersonal communication and counselling for treatment adherence. 2. Doctors and nurses have improved knowledge and skills on interpersonal communication and counselling, as measured by pre- and post-training tests. Final measure of communication success (outcome): 1. Doctors and nurses use their new skills to provide thorough TB treatment information to their clients and support them on an ongoing basis throughout the course of treatment. The ultimate impact we want to see from doing this activity is that treatment adherence improves and thus treatment success in District Y increases. What we want to see is that treatment success increases from 72% to a higher percentage, ideally to our national target. We can measure that by looking at changes in the annual District Y treatment outcome data over the next several years.

Now try planning your own communication activities using the blank matrix on the following page.

Tool 2.9: Communication planning

Communication planning matrix

Organisation:_____ **Time period:**_____

Question	Answer
What TB control challenge would we like to address with communication activities?	
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with communication?	
What specific change (outcome) do we want to see as a result of our communication activities?	
What audience are we trying to reach with our communication activities?	
What messages do we need to deliver to our audience?	
What activities will we do to deliver these messages and by what methods?	
How will we measure the success of this communication work?	

Tool 2.10:
Social mobilisation planning

What is social mobilisation?

Social mobilisation in TB is a long-term process of building alliances, engaging stakeholders and increasing community participation to:

- bring visibility and a sense of urgency to the issue of TB (including TB/HIV and MDR-TB)
- give a push or add momentum to communication and advocacy efforts
- help society, officials and the media realise that TB issues are important and urgent
- involve community members and other sectors in the fight against TB.

Social mobilisation **changes** level of interest, participation and commitment to ending TB. It **targets** all relevant sectors of society, such as communities, policymakers, influential individuals, businesses and religious institutions. Successful social mobilisation results in increased attention to TB as an issue, more people and groups involved in the fight against TB, and increased energy – all of which result in increased *action* to combat TB. In doing social mobilisation, you are really taking two different but interconnected steps. First, you are designing activities that will engage new groups in the fight against TB; second, you are working with these groups to take specific actions to stop TB. This is an important point. Once you mobilise a group of people, you must have something specific for them to do, otherwise they will quickly lose interest in participating.

Social mobilisation can be divided into the target groups you are trying to mobilise:

- Political mobilisation engages decision-makers and politicians to raise the profile of the TB issue in support of the advocacy and communication activities that you may be implementing.
- Government mobilisation engages government officials and departments.
- Corporate mobilisation engages the business sector in fighting TB.
- Beneficiary mobilisation engages affected people and their families.
- Community mobilisation engages community organisations such as churches, schools, leaders, women's groups and others.

As CSOs, you will often be doing community mobilisation and beneficiary mobilisation work. However, there will still be times when mobilising other sectors will be important to accomplishing your objectives.

Planning social mobilisation follows the same general process steps as the planning for advocacy or communication activities. An example is provided on the next page, followed by a blank template to plan your own social mobilisation activities.

Key resources

USAID and Stop TB Partnership (2011). Overcoming barriers to TB control: the role of advocacy, communication, and social mobilization. Available at: http://www.path.org/publications/detail.php?i=2030

The Global Fund (2011). Community systems strengthening framework August 2011. Available at: www.theglobalfund.org/WorkArea/DownloadAsset.aspx?id=5485

Tool 2.10:
Social mobilisation planning

Key resources

International HIV/AIDS Alliance (2006), 'All together now! Community mobilisation for HIV/AIDS'.
Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=228

International HIV/AIDS Alliance (2006), 'Tools together now! 100 participatory tools to mobilise communities for HIV/AIDS'. Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=229

Mercy Corps (2009). Guide to community mobilization programming. Available at: http://www.mercycorps.org/sites/default/files/CoMobProgrammingGd.pdf

You can access many additional advocacy, communication and social mobilisation resources through the ACSM community of practice. Available at: http://www.aidsportal.org/web/acsm/resources;jsessionid=D17DB2489EB1524E2DBE69158284EDD5.node1

Social mobilisation planning example

Social mobilisation activities may be able to address some of the challenges and barriers you have identified by using the Cough-to-Cure Pathway (Tool 2.6). You can use the step-by-step process below to develop the details of how you will implement social mobilisation activities to make the change you would like to see. An example is provided, and then you have a blank template you can use for each barrier you would like to address with social mobilisation activities. Make as many copies as you need to develop activities for each barrier.

Question	Answer
What TB control challenge would we like to address with social mobilisation activities?	Certain TB treatment units in rural areas of District Z have low treatment success rates (below 60%) and a high percentage of clients who are lost to follow-up ("default" in the data reporting).
What barriers have we identified through the Cough-to-Cure Pathway that can be addressed with social mobilisation?	Community-based DOT and treatment support are not available in the rural areas of District Z.
What specific change (outcome) do we want to see as a result of our social mobilisation activities?	1. One community group in the area of each poorly performing TB treatment unit is participating in the fight against TB and is linked with the TB treatment unit. 2. Each community group provides treatment support services to community members with TB throughout their course of treatment.

Tool 2.10:
Social mobilisation planning

Question	Answer
What groups or individuals are we trying to mobilise with our activities?	One community group from each area.
Who can help mobilise them?	1. The village leaders in those areas. 2. The TB treatment unit managers.
What activities will we do to mobilise these groups?	1. Conduct a rapid situation analysis to create a list of existing community groups in those areas. 2. Meet with the village leaders and TB treatment unit directors to get their support for the use of community-based DOT and treatment support. 3. Have a meeting in each area with the village leader, community groups and the TB treatment unit manager to explain the problem and invite their participation in community-based TB care.
Once they are mobilised, what do we want them to do?	1. Attend a one-day training on providing DOT and treatment support for people with TB. 2. Provide DOT and treatment support to members of their community who are being treated for TB, equivalent to 10 people with TB per year for each community group member.
How will we measure the success of this social mobilisation work?	Interim measures of success (output): 1. At least one community group agrees to participate in each area. 2. All groups participate in the one-day training. Final measure of success (outcome): 1. All trained community groups are providing DOT and treatment support services at the target level to people with TB in their communities. The ultimate impact we want to have is a decrease in the percentage of people lost to follow-up (default) and an increase in the treatment success rate for each treatment unit. We are aiming to reach the national target. We can measure our progress by looking at the treatment outcome data for these treatment units over the next several years and comparing it with the current data.

Now use the blank matrix on the following page to try developing your own social mobilisation activities.

Tool 2.10:
Social mobilisation planning

Social mobilisation planning matrix

Organisation:_____ Time period:_____

Question	Answer
What TB control challenge would we like to address with social mobilisation activities?	
What barriers have we identified through the Cough-to-Cure Pathway that can be addressed with social mobilisation?	
What specific change (outcome) do we want to see as a result of our social mobilisation activities?	
What groups or individuals are we trying to mobilise with our activities?	
Who can help mobilise them?	
What activities will we do to mobilise these groups?	
Once they are mobilised, what do we want them to do?	
How will we measure the success of this social mobilisation work?	

Tool 2.11:
Service delivery planning

Planning service delivery is an activity that should be done in close collaboration with the local units of the NTP and NACP to ensure that activities are in line with national guidance and meet other regulatory requirements. It is not possible to cover all aspects of service delivery planning in this tool, so we will focus mainly on possible community-based services you can incorporate into your current work. There are some additional resources below that you can consult for more information on service delivery topics.

Key resources

Elisabeth Glaser Pediatric AIDS Foundation. 'Clinical standard operating procedure (SOP) templates: implementation of tuberculosis activities at HIV/AIDS service delivery sites'. Available at: www.pedaids.org/Publications/Toolkits#Clinical_Standard_Operating_Procedure__SOP__Templates

Granich, R., Akolo, C., Gunneberg, C., Getahun, H., Williams, P., Williams, B. (2010) 'Prevention of tuberculosis in people living with HIV', *Clinical Infectious Diseases* HIV. Clin Infect Dis. 2010 May 15;50 Suppl 3:S215-22. doi: 10.1086/651494. Available at: www.ncbi.nlm.nih.gov/pubmed/20397951

Tool 2.11:
Service delivery planning

Below is a template that lists HIV-related activities you may be engaged in providing already, along with suggested TB activities that can be added on with minimal inputs of additional staff or resources. This will help you think about where to start integrating TB into your HIV work. Tick the HIV activities in the list that you are already implementing, and then tick suggested TB activities that your organisation might be able to incorporate easily.

HIV activities	Suggested complementary TB activities
☐ **Advocacy, outreach and education** ☐ HIV policy advocacy ☐ HIV resource mobilisation advocacy ☐ HIV prevention education ☐ HIV education for the general public ☐ Stigma reduction ☐ World AIDS Day events ☐ Production and distribution of educational materials ☐ Other _____	☐ **Advocacy, outreach and education** ☐ TB policy advocacy ☐ TB resource mobilisation advocacy ☐ TB prevention education ☐ TB education for the general public ☐ Stigma reduction ☐ World TB Day events ☐ Production and distribution of educational materials ☐ Other _____
☐ **Prevention and diagnosis** ☐ Condom distribution ☐ Prevention of mother-to-child transmission (PMTCT) ☐ Male circumcision ☐ Referral for HIV counselling and testing ☐ HIV counselling and testing ☐ Other _____	☐ One-to-one TB/HIV education ☐ Community-based screening for TB symptoms using a questionnaire ☐ Referral of people with TB symptoms for evaluation at a health facility ☐ Screening of people living with HIV for TB symptoms ☐ Referral of people living with HIV for TB evaluation ☐ Screening of women and children for TB at PMTCT locations ☐ Referral of women and children with TB symptoms for evaluation
☐ **Clinic-based treatment** ☐ ART ☐ CPT ☐ IPT ☐ Laboratory services ☐ Other _____	☐ One-on-one client education on TB/HIV ☐ TB symptom screening ☐ Sputum collection and transport ☐ Sputum smear microscopy ☐ DOT ☐ Peer treatment support groups
☐ **Community-based treatment** ☐ ART ☐ CPT ☐ IPT ☐ Other _____	☐ Family and community education on TB/HIV ☐ Distribution of educational materials ☐ TB symptom screening and referral for evaluation ☐ Community-based sputum collection and transport ☐ DOT ☐ Contact tracing

☐ **Treatment support** ☐ Home visits ☐ Nutritional support ☐ Transportation ☐ Financial support/microloans ☐ Peer support groups ☐ Other_____	☐ Family and community education on TB/HIV ☐ Distribution of educational materials ☐ TB symptom screening and referral for evaluation ☐ Community-based sputum collection and transport ☐ Contact tracing ☐ Instruction on community infection control ☐ Tracing of clients lost to follow-up ☐ Peer support groups ☐ DOT ☐ Nutritional support ☐ Transportation ☐ Financial support/microloans
☐ **Training** ☐ Training for health care providers from the national health system ☐ Training for private health care providers ☐ Training for community volunteers ☐ Other _____	☐ **Training** ☐ Training for health care providers from the national health system ☐ Training for private health care providers ☐ Training for community volunteers ☐ Other _____