THE UGANDA TUBERCULOSIS COMMUNICATION STRATEGY

MINISTRY OF HEALTH

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National Tuberculosis & Leprosy control programme
& Health promotion and Education Division,
Ministry of Health, Uganda

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Foreword:

TB is a preventable, treatable infectious disease that is on increase in Uganda . The TB epidemic in the country has worsened over the last twenty years presenting a great challenge to health services. This is in-spite of the reactivation of the TB control services by the Ministry of Health in the early 1990s following the deterioration in the services during the 1970s and 1980s.

As a result of the National TB & Leprosy reactivation there was a gradual increase in case detection rate from very low levels to 53% in 2004. However performance has now stagnated and case detection rate was at 50.2% in 2005. Communication for TB control has been identified as a vital tool in addressing the performance problem yet there has been a gap in the area of a clearly defined communication strategy.

The weakness in communication for TB control affects the health workers and community members' knowledge about TB and the communities' utilization of the services available. In order to address the weakness in communication, the MoH with the support of partners has developed this communication strategy document. The development of the strategy was participatory involving stakeholders from the community to the national levels through stakeholder workshops and meetings. It provides a framework and guidance on implementation of Advocacy, Communication and Social Mobilization activities that are envisaged to contribute to the improvement of TB control services at different levels. It is thus intended to guide all stakeholders involved in communication activities for TB and I strongly recommend that all partners and implementers utilize it.

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List of Acronyms

ACSM-WG	Advocacy Communication and Social Mobilization Working Group
ARI	Annual Risk of Infection
BCC	Behaviour Change Communication
CB-DOTS	Community Based- Direct Observed Treatment of TB on Short Course
CDFU	Communication and Development Foundation of Uganda
DOTS	Direct Observed Treatment of TB on Short Course Strategy
DHT	District Health Team
GLRA	Germany Leprosy Relief Association
HIV	Human Immuno Deficiency Virus
HSSP II	Health Sector Strategic Plan 2005/06 – 2010/11
HSD	Health Sub-District
ICM	International Medical Corps
IEC	Information, Education and Communication
IDP	Internally Displaced People
IUATLD	International Union Against Tuberculosis and Lung Diseases
KAP	Knowledge Attitude and Practices
MOH	Ministry of Health
NTLP	National Tuberculosis and Leprosy Program
NGOs	Non Governmental Organizations
PDC	Parish Development Committee
PLWHAs/PHAs	People Living With HIV/AIDS
TASO	The AIDS Support Organization
TB-SS	Tuberculosis Sputum Smear
THETA	Traditional Healers T..... Association
USAID	United States Agencies for International Development
USTP	Uganda Stop Tuberculosis Partnership
WHO	World Health Organization

Executive Summary

Ministry of Health emphasizes the need to promote health services with the aim of increasing access and utilization of the services. Prevention and control of Tuberculosis is one of the priority services of the health sector that has had inadequate promotion as a result of lack of communication strategic guidelines. This has made it difficult to achieve the national TB control programme objectives/targets of detecting 70% of new TB infectious cases and successfully treat 85% of them using DOTS strategy and worse still in an environment in which HIV/AIDS has complicated the management of TB.

However, with limited programme campaigns Uganda has been able to detect 50.2% of TB infected people and achieved treatment success of 70.5%. Arising from this situation, there was a need to develop a comprehensive communication strategy to reach the set national targets.

This would be possible through putting in place a public education tool that could address reduction in missed opportunities in detecting infectious cases at health facilities, change negative attitudes towards TB treatment and public misconceptions about its spread.

This TB communication strategy has therefore been developed purposely to assist the programme to address these concerns so as to create more awareness about TB, change attitudes towards case detection, adherence to treatment and to subsequently increase public demand for TB existing services.

NTLP in collaboration with USAID commissioned CDFU as consultants to develop the strategy. The task involved conducting literature review and a survey to establish a database of existing knowledge, attitudes and practices in regard to Tuberculosis control. There was a wider consultation to solicit views of policy makers and implementers of TB activities in the MOH, Health communication specialists, District based Health workers, representatives from NGOs and expert TB patients.

The findings from health facilities revealed the a need to develop IEC/BCC to address communication gaps linked to case detection and the treatment of cases using DOTS strategy.

The strategy describes priority behavioral issues, goals, communication objectives, audience, benefits, key messages/concepts, channels and desired responses. Specific monitoring and evaluation indicators are proposed to monitor outputs, outcomes and impacts.

In conclusion, the communication strategic guidelines would enable the programme to address priority behavioral issues, which could lead to improved access and utilization of TB existing services by the general population. It is therefore envisaged that the operationalization of this strategy will contribute to the achievement of the goals of HSSP II through reduction of National disease burden.

1.0 INTRODUCTION AND BACKGROUND INFORMATION:

1.1 Introduction

M. tuberculosis infects a third of the world's population. Globally, an estimated 9,2 million new cases and 1.7 million deaths from TB occurred in 2006 in which 0.7 million cases and 0.2 million deaths were HIV-positive. 95% of TB cases and 98% of TB deaths are in developing countries. In 2006 Sub- Saharan Africa had the highest TB incidence rate (363/ 100,000 per year) although the incidence is also beginning to plateau (WHO, 2008).

TB is also one of the most common causes of morbidity and one of the leading causes of mortality in people living with HIV/AIDS (PLWHAs). By the end of 2000 about 11.5 million HIV infected people worldwide were co-infected with M. tuberculosis. 70% of those co-infected people were in Sub- Saharan Africa, 20% in South- East Asia and 4% in Latin America and the Caribbean, (WHO, 2004). *Consider whether to maintain this paragraph or delete it altogether. If to maintain then update it with more recent information*

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Uganda is 15th among the high-burdened countries with TB. The country has an estimated annual risk of infection (ARI) of 3% equivalent to 150-165 new smear positive TB cases per 100,000 populations per year or 300-330 total TB cases per 100,000 per year. Uganda is yet to attain the case detection and treatment success targets of 70% and 85% respectively. In 2006, the country detected 49.6% of the expected new smear positive cases, and successfully treated 73.2% of the 2005 cohort.

A comprehensive advocacy and social mobilization effort to increase knowledge on TB is needed if the national and global targets for TB control are to be attained.

1.2 Background

Uganda is one of the world's 15th high burdened countries with TB that bear 80% of the world burden of TB. It is estimated that Uganda has 70- 80,000 new cases of TB annually, and the disease affects the most economically productive age. In Uganda, TB is among the diseases responsible for the largest proportion of morbidity and mortality and it is also estimated that 50% of TB patients are Human Immunodeficiency Virus (HIV) positive.

Though curable, many people still suffer and die from the disease. *Note this paragraph seems to be a repetition of paragraph 3 above. Consider marrying the two.*

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Directly observed therapy short course (DOTS) is the international WHO/IUATLD recommended strategy for TB control to ensure high cure rates, prevent emergence of multi drug resistance strains of TB and reduce spread of the disease.. Uganda adopted the DOTS strategy in 1996 and the Ministry of Health (MOH), successfully piloted and adopted the decentralized model of TB control called Community Based DOTS (CBDOTS) as a national policy in 1999. . Under CB-DOTS, patients diagnosed with TB at health facilities are offered health facility or community based DOT options. Sub county health worker based at Health Centre III mobilizes the community through the local councils and Parish Development Councils (PDCs) to identify and select volunteers. The sub county health worker trains and supervises the volunteers.

The goal for the National TB and Leprosy Programme (NTLP) is to detect 70% of the new smear Pulmonary Tuberculosis sputum smear positive (TB SS+) cases to successfully treat 85 % of the new TB SS+ cases utilizing the DOTS strategy. Uganda has reached 49.6% case detection and 73.2% treatment success rates; therefore there is need for efforts to reach the targets. Low case finding has been attributed to factors such as:

- Health facilities not utilizing every opportunity to detect TB especially among Out Patient Department (OPD) attendees.
- Negative attitudes towards the TB disease.
- Misconceptions about the spread of the disease.
- Poor knowledge and skills
- Poor access to TB diagnostic services.

The priority of an effective TB control programme is to achieve high cure rates among sputum smear positive cases and to increase the proportion of health workers who refer all patients who have coughed for more than three weeks for TB test (sputum smear examination).

A comprehensive and effective IEC / BCC is a vital requirement in order to make positive contributions towards:

- Creating awareness about the disease and the importance of treatment.
- Changing attitudes towards detection and treatment.
- Creating awareness about the quality of TB services.
- Increasing demand for the services.

- Advocating for TB control.
- Improving communication between caregiver and patient.

Whereas previously TB was not given the attention it deserved, it is time to exploit synergies in supporting TB service providers to deliver adequately. Since TB is not just a health problem but requires joint efforts of all stakeholders up to community level for the realization of effective responses by the targeted beneficiaries. TB should be integrated in other health services. Therefore to guide this process, development of a TB Communication Strategy and tool is critical in addressing key behavioral issues in the implementation of TB activities.

2.0 KEY BEHAVIOURAL ISSUES

Key behavioral issues were identified through consultations with stakeholders and a survey to establish the existing knowledge, attitudes and practices in regards to TB treatment and control. The key issues identified were:

2.1 The poor organization of the Health service delivery system

The institutional capacity of health facilities, poor staffing and training of health workers and the poor referral system of most health facilities have greatly contributed to a number of factors like;

- increased patient over load to Health workers
- poor attitudes of health workers towards TB patients
- lack of user friendly treatment guidelines
- poor record keeping in health facilities

2.2 Low comprehensive knowledge about TB

There is still low comprehensive knowledge about T.B in the general population.

Knowledge is lacking in the following areas, which have greatly led to low motivation of health workers;

- The causes and nature of TB disease.
- The possibility of cure
- TB service delivery points

2.3 Low utilization of TB/HIV collaborative services

The relationship between TB and HIV is increasing the burden of both diseases. HIV presents a massive challenge to patients, with 50% of TB patients estimated to also be co-infected with HIV.

Efforts have been made in collaboration of the two diseases through the existing policy guidelines and communication strategy on TB/HIV.

However the collaborative activities have been undermined by the following factors:

- Double stigma among co-infected persons.

- Lack of information on the collaborative activities
- Slow integration of TB/HIV services
- Poor accessibility of the collaborative services

2.4. Inadequate adherence to TB treatment

Adherence to TB treatment means taking of the dugs correctly and consistently as instructed by a qualified Health worker.

There are a number of factors that are contributing to low adherence among TB patients like:

Patient factors

- Inadequate knowledge on the benefit of completing treatment
- Fear of side effects
- Misconceptions about the disease
- Long treatment duration
- Inadequate nutrition
- Large quantities of doses

Service providers

- poor knowledge and skills about TB treatment
- poor communication between care givers and the patient
- negative attitude of Health workers

2.5 Inadequate nutritional requirements for TB patients

Good nutrition is an important requirement for TB treatment.

However, there are factors contributing to inadequate nutrition among TB patients like;

- inadequate food supplies
- Lack of knowledge on the benefits of appropriate nutrition during treatment.

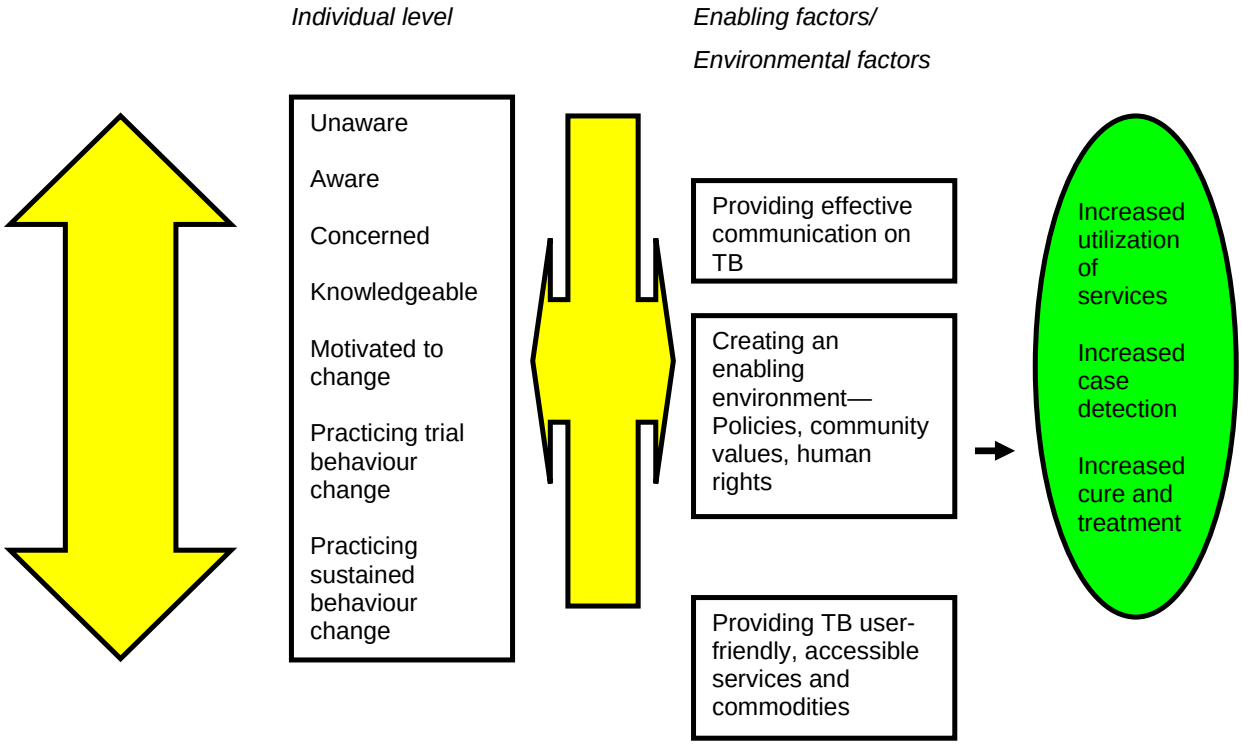
3.0 COMMUNICATION OBJECTIVES (KAP)

- Increase comprehensive knowledge about TB in the general population
- Increase the proportion of health workers with knowledge on appropriate management of TB referrals
- Increase the proportion of health workers oriented in interpersonal communication and TB management
- Increase treatment success rates
- Increase the proportion of the population who seek early TB detection and treatment
- Increase the proportion of VHTs/volunteers who support TB referrals

4.0 GUIDING FRAMEWORK – THEORIES: SOCIAL AND PSYCHOLOGICAL

Figure 1: A Frame work for BCC Design

Stages of behavior change Outcomes Continuum;



5.0 TARGET AUDIENCES FOR IEC/BCC INTERVENTIONS

The audiences have been presented according to objectives of this communication strategy. They are characterized as primary and secondary. Primary audiences by definition are those individuals whose current behaviour puts them at risk of the problem e.g. acquiring TB, not using available services while secondary audiences are those that have influence over the primary audiences and could lead

them to act in the direction in which the programme would wish the primary audience to act. For advocacy, the categorization differs. We have beneficiaries, partners, adversaries and decision makers. Beneficiaries are those individuals or communities that would directly benefit from a result of an advocacy intervention e.g. a policy framework that makes all TB services free. All Tb clients would be beneficiaries of that policy. Partners are those individuals and organizations that share the cause for an advocacy intervention e.g. WHO, MoH, NTLP, USTP, GLRA and IUATLD could be partners in the cause for TB services. Adversaries are those that stand against an issue while decision makers are those individuals that ultimately endorse a policy decision.

Objective 1: To increase the proportion of health workers with knowledge on appropriate management of TB referrals

Primary target audiences

- Health workers (Medical doctors/officers)
- Nurses
- Laboratory technicians
- Midwives
- Coordinators

Secondary target audiences are:

- DHTs
- Community Health Volunteers

Messages:
Adequate knowledge on TB prevention and treatment improves its management at facility and community levels.

Objective 2: To increase the proportion of health workers oriented in interpersonal communication and TB management

Primary target audiences

- Health workers (Medical doctors/Clinical officers)
- Nurses

- Laboratory technicians
- Midwives
- Coordinators
- Microscopists
- Nursing Assistants

Secondary target audiences are:

- Community Health Volunteers
- District Health Teams.

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Messages:

- *Effective communication improves relation between health worker and TB patients*
- *It may improve patient compliance to treatment*

Objective 3: To increase comprehensive knowledge about TB in the general population.

Primary target audiences

- OPD attendees
- CBDOTS community volunteers
- general population

Secondary target audiences are:

- Health workers (Medical doctors/Clinical officers, Nurses, Laboratory technicians, Midwives)
- Community Health Volunteers
- Family members of TB patients

Messages :

- *Population which is knowledgeable about TB can protect itself from TB infections*
- *Community leaders, who are knowledge about TB can be good advocates in management of T.*
- *Leaders have a social responsibility of improving quality of life of their people through keeping them informed of ways of protecting themselves from illnesses such as TB*

Objective 4: To increase the proportion of the population who seek early TB detection and treatment.

Primary target audience are:

- Family members
- VHTs

Secondary target audiences are:

- Health workers
- Community Health Volunteers
- Family members of TB patients (e.g. spouse, children)

Messages:

- *Early detection and treatment of Tuberculosis in patient promotes cure in individuals.*
- *Promotion of early management of TB can reduce the spread of TB at household and community level*

Objective 5: To increase the proportion of family members with TB patients and community elders who understand the importance of following TB treatment to minimize default.

Primary target audiences are:

- Heads of Households
- Elders/ cultural leaders
- LC I Chairpersons.

Secondary target audiences are:

- Village Health Teams
- Opinion leaders such as elders
- Religious Leaders
- Local Council leaders at lower levels (LC I, LC II)

Messages:

- *Promote DOTS approach for improved adherence to TB treatment.*
- *Increased participation of elders and heads of households in TB management influences their people to access treatment for effective cure.*

Objective 6: To increase the proportion of VHTs who support TB referrals.

Primary target audience are:

- Village Health teams
- Health workers

Secondary target audiences are:

- Cultural leaders
- Local Council leaders at lower levels (LC I, LC II)
- Local Administration

Messages:

- *Support TB referrals for better management and care of people. suffering from TB at nearest health facility.*
- *Leaders are proud of leading a healthy and productive population.*
- *Population is happy to access quality TB services.*
- *Maintaining proper referrals improves treatment compliance.*

6.0 STRATEGY DEVELOPMENT PROCESS

The strategy development involved stepwise approach in which stakeholders were key players in formulation of critical concepts as basis for building up the frame-work. Literature review was made on a number of behavioral and other studies done by NTLP and its partners. In a series of workshops the technical teams validated the key behavioral issues pulled out and provided justification for the intended target audience, communication objectives, and channels of communication and monitoring and evaluation indicators. The process was finalized through a consensus meeting for the purpose of ownership and utilization.

7.0 SERVICE DELIVERY STRATEGY

7.1 TB BCC/IEC and Advocacy strategic approaches and activities

The strategic approaches are ways in which the intended target audience for various TB services can be reached with appropriate messages and materials for behaviour change. It is envisaged that these approaches will be utilized at different levels of implementation, which include National, district, facility and community levels. At national and district levels advocacy for the resource support and utilization of services would be critical for improved delivery of TB services. Whereas at community and household level mobilizing the people for partnership in implementing TB activities will be very important to increase community participation in TB control initiatives.

The following activities shall enhance advocacy and social mobilization efforts:

National level:

The Program Manager of NTLP will present concepts of collaboration to relevant Sect oral Managers and Senior Management. Other opportunities that can be used are National Health Assembly, National TB day and Uganda Stop TB partnership meetings.

District level:

MOH Area teams will meet with district leaders and district health teams to support TB officers to advocate for increased resource allocation for TB activities with in their annual budgets and strategic plans.

The DHT will present concepts on TB to HSD and Sub County planning and management fora.

Facility level:

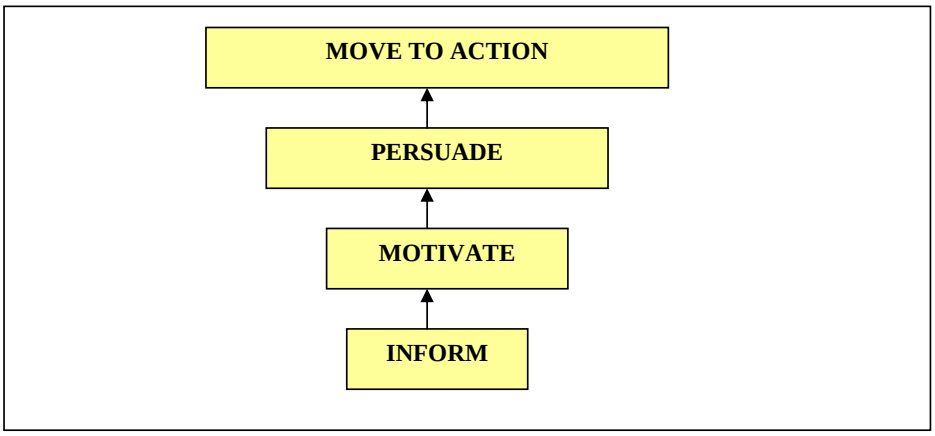
The health workers and health committee are an important entry point for the TB patients and their care-givers. The application of suitable messages/ materials to support them build capacity for TB community response is critical in improved utilization of TB services.

Community level:

There are various leaders at this level, political, cultural and religious leaders, who greatly influence decision making in the communities they lead. These leaders are therefore important in influencing and enforcing behaviour change through social mobilization for increased partnership and implementation of TB services.

Various approaches will be used as guidelines in the implementation of the different BCC/IEC and Advocacy activities at all levels. These approaches proposed will be based on previously successful IEC/BCC theories, selected because of their effectiveness in enforcing desired behaviour change in different cultural and social settings. These theories are also linked to the strategic communication model for service delivery system as shown below:

Strategic Communication Model for Service Delivery:



In order to ensure that the messages developed and disseminated reach a wider target audience, with various characteristics the following BCC/IEC strategic approaches should be applied:

Interpersonal communication

This approach delivers messages using face to face interaction there by providing an opportunity for immediate feed back from the persons involved in the communication process. This immediate feed back facilitates motivation to change behaviour.

The interpersonal approaches will include continuous medical education through counseling using flip charts, peer education and workshops for health workers to update them about current TB interventions.

Various activities shall be used to improve interpersonal communication for TB interventions, like:

- MOH Area teams, Uganda Medical Association teams, Uganda Private Medical Practitioners shall utilize the opportunity when they visit districts to up date health workers on TB interventions.
- Skills building workshops for Health workers should be used to provide information on Tuberculosis. For example the Health Manpower Development Centre should include TB management in the distance learning program.

- Using existing training workshops for care givers to educate them about community based DOTS.
- Health talks at health facilities should be used to provide information on TB management and prevention issues.
- School talk shows can also provide an opportunity to address issues on TB disease.
- The MOH officials should work with managers and leaders of congregate settings like prisons, military barracks, police, IDP camps, schools, markets, national Council of sports to integrate TB activities in to their plans and programs.
- Health managers should work with health workers who have previously had TB to give their testimonies to fellow health workers so as to improve their attitudes towards TB.

Enter education (Folk media)

This approach utilizes entertaining activities to deliver health messages. This approach is used because people learn best through approaches, which are both entertaining and educative. The channels under this approach include, theater drama, video shows, puppetry shows, music shows all containing TB messages.

The proposed activities include:

- Organize drama and video shows to educate communities about TB. These shows are very adequate in congregate settings like IDP camps, schools, markets, bus parks, taxi parks and fishing villages.
- Districts should work with existing drama groups and clubs to facilitate them to include shows on TB prevention and management.

Mass Media

The mass media approach uses different channels that may be print or electronic in nature. It delivers messages to many people instantly because it maximizes the coverage of the targeted population.
This approach uses different materials to deliver messages to the masses, like news letters for health workers, brochures, flip charts, posters, radio spots/jingles, talk shows, fact sheets, etc.

The activities to be implemented under this approach will include both print and electronic media like:

- Develop an information pack that includes fact sheets and brochures on TB, translated in to various local languages. These will be distributed at various functions and meetings.
- Health workers and care givers should be provided with BCC materials on TB prevention and management.

- Pull outs on TB will be distributed within news papers.
- Orientation of journalists through pres briefings, on TB activities and interventions.
- Key MOH and NGOs officials will be hosted in existing talk shows to discuss TB prevention and care interventions.
- Radio spots/jingles which will consider cultural differences regionally.
- Market radio shows be used to provide information to informal congregate settings like markets.

Collateral media

This approach delivers messages using attached commercial on items or commodities of value. The targeted audiences are motivated to read the messages because of the attraction to the commodity utilized. Key precise messages will be packaged and delivered to targeted audiences, through items like, pens, T-shirts, bill boards and cups.

The following activities will be used to produce these collateral media items like:

- The public sector shall work with the private sector to educate the public through tagging TB messages on their products.
- Using existing talk shows to host key MOH officials and NGOs.
- Radio jingles, which will consider cultural differences regionally.
- Materials used on national campaign days like banners, drinks, caps, T-shirts could have messages on TB.
- The transport industry shall be used to provide information on TB by tagging messages on their buses, taxis, boats etc.

Social Mobilization

It is an important approach that builds alliances and partnerships in support of TB interventions. It aims at increasing participation and ownership of the TB programme. This will be done through: workshops, joint events, study tours, periodic meetings and campaigns.

Advocacy

This strategy involves soliciting support for TB from stakeholders at different levels and mobilization of resources for implementation of the program. Advocacy is the process of soliciting support from policy makers/decision makers. This will be done through: workshops, joint events, seminars, match, periodic meetings and campaigns.

Training

This strategy involves equipping the target audience with knowledge and skills about TB. It is important to note that TB had been ignored until it started increasing; this rendering it as a new concept for most health service providers and this is not any different for health educators and communicators therefore necessitating training and provision of correct and consistent information.

Skills Development

This strategy precedes training and enables the target audience to develop the skills of the communities. It can be done through training and mentoring. The strategy therefore aims at building capacity in order to facilitate sustainability.

8.0 STRATEGIC GUIDELINES

The Following guidelines are meant to help communication agencies in ensuring that all activities and materials adhere to the TB communication strategy outlined in this document. The areas covered include communication and outreaches.

8.1 Programme Communication

This includes mass media, drama and print materials.

- The emotional tone of the visuals will be caring, compassionate and oriented towards the well-being of others in the family or community as well as the individual.
- All key messages in the mass media will include an action that is the desired outcome and a benefit that will include the family/community and the individual.
- Whenever possible, information will be provided that enables an individual to act on a decision he or she may take. For instance, user-friendly maps and directions or instructions on how to reach TB centers or clinics will be made easily accessible at the level of the general population and be distributed during the interactive sessions of peer groups and participatory theatre.
- Spokespersons and endorsers will be chosen who represent a caring response to the epidemic such as health workers, partners, TB patients, caregivers in the family, etc.

8.2 Community-based interactive approaches

This includes peer facilitation, training, discussion groups, print materials and participatory community theatre.

- Peer education will be replaced by peer facilitation to signify a participatory process in which individuals will chart own route towards attitude and behaviour change.
- Direct training of peer facilitators will be preferred to a cascade approach based on Training of Trainers and its attendant dilution of skills and information from level to level. The objective will be highly informed and trained cadre of peer facilitators at the community level.
- Discussion and facilitation process will target smaller and selected groups of community members rather than try to reach as many people as possible.
- Radio will be used to magnify the discussions and decisions taking place at the community level in discussion groups.
- Individuals in communities will be encouraged to speak up and become spokespersons and role models for behaviour and attitude change. Those that are willing to speak up will be highlighted before their communities through radio as well as other traditional media like theatre presentations.

8.3 Implementation Mechanism

ROLES OF STAKEHOLDERS

NATIONAL LEVEL	
Partners and Stakeholders	**Roles**
Parliament (Social Services Committee)	• Advocate for endorsement of policies on TB • Advocate for increased resources for TB
Ministry of Health (Top Management and Technical Departments)	• Advocacy for incorporation of TB activities into strategic plans • Allocate financial and other resources for TB control • To provide policies, standards and guideline on TB • To provide technical support in the area of TB • Conduct routine support supervision, monitoring and evaluation • Develop messages and materials on TB • Conduct operational research
Development partners	• Participate in development of policies, standards and guidelines • Provide financial and other resources • Provide technical guidance
Line Ministries	• Integrate TB activities into their programs

	• Implement TB initiatives
NGOs/FBOs/Private Sector	• Integrate TB activities into their programs • Use communication strategy to develop and disseminate messages on TB
Media	• Provide coverage prominence to TB issues
DISTRICT LEVEL	
Departments, Organizations and Institutions	**Roles**
Local Council Members	• Advocate for increased funding for TB activities • Counter negative information on TB by disseminating the correct information • Mobilize communities to demand and utilize TB services
District Health Management Team	• Design an operational plan and budget for implementing the strategy • Participate in planning activities and implementing TB activities • Operationalizing the TB communication strategy • Coordinate activities on Tb • Provide technical support to lower levels • Produce and disseminate integrated IEC materials on TB
	•
NGOs	• Integrate TB activities in their programs • Develop operational plans using the TB strategy
HEALTH FACILITY LEVEL	
Organizations/Institutions	**Roles**
SCHCs/HUMCs	•
CBOs	• Integrate TB activities in their programs • Develop operational plans using the TB strategy
Religious leaders	• Integrate TB activities in their programs • Disseminate messages on TB • Mobilize communities for TB services' utilization
Women and Youth Councils	• Integrate TB activities in their programs • Disseminate messages on TB
CORPs/VHTs	• Disseminate messages on TB through interpersonal communication • Mobilize communities for TB services'

	utilization • Conduct home visits to TB clients • Hold counseling sessions

9.0 MONITORING AND EVALUATION MECHANISMS AT ALL LEVELS

Monitoring is an important management tool and, as such, TB programmes at all levels will be routinely monitored. It will help stakeholders to assess the impact of TB key indicators and coordination across the programme. At the operational level, evaluation will be separated from monitoring during the planning and budgeting for regular work plans. BCC evaluation activities will focus on tracking impact, reach, scaling up integration of BCC with other TB programme components. The numerical information about the impact and coverage of BCC interventions for key target audiences will be provided by quantitative methodologies while the qualitative methods will be employed to examine the behaviour change, process and effectiveness of the stakeholders' interventions in causing desirable changes.

9.1 Monitoring and Evaluation Indicators for IEC/BCC Interventions

Key indicators derived from the communication objectives and activities will be used to monitor the progress made by stakeholders in implementing different interventions and the attainment of set targets/objectives at different levels. The indicators used to monitor progress towards attaining the set objectives are as reflected below:

NATIONAL LEVEL:

- Proportion of National stakeholders with TB Advocacy plans.
- Operational National IEC and BCC Strategy for TB control in Uganda.
- An Advocacy, Communication and Social Mobilization Committee empowered and fully operational.
- Proportion and type of IEC materials for TB messages developed and distributed to districts.

- Proportion of National stakeholders who advocate for comprehensive TB care services including CB DOTS

DISTRICT LEVEL:

- Proportion of districts with a comprehensive TB advocacy plan
- Proportion of districts disseminating comprehensive TB IEC/BCC material
- Proportion of districts with TB committees

HEALTH FACILITY LEVEL:

- Proportion of health facilities distributing IEC/BCC materials on comprehensive TB care including CB DOTS to clients and community members
- Proportion of Health workers trained and disseminating TB messages and distributing IEC/BCC materials in their outreaches.
- Proportion of health Sub-Districts with comprehensive TB Advocacy Plans

COMMUNITY LEVEL:

- Proportion of community leaders participating in health promotion activities on comprehensive TB care including CB DOTS
- Proportion of community volunteers, village health team members and Parish Development Committee members distributing IEC/BCC materials on comprehensive TB care including CB DOTS.
- Proportion of clients demanding and accessing TB care and prevention services
- Proportion of communities participating in comprehensive TB care including CB DOTS.

Matrix

PROGRAM AREA: IEC/BCC FOR TUBERCLOSIS PREVENTION AND CONTROL

ISSUE 1	**THE POOR ORGANIZATION OF THE HEALTH SERVICE DELIVERY SYSTEM**					
TARGET AUDIENCE	**DESIRED ACTION**	**COMMUNICATION OBJECTIVES**	**ACTIVITIES**	**MESSAGE CONCEPTS**	**CHANNELS**	**INDICATOR**
Issue 2	**Low comprehensive knowledge about TB**					
National & District						
Programme management						
Community						
House hold						
Issue 3	**Low utilization of TB/HIV collaborative services**					
National & District level						
Programme management						

Community						
House hold						
Issue 4	**Inadequate adherence to TB treatment**					
National & District						
Programme management						
Health facility						
community						
House hold						
Issue 5	**Inadequate nutritional requirements for TB patients**					
National & District						
Programme management						
Health facility						
community						
House Hold						
