Forging Partnerships to Eliminate Tuberculosis

1995

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for Prevention Services
Division of Tuberculosis Elimination
Atlanta, Georgia

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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A Call to Action

After a decades-long decrease in the number of tuberculosis (TB) cases in the United States from 1953 through 1984, TB reemerged as a serious national problem. From 1985 through 1994, the number of new TB cases increased by 10% (from approximately 22,000 to 24,000). This increase in reported TB cases can be attributed to at least four factors:

- the association of TB with the HIV epidemic
- immigration from countries where TB is common
- the transmission of TB in congregate settings (e.g., health care facilities, correctional facilities, homeless shelters)
- the dismantling and subsequent deterioration of TB prevention and control programs when TB was no longer seen to be a threat

Other problems, such as multidrug resistance, homelessness, substance abuse, and inadequate strategies to reach populations with special needs, have hampered efforts to control the disease in many areas.

In response, federal, state, and local officials are working to reestablish effective TB prevention and control programs. From 1993 through 1994, the number of reported TB cases decreased by 3.7%, despite an increase in the number of cases reported among foreign-born persons. This recent decrease is attributable in large part to renewed TB control efforts. As TB once again begins to decline in the United States, our challenge will be to persevere until ongoing transmission and the development of drug-resistant strains of *Mycobacterium tuberculosis* are halted. If we are to attain the goal of controlling and eventually eliminating TB from the United States, we must identify and treat persons with TB disease, provide services to groups at high risk for TB, and expand the use of methods to ensure completion of TB treatment, such as effective case management and directly observed therapy (DOT).

State and local health departments have the legal responsibility for controlling TB; they are responsible for surveillance, contact follow-up, training and education, and the monitoring and evaluation of case management. Three basic strategies are fundamental to TB prevention and control.

1. Identify persons who have TB disease and ensure that they complete appropriate therapy.
2. Perform effective contact investigations, which consist of
    a. identifying persons who have been in contact with a person who has infectious TB

b. screening these contacts to determine whether they have TB infection or disease

c. providing appropriate therapy when indicated

3. Screen persons at high risk for the development of TB disease, which consists of

   a. identifying those infected with *M. tuberculosis*

   b. providing preventive therapy to those who could benefit from it

   Screening is a lower priority activity than either case finding and completion of therapy or contact follow-up, and should be undertaken only after consideration of overall costs and benefits to the TB prevention and control program.

In 1989 the Advisory Council for the Elimination of Tuberculosis (ACET), which comprises representatives of public- and private-sector organizations across the country, was formed and developed the Strategic Plan for the Elimination of Tuberculosis (1). This plan calls for effectively controlling and eventually eliminating TB by

- more effectively using existing prevention and control methods
- developing and evaluating new prevention, diagnostic, and treatment technologies
- assessing and transferring new technologies

The Strategic Plan is a call to action for the medical community and the public; it is intended "to stimulate positive, constructive discussion and action, to increase the public's level of awareness of TB, and to encourage a commitment to the elimination of TB." The plan stated that "members of high-risk groups and their healthcare providers should be apprised of [their high risk for TB] and involved in the design, implementation, and evaluation of case-finding and prevention programs." By "forging partnerships" with high-risk groups, their health care providers, the medical community, and the public as suggested in the strategic plan, we can bring people together to work toward a common goal: TB prevention and control.

Since the adoption of the Strategic Plan, the Centers for Disease Control and Prevention (CDC) has been working with the American Lung Association (ALA), its state and local affiliates, and with state and local health departments to make the public aware of the TB problem and to build partnerships for state and local prevention and control efforts. From 1990 to 1992 three workshops ("Mobilization for TB Elimination") were held, bringing together key state,

big-city, ALA, and CDC personnel for training in the epidemiologic analysis of TB morbidity, as well as in coalition building, marketing, media relations, resource acquisition, community participation, and health promotion. Participants also began work on TB prevention and control plans tailored to their specific areas.

This document is based loosely on those workshops and is meant to serve as a resource guide for state and local health departments working to improve their services and build partnerships to control TB in their jurisdictions. At the national level, CDC and ALA have joined with a wide variety of voluntary and professional organizations to establish a national coalition for the elimination of TB. (See p. 13 and appendix C.) It is our hope that this document will provide a valuable resource for replicating and expanding upon this effort at the state and local levels.

Objectives

Forging Partnerships to Eliminate Tuberculosis provides a framework for TB prevention and control programs to use in planning new intervention strategies and strengthening existing ones; the resource section at the end of this guide provides further information for programs that wish to explore topics in greater depth. No single solution or plan will meet the needs of every program —creativity and perseverance, along with hard work, are needed to make the TB prevention and control effort successful. After reading *Forging Partnerships to Eliminate Tuberculosis*, you should be able to do the following.

- ☑ Explain why forging partnerships is an important part of the effort to control and, eventually, to eliminate TB from the United States.
- ☑ List several types of partnerships and explain the differences between them, giving examples of how TB prevention and control programs can use these models.
- ☑ Explain how to forge a partnership and list several activities involved in the following steps: preparation, groundwork, organization, maintenance, and evaluation.
- ☑ Describe three important strategies that partnerships can use to meet TB prevention and control objectives: marketing and media relations, resource acquisition, and community participation.

Assess the need for partnerships that will help reach specific TB prevention and control program goals and objectives and prepare an action plan for forging and expanding partnerships in your program area.

Executive Summary

Why should we forge partnerships? The forging of partnerships can bring people together to work toward a common goal: TB prevention and control and, eventually, elimination from a specific area. Partnerships can ensure that information and services are available to TB patients and high-risk communities when and where they are needed and in a form that is acceptable and effective. Partnerships can increase the visibility, momentum, and impact of TB prevention and control efforts by uniting diverse elements and pooling their talents and resources. Partnerships can reduce duplication of efforts and can therefore maximize the effectiveness and efficiency of the various groups and individuals interested in TB prevention and control.

What kind of partnership do we need? All that is needed at the start is a common goal and a number of concerned, committed people; then, with the use of team building and group facilitation skills, the partners can move forward to support their mutual interests and goals. Many types of partnerships have been used in different areas to strengthen TB prevention and control efforts. The needs and problems of specific high-risk communities should help determine the type of partnership to form. The broader the scope of the problem addressed and the longer the projected lifetime of the partnership, the more complex, tightly linked, and formal the partnership should be. Problems that are more limited and require a short-term, concerted effort may require a less formal, less complicated approach.

How can we forge a partnership? Five basic steps are required to build a coalition or partnership:

- Preparation — planning and assessment to determine the need for, and purpose of, the partnership
- Groundwork — to establish the partnership and clarify its purpose and scope
- Organization — to clarify the functions and responsibilities of coalition leadership and members
- Maintenance — to sustain efforts and keep the group on track
- Evaluation — to maximize the effectiveness and efficiency of the group

What can a partnership accomplish? Partnerships can help interested individuals, communities, and organizations more effectively use the following strategies to control and eventually eliminate TB disease.

- Market TB prevention and control activities, communicate problems, and publicize TB prevention and control strategies and successes to policymakers, organizations, high-risk groups and their health care providers, using the media when appropriate.
- Identify and acquire the additional resources needed to fully implement strategies to improve TB prevention and control.
- Use effective community participation strategies to direct high-quality services to high-risk persons and encourage their participation in TB prevention and control activities.

Marketing involves analyzing the needs of the TB partnership's clients and supporters, designing appropriate services to meet their needs, and using effective communication and distribution to inform, motivate, and gain the participation of these persons in high-priority activities. TB partnerships in each area need to develop specific plans and strategies for acquiring funds and other resources to support the implementation of TB prevention and control activities; in addition, partnerships can be of enormous value in educating key elected officials. Finally, an important function of a partnership is designing and planning activities; a community participation approach is the approach best suited to a partnership's activities because it seeks to involve a wide range of local health professionals, health institutions, community groups, and private citizens in a collective attack on TB and the conditions that produce and encourage TB transmission.

Conclusion. Although *Forging Partnerships to Eliminate Tuberculosis* is meant to provide a framework for collaborative efforts, it is not a cookbook of specific steps. Organizations are unique, and solutions must be found on the local level. Forging successful partnerships requires a firm commitment to the goal of TB prevention and control, a strong faith that collaborative effort will help reach important goals and objectives, and an enormous amount of elbow grease and patience.

Why Should We Forge Partnerships?

How can forging partnerships with community groups help reach the goal of controlling and eventually eliminating TB from the United States? The primary rationale for developing such partnerships is to ensure that program strategies are population-based — that is, designed to successfully reach **all** persons with TB disease, their communities, and their health care providers. Too often, health department staff face serious problems such as losing patients before they have completed treatment, poor clinic attendance, cultural and linguistic barriers to effective service delivery, and ineffective screening and prevention programs. The forging of partnerships can help solve these problems. In addition, partnerships can help ensure that acceptable and effective TB services are available to TB patients and high-risk communities when and where they are needed.

Optimal TB prevention and control activities require a multifaceted, multidisciplinary approach because each community or area in the country presents its own set of special needs. Collaborative efforts between TB prevention and control programs and community groups, health care providers, and other organizations serving TB patients can meet the following objectives.

- Help educate the public about TB.
- Ensure that community leaders, health care providers, and policy makers are knowledgeable about TB.
- Identify all persons with TB disease and ensure that they complete an appropriate course of therapy, using DOT whenever possible.
- Identify all contacts of persons with infectious TB disease and ensure their appropriate evaluation and treatment, if indicated.
- Coordinate and, in some instances, provide screening and prevention services for persons at high risk for the development of TB disease.

Public health activities that are culturally appropriate and have broad-based community support have been shown to affect greatly the health status of high-risk communities. Too often, TB patients and high-risk persons are suspicious or simply unaware of TB prevention and control services that are available to them. To ensure the quality, effectiveness, and appropriateness of activities, TB prevention and control programs need help from local groups in high-prevalence communities. Partnerships with community-based organizations (CBOs) and health care providers that have established relationships in the community can help ensure that high-risk populations have access to TB prevention and control services that are credible and attuned to local needs.

Such partnerships can build bridges between TB prevention and control programs, community residents, CBOs, and local health care providers, and can eventually foster community involvement in planning and implementing successful activities, whether service delivery or lobbying for funds. TB programs can serve as a resource for CBOs and local health care providers who want to improve their community TB control activities by providing

- access to health department resources and technical support
- increased access to TB information and education
- training and education on strategies for patient care
- assistance in setting up and managing service delivery programs

In addition, community residents and local health care providers benefit when they participate in TB prevention and control activities, begin to see a decrease in TB incidence in their communities, and ultimately halt TB transmission to themselves and their families.

Potential partners can represent various groups, organizations, and constituencies that are in some way affected or influenced by the TB problem and are willing to work together in an all-out effort to tackle this problem on behalf of themselves and their constituencies. A wide range of governmental, professional, voluntary, and other nongovernmental organizations can help provide the resources and community support that are crucial for this effort.

It is essential for partnerships to include important decision makers such as key government officials, policymakers, elected officials, managed care providers, and third-party payers (e.g., Medicaid, Medicare). Depending upon the needs and characteristics of specific high-risk communities, TB control programs can benefit from partnerships that also include a wide range of organizations, such as

- cultural and ethnic organizations
- refugee resettlement and immigration organizations
- American Indian tribes
- citizens or residents associations
- business associations
- financial institutions
- employers
- public and private schools

- communications organizations (the media)
- community clinics
- government health care providers (e.g., Indian Health Service clinics, Veterans Administration hospitals)
- private health care providers
- long-term residential facilities
- corrections and probation officers and counselors
- advocacy groups
- substance abuse treatment and rehabilitation programs
- shelters and low-income housing programs
- professional societies
- lung associations and other voluntary agencies
- schools of medicine or nursing
- schools of public health
- benevolent organizations
- local immigration and border officials
- community churches and religious groups
- HIV/AIDS prevention organizations

Persons representing these organizations can potentially provide funding and other needed support. Organization representatives can actively advocate and educate others about TB prevention and control programs by raising the level of awareness and commitment in the state or community. Partnerships can increase the visibility, momentum, and impact of TB prevention and control efforts by uniting diverse elements and pooling their talents and resources. Partnerships can reduce duplication of efforts and can therefore maximize the effectiveness and efficiency of the various groups and individuals interested in TB prevention and control activities.

What Kind of Partnership Do We Need?

Partnerships can be established at various levels — national, state, or local; partnerships can even be forged with existing partnerships or coalitions that were developed to address broader problems encompassing TB (e.g., health of minority groups, homelessness, substance

abuse). All that is needed at the start is a common goal and a number of concerned, committed people; then, with team building and group facilitation skills, the partners can move forward to support their mutual interests and goals. Each potential partner in the TB prevention and control effort can play a number of potential roles. (See p. 10.)

We often use different names for partnerships, depending on how they are organized, the role they will play, and their level of involvement in a movement or program. Some examples of partnerships that are often used in public health are defined in the glossary: coalitions, task forces, advisory committees, and networks. These general types of partnerships can be viewed as points on a continuum in the following areas:

- Complexity of purpose: There is a gradation of complexity in the purpose of partnerships from simple information sharing to complicated, joint problem solving and operations.

- Intensity of linkages: The degree to which organizations are linked in their working relations is articulated and influenced by common goals, shared tasks, and resources committed by the members.

- Formality of agreements: The degree of formality among the participating organizations is determined by rules and agreements that delineate the structure, operating procedures, and policies of the organization (2).

A blank worksheet similar to that on page 10 is included in appendix D. Local areas can use this worksheet to inventory potential partners and the role they can play in TB prevention and control efforts. Partners can be involved in many different roles, and this worksheet is not exhaustive. Keep in mind, too, that partners can be involved in each role at the planning, implementation, or evaluation stage, or at all stages in the process.

Purpose of the Partnership

Many types of partnership have been used in different areas to strengthen TB prevention and control efforts. The needs and problems of specific high-risk communities should help determine the type of partnership to form. When the idea of forging a new partnership has been put forward, TB prevention and control programs, state or local lung associations, and their potential partners should first ask several questions.

Partnership Inventory Worksheet

Potential Partners	Roles								
	Advocacy & Resource Acquisition	Medical or Technical Consultation	Funding	Service Provision	Marketing & Media Relations	Education	Outreach Services	Coordination	Training
TB program	√	√	√	√	√	√	√	√	√
Voluntary agencies	√	√	√		√	√		√	√
Professional organizations*	√	√			√	√		√	√
High-risk persons	√				√	√	√		
Health care providers	√	√	√	√		√	√	√	√
Policymakers, elected officials	√		√			√			
Media	√				√	√			
General public	√		√			√	√		
Third-party payers			√			√	√		
Managed care providers	√	√	√	√	√	√	√	√	√
CBOs and advocacy groups	√	√		√	√	√	√	√	√
Academic institutions	√	√		√	√	√	√	√	√
Foundations	√	√	√		√			√	√
Residential facilities**		√		√		√		√	√
Social service providers	√	√	√	√		√	√	√	√

* Such as the American Thoracic Society, American College of Chest Physicians, American Public Health Association, or American Academy of Pediatrics.
** Such as correctional facilities, drug treatment centers, nursing homes, and detention centers.

1. Based on an epidemiologic analysis of the TB problems in the area, what high-risk persons (and their health care providers) should partnerships represent?
2. Are there gaps in existing services to high-risk groups that would best be met by forging partnerships?
3. Are there organizations that need to address TB as a problem for their members or clients?
4. Is there an **existing** group that could provide the services or input needed to resolve the problem or fulfill the program's objectives?
5. What level of partnership organization is needed to solve the problem or problems?
6. What role is foreseen for this partnership in the overall TB prevention and control effort?
7. What type of partnership (see Types of Partnerships, pp. 12-16) will be culturally appropriate for the communities affected?
8. Will high-risk groups participate effectively and efficiently in this format?
9. Can control of the TB program be legally and politically shared? (Who has the ultimate authority and responsibility for TB prevention and control?)
10. To what extent can outside input (even criticism) influence or shape the TB prevention and control program (3)?

These questions can be answered by brainstorming at an initial meeting. If specific gaps or needs to be met become evident, other organizations not represented at the meeting may be interested in helping. Do any other organizations share the group's goal? What other groups may be able to serve as effective partners? Groups that are present should inventory activities they already support and discuss the type of partnership they would be willing to participate in. By answering these questions up front, the partners will buy in to the concept of working together to improve TB prevention and control.

The TB program should provide guidance to make sure that the partnership's goal is attainable and within the scope and mission of the overall program. Partners need to keep in mind that completion of therapy for persons with TB disease is the first priority for TB prevention and control; therefore, completion-of-therapy rates should be very high (95% or more) before programs and their partners divert significant staff time and resources to other activities (e.g., the screening of high-risk groups). Obtaining a high completion-of-therapy rate

may be an appropriate initial goal for partnerships in areas in which this rate has been less than desired.

Types of Partnerships

The broader the scope of the problem and the longer the projected lifetime of the partnership, the more complex, tightly linked, and formal a partnership should be. Problems that are more limited and require a short-term, concerted effort may require a less formal, less complicated approach. The following section further defines the various types of partnerships and gives specific examples of their use in TB prevention and control. These examples are provided to illustrate partnership models; note that specific terms (e.g., coalition, network, task force) have a certain amount of overlap in meaning and can often be used interchangeably, depending on which aspect of the partnership is emphasized.

Coalitions: Partnerships for Collaborative Action. The following are characteristics of coalitions as defined by Feighery and Rogers (3).

- Coalitions maximize the power of participating groups through joint action and the pooling of talents and resources.
- Coalitions minimize duplication of efforts among groups that would normally compete.
- Coalitions develop and demonstrate widespread public support for issues, actions, or unmet needs.

A formal coalition is a complex organization used to coordinate long-term efforts through joint planning and collaborative action. Building such a coalition requires sustained effort and the forging of tight links between its members. Coalition members work together to reach their goals: raising awareness, implementing specific projects, and improving services. Often, a coalition works on several activities at once through various subcommittees or task forces that address specific issues. The coalition then serves as an umbrella organization that sets an agenda, solicits funding, handles marketing and publicity, and evaluates progress jointly for its subcommittees or task forces. (See example, p. 13.)

Further information on coalitions can be found on page 17, under How Can We Forge a Partnership?

Example

The National Coalition to Eliminate Tuberculosis (NCET)

NCET was established in June 1991 after national leaders agreed unanimously that a national coalition was needed to achieve the goal of TB elimination by 2010. NCET's objectives are the following:

1. To ensure that health care providers, especially those who practice in communities heavily affected by TB, are knowledgeable about the diagnosis, treatment, and prevention of the disease
2. To increase public awareness, especially in heavily affected communities, of the magnitude of the TB problem in the United States
3. To advocate adequate public and private response to achieve TB elimination
4. To encourage nongovernmental, community-based organizations (CBOs), especially those working at the grass-roots level, to commit to the elimination of TB and to support their efforts in this endeavor

NCET consists of more than 60 patient advocacy, service provision, and health promotion organizations working together to address TB elimination issues that affect their constituencies; this collaboration has enabled TB prevention and control programs to reach high-risk groups more effectively and to provide services that are culturally appropriate. NCET currently works through four task forces that focus efforts on the following groups: community-based organizations, policymakers, health professionals, and the public. A list of the members currently involved in NCET activities appears in appendix C.

Task Forces: Partnerships for Problem Resolution. A task force is often used to coordinate an intense, short-term effort that requires input from many diverse groups. Its goal is to complete a specific and well-defined task in a limited time. Task forces are most often formed to resolve a specific problem or crisis (e.g., TB transmission in correctional facilities, high drug-resistance rates in a specific community). Problem resolution is often given in the form of recommendations or a report written jointly by task force members. This type of

organization can dissolve once appropriate and effective problem-solving measures have been implemented, or it can develop into a more comprehensive coalition and go on to address broader concerns.

Example

Task Force on TB in the Criminal Justice System

The New York City Task Force on Tuberculosis in the Criminal Justice System was convened in December 1991 to address the growing problem of TB in New York City's correctional facilities. Comprising leaders in criminal justice and public health, the task force reviewed critical issues related to combating TB in the correctional system, including data on the prevalence and transmission of TB; strategies for more effective case finding and case management; conditions in police lockups, court pens, and jails; and characteristics of the criminal justice system that may help or hinder efforts to control TB. Because this problem was urgent, the task force was asked to issue specific recommendations by early 1992.

The task force met formally on three occasions. Two public forums were held for advocacy and labor organizations to present their views to the task force. Smaller working groups also met to focus on specific issues. The result of these efforts was a series of recommendations published in a final report in June 1992; these recommendations called for a number of improvements in service provision and in the physical environment of the correctional facilities. Because of the complexity of the measures required to control TB in the criminal justice system and the numerous agencies and organizations that would be involved in implementing the published recommendations, the task force recommended that an implementation committee be appointed to oversee the project.

Advisory Committees: Partnerships for Joint Planning. An advisory committee is usually a group of experts who advise a specific organization and use their combined knowledge and skills to review, plan, and evaluate the program's strategies, activities, and impact. The expertise needed is not only medical and technical knowledge but also concrete knowledge of the community and of other important factors in the area's TB problem (e.g., HIV infection, immigration from areas where TB is common, drug use). An advisory committee usually

provides recommendations or validation to direct and monitor the activities of a program. Advisory committee members provide valuable input and constructive criticism that can improve service delivery and program outputs.

Example

The Advisory Council for the Elimination of Tuberculosis (ACET)

ACET was formed as a result of the challenge to eliminate TB from the United States. Its function is to provide advice and recommendations regarding the elimination of TB to the Secretary of Health and Human Services, the Assistant Secretary for Health, and the Director of the CDC. The objectives of the council are to

- make recommendations regarding policies, strategies, objectives, and priorities
- address the development and application of new technologies
- review the extent to which progress has been made toward eliminating TB

One of ACET's first tasks was to develop the *Strategic Plan for the Elimination of Tuberculosis*, which was published in 1989. The Strategic Plan calls for using existing prevention and control methods more effectively; developing and evaluating new prevention, diagnostic, and treatment technologies; and assessing and transferring new technologies. ACET advises CDC staff on how best to control and eliminate TB, reviewing current issues and problems, and issuing recommendations. In addition, ACET has provided leadership and encouragement for devising strategies to reach high-risk populations. ACET's charter, which was signed by the Secretary of Health and Human Services, is in appendix C.

Networks: Partnerships for Information Sharing. A network is often an informal, loosely associated organization that brings together people or groups with similar interests. Its purpose is usually to communicate and share information between and among its members. Networks often promote the sharing of ideas through newsletters, conferences, or informational meetings. Increasingly, networks are making use of electronic information sharing through electronic mail or other on-line information systems. TB service providers may

create networks to share patient information by linking to a central TB registry or to share strategies for improving completion of therapy rates. A network usually does not demand too much time or effort from its members; instead, it facilitates their work by providing a forum for the exchange of ideas and information.

Example

Public Health Training Network

The Public Health Training Network (PHTN) is a distance-learning system that links partners in prevention with a core curriculum of essential knowledge and know-how through a variety of media (e.g., live video- and audioconferences, print and computer-based self-study courses, instructional videotapes). The PHTN offers timely training information through an online training catalog and distance-learning coordinators in every state. Training in a variety of topics, including TB, is available through the PHTN and allows participants to earn continuing education units (CEUs) and continuing medical education (CME) credits without having to travel to attend courses. For information on the PHTN, call 1 (800) 41-TRAIN, or fax a request to (404) 639-0050.

The PHTN is sponsored by the CDC and brings together a variety of public health partners, including

- Association of Schools of Public Health
- Association of State and Territorial Health Officials
- Association of State and Territorial Public Health Laboratory Directors
- Black College Satellite Network
- Council of State and Territorial Epidemiologists
- National Association of County and City Health Officials
- Public Health Foundation
- State health departments

How Can We Forge a Partnership?

No matter what type of partnership is formed, the basic steps to be followed are similar. Because a coalition is the most complex type of partnership, it requires the greatest amount of preparation, initial effort, and maintenance. In this booklet, we use building coalitions as a model for forging partnerships in general. TB prevention and control programs and partners that work to create a task force, an advisory committee, or a network can adapt and simplify this model. Indeed, several types of partnerships may be necessary to meet the changing needs of high-risk populations and to maximize progress toward TB prevention and control. The Checklist for Coalition Building on page 28 can serve as a reference for the formation of partnerships of any type, provided that it is adapted to meet the requirements of local circumstances.

Five basic steps are required to build a coalition or partnership:

- Preparation — planning and assessment to determine the need for and purpose of the partnership
- Groundwork — to establish the partnership and clarify its purpose and scope
- Organization — to clarify the functions and responsibilities of coalition leadership and members
- Maintenance — to sustain efforts and keep the group on track
- Evaluation — to maximize the effectiveness and efficiency of the group

Preparation

To prepare for coalition building, it is important to do an initial assessment of needs that is based on a thorough evaluation of current programs, funding, and resources for TB prevention and control. To do this needs assessment, the TB control program should follow these steps:

1. Analyze TB morbidity (and the prevalence of TB infection, if available) to identify persons and groups at high risk for TB toward whom activities should be directed.
2. Obtain data on program inputs (e.g., funding, equipment) and outputs (e.g., the percentage of patients completing therapy), and review program goals and objectives.
3. Analyze the TB program's current results, comparing them with existing program goals and objectives.

4. Recognize and delineate problem areas and gaps in services.
5. Determine possible strategies for improving performance and estimate the partnerships and additional resources needed to help implement those strategies and meet new program objectives.

When these steps have been taken, the TB prevention and control program can determine whether a partnership is needed to implement possible strategies and the type of partnership that might be most appropriate. This is a good point at which to invite several potential partners to an exploratory meeting to discuss the questions listed on page 11 and determine the type and purpose of partnership needed; the participants in this meeting can serve as coalition organizers.

If the TB prevention and control program, the lung association, and their partners have determined that a coalition or other partnership is needed, then the coalition organizers' initial step should be the clear definition and statement of the coalition's mission or purpose. It is also important to define the partnership's scope (i.e., high-risk population). To do this, the partnership should use the TB profile of the area (developed in step 1) and additional data on demographics, economic status, housing, health care, and facilities that work with the high-risk population.

Once the goal and the scope of the partnership are known and the TB program and the state or local lung association have gained initial support for building a coalition, coalition organizers should determine which potential members are interested in and committed to reaching the stated goal. An inventory of potential members (as discussed on p. 9) should be done, based on what the coalition's major functions may be; invitations should be extended to the individuals or organizations that are essential for the success of the coalition, as well as to others who may have expressed an interest in the problem to be addressed. Coalition organizers should begin to name existing CBOs that are already involved with risk groups in TB-related or other activities. It is also important to reach community leaders who represent individuals or groups at high risk for TB. A coalition with a broad base at the grass-roots level will be more effective, because it will have the capacity to better understand the community and its TB problem.

Some authorities suggest that organizers inventory potential coalition members by snowballing: this is done by asking many people who are familiar with the high-risk population to identify leaders. The names that are heard again and again are people who may make good coalition members. This method can also be used to get the word out about the new partnership and generate enthusiasm for its goal.

Potential members should have at least two of the following characteristics:

- interest in TB
- knowledge of, and credibility in, high-risk communities
- credibility with, and access to, high-level policymakers
- contacts with other potential members
- familiarity with the political system
- materials or expertise in program development, health promotion, implementation design, or evaluation
- financial resources or fund-raising ability (3)

Above all, members must be committed to the idea of collaborating and cooperating to control TB.

Coalition organizers must be able to show potential members how they can benefit from the coalition; people will respond to a partnership that offers greater impact or efficiency and new opportunities to network or showcase their skills. Most organizations will also want to know their role in the coalition; the organizers should specify as clearly as possible the skills and resources that are needed (e.g., program development and implementation skills, technical advice, financial management skills, communications skills). They may want to know how much work will be involved and how many meetings they will need to attend. Partners creating the coalition should be prepared to present the purpose and the scope of the proposed partnership; however, when the group initially meets, a full discussion of authority, responsibility, purpose, scope, and expected work product will be necessary so that the members have a shared vision of what the coalition wants to accomplish. (See example on p. 20.)

Groundwork

Regardless of how potential members are identified, coalition organizers need to meet with and take the time to get to know them. Once the group's goal and the idea of building a coalition have been discussed with each potential member, letters of invitation should be sent, formally requesting members' participation and outlining clearly what is expected of them. Any time limits for membership or any other conditions for participation in the coalition should be specified in the letters. Next, the coalition organizers should request a confirmation of each member's commitment. Once members have confirmed, they should be immediately thanked and provided with information on how the coalition will proceed. Although coalition organizers may want to get endorse-

Example

The DOT Provider Network

In 1992 the New York State Department of Health successfully created a network of public and private community providers to deliver DOT services to TB patients. The DOT Provider Network includes many CBOs, social service providers, and advocacy organizations that were already serving high-risk, hard-to-reach individuals. This network has allowed New York to offer DOT both at fixed treatment centers (e.g., chest clinics, drug treatment centers) and, through outreach, at locations in the community convenient to the individual being served. DOT Network providers are reimbursed through Medicaid and work very closely with the local health department.

In New York City, more than 20 institutions representing more than 70 discrete, fixed treatment centers have become part of the network and now provide outreach services as well. More than 1,700 referrals to the state's TB DOT Provider Network were reported by the end of 1993. Efforts continue to maximize referrals and expand the network in innovative ways. These new alliances between DOT providers and CBOs can establish support systems for patients, assist in promoting adherence to therapy, and help address the health and social problems that place their clients at high risk for TB.

The DOT Provider Network is currently more of a coalition as defined in this document than a network. This organization consists of a collaborative effort with complex and formally established links between members.

ments from certain high-profile organizations or individuals not directly involved in coalition activities, they should be careful about the number of organizations they contact and focus their attention and efforts on individuals and organizations key to the success of coalition activities.

It is important to be on the lookout for pitfalls in the coalition-building process. Potential coalition members may have reservations about collaborating with other coalition members because of one or more of the following issues:

Commitment

- belief that TB is not a priority problem
- lack of faith in the value of prevention
- negative attitudes toward, or isolation from, risk groups
- distrust of governmental organizations or of CBOs

Capacity

- lack of knowledge about TB prevention and control strategies
- lack of technical knowledge or training
- limited staff or resources
- lack of power or skills necessary to mobilize people

Cooperation

- competition for limited funds and time
- lack of collaboration in the past
- territorial claims, or “turfdom”
- confidentiality issues
- language or cultural barriers

It is important to point out to members the ways in which these problems can be resolved or minimized through a collaborative effort. It may be necessary to educate coalition members about

- the epidemiology of TB in their communities
- the transmission and pathogenesis of TB
- TB prevention and control strategies and their effectiveness
- the potential impact of strengthened TB prevention and control activities on the populations they represent or serve

Potential members who seem unwilling to commit or to cooperate should not be invited to join the coalition.

When most invited members have responded, the coalition organizers should have a meeting of all interested members to discuss and clarify coalition goals and objectives. Coalition members should be ready to discuss their individual goals and their potential contribution (including resources) to the partnership. Several very important concepts in starting to build a coalition include

- ensuring that organizational identity is retained, with recognition and respect for all members
- building consensus by working toward a common goal
- integrating, when feasible, other important goals of members into TB prevention and control efforts
- sharing resources to support coalition activities and maximize output
- recognizing and minimizing possible barriers to collaboration
- ranking objectives in priority and, if need be, dividing them into long-term and short-term objectives (4)

The coalition organizers need to communicate honestly with the members, listen to their opinions, encourage participation of all members, and share discussion time as equally as possible. Group facilitation and team-building skills are critical to the successful cohesion of the group. By the end of the first few meetings, the coalition members should be able to write a brief mission, or position, statement that establishes the group's name and clarifies its purpose, goal, and scope of activities. See appendix C for the mission and goals of the Missouri Advisory Committee for the Elimination of Tuberculosis. The group can then begin to develop a plan of action for the coalition's first activities.

Organization

Leadership is very important for a coalition. Although the coalition organizers may have been initially identified by the TB program and the state or local lung association, the group will eventually need to elect a chairperson. A good chairperson needs to be able to set agendas, run meetings efficiently, keep members focused, and foster good communication. It is extremely important to clarify the relations between, responsibility and accountability of, and relative authority of the chairperson, other coalition members, and TB program staff. Although the TB prevention and control program should offer guidance and technical advice, the coalition must operate autonomously if it is to succeed. As the group progresses, it should establish clear ground rules or bylaws defining

- how a leader is to be chosen
- how members are appointed
- what terms will be set for leaders and for members
- how decisions will be made (i.e., by consensus or by majority rule)
- what constitutes a quorum for decision making

- how work will get done (i.e., by the full coalition or by task forces or committees)
- who will be the media spokesperson
- how members will be credited for their contributions
- what mechanism will be used for issuing statements and reports

The structure of a coalition can be very centralized and authoritarian or loose, informal, and highly participatory. Each coalition (or any other partnership, for that matter) should determine the model that works best for its specific needs, although it is important to have at least some mechanisms to ensure participation by all members. Coordination is always important, especially if work is done by several committees or task forces. Officers or chairpersons of committees may need to participate in a steering committee that will oversee the coalition's overall progress toward its goal.

A possible model for the organization of a TB coalition is presented in the figure on page 24. Regardless of the structure established for the coalition, it is important to define very early the responsibilities of each of the various organizational groups (e.g., steering committee, task forces, subcommittees), although their responsibilities will, of course, evolve as the coalition matures. It is important that responsibility and credit be shared in the group and that everyone be included in planning.

The coalition needs to resolve several operational issues early; leadership should facilitate group decision making to clarify these important issues. The group should set a meeting schedule that specifies both the frequency of meetings (e.g., annual, semiannual, quarterly) and their scope (e.g., the entire coalition or subcommittees). In general, it is best to avoid meetings that are too large; more frequent task force meetings can often be productively followed by an annual general meeting. The coalition should decide on the length of meetings and the responsibility of the organization that sponsors the meeting. If travel and per diem funds are involved, who will pay them? If resources will be needed for these meetings — money, services, meeting space, support staff — who will provide them? The coalition needs a contact point for the organization of its business (e.g., answering questions, sending out invitations). This duty can be assigned to a member or rotated through the group on a fixed schedule; in general, it is best not to create a paid position, since the salary is rarely sustainable over time.

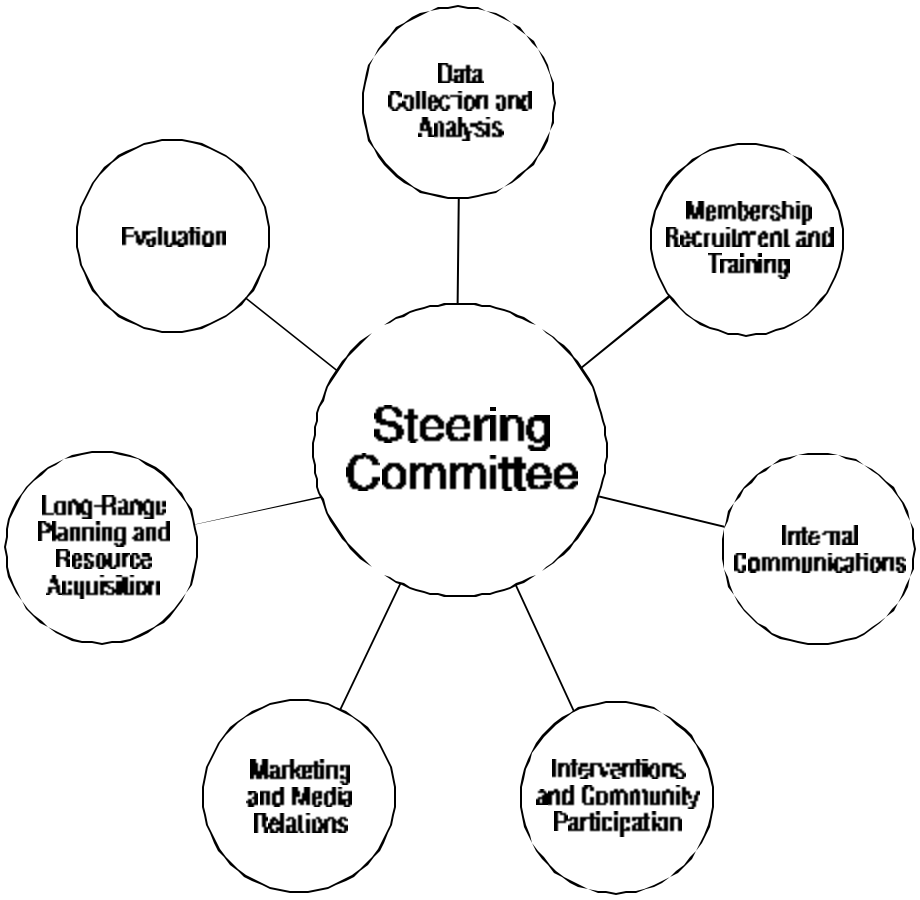

Figure. Model for the organization of a TB coalition.

Maintenance

Members must be convinced that **they** are the coalition and that they are in control of its destiny. They need to understand the TB problem and the rationale and process for forging partnerships. This is why training coalition members is important; good training and communication will encourage members to stay and eventually to recruit others. By encouraging participation, monitoring and publicizing progress, and rewarding or recognizing the contributions of individual members, leaders will maintain enthusiasm for the coalition's activities. Coalition leadership must be constantly in touch with members to give them feedback and support and to encourage progress on current activities; often, a coalition will designate one person to fill this role.

Once the coalition is set up and begins work, common organizational problems include

- a lack of administrative support for coalition activities
- threats to the autonomy of members
- lack of consensus about membership criteria or coalition structure
- disagreements about responsibilities for service provision
- inadequate attention to members' other priorities

These problems can best be resolved or averted by obtaining definite commitments from members, paying special attention to team building and consensus development during meetings, and setting up clear ground rules and lines of authority from the start. Other problems that can arise — fear of change, poor communication, lack of commitment, incompatibility of organizations or personalities, inadequate participation of community constituencies, disagreements regarding community needs — can best be avoided by careful planning, communication, flexibility, and sensitivity to how coalitions develop.

All coalition members, and leadership in particular, must be able to listen, negotiate, and communicate effectively. They need to encourage the sharing of resources, information, ideas, and contacts; they should be patient, persistent, sensitive to diversity, and willing to share credit with other coalition members. They should acknowledge ideas and encourage the participation of all members. For successful group facilitation and management of meetings, leaders need to be able to guide and coordinate without being too controlling or rigid; however, tight planning and organization are still needed. A good leader is a good facilitator who will use judgment to make sure the group stays focused, sticks to the ground rules, and follows through with proposed agendas unless important deviations are necessary. Leaders should have the ability to summarize and to maintain direction by anticipating and controlling conflict. Momentum will best be maintained through clear communication, continuing commitment, and mutual trust between members.

Communication with the public, especially the coalition's high-risk populations, is very important to the success of a coalition. Activities should be publicized through news stories, press conferences, and other media events. Press releases, flyers, pamphlets, newsletters, posters, slides or videos, proclamations by government officials, endorsements by celebrities, appearances on talk shows, and public service announcements have been successfully used to provide visibility and market coalitions and other partnerships. Internal communications are equally important. The coalition may decide to develop a coalition

newsletter, organize special mailings, or set up a phone bank to let members know what they are supposed to do when a particular strategy is being used. (See Marketing and Media Relations, p. 29.)

Advocates for TB prevention and control should understand that decisions about resource allocations and the awarding of grants are sensitive and inherently controversial. To compete successfully for their fair share of resources, coalition members must be aware of how the process works and learn to make it work to their advantage. Coalition members can help the TB prevention and control program make convincing arguments for the value of their proposed activities, based upon sound epidemiologic and cost-benefit data. The job of winning support for TB prevention and control requires political acumen, marketing insight, skill at working with coalitions, and plenty of persistence. Because funding sources often prefer to work with a coalition rather than competing organizations, a coalition is more likely to get funding because it represents a collaborative effort. If the coalition tries to identify funding sources that can provide sustainable levels of funding, this can help maintain its momentum and stability.

Evaluation

As mentioned on page 17, TB prevention and control programs should analyze program data collected each year to determine morbidity rates, completion-of-therapy rates, trends, and the demographic characteristics of the TB patient population in their area. This analysis can be used to identify high-risk communities and present information on the TB problem to potential partners at the initial stages of coalition development. In working with service providers in high-risk communities, TB prevention and control programs should stress that timely and complete reporting by all providers in the area is essential for public health planning and assessment. In addition to helping describe the TB problem, a thorough analysis of TB control program data and of demographic data in the coalition's area can be used to identify needs and can serve as a basis for program planning, monitoring, and evaluation.

Coalitions should use baseline program data to define specific objectives for their activities during the planning stage. These objectives should be **s**pecific, **m**easurable, **a**ppropriate, **r**ealistic, and **t**ime-framed (SMART). An example of such an objective is the following:

> Ninety-five percent of all TB cases reported from the project area from 1/1/96 through 12/31/96 will be enrolled in the case management program and will complete an intermittent DOT therapy regimen within 12 months of enrollment.

This objective would be very appropriate in an area where a DOT program has been initiated and the coalition is working to increase enrollment in this program from a lower baseline to a very high level of participation. At least annually, the coalition should use TB program data to help assess progress toward the achievement of the coalition's specific objectives.

The coalition should assess overall program performance by reviewing the rates for completion of therapy, contact identification, and the initiation and completion of preventive therapy. These data are best obtained from the health department after periodic patient cohort reviews of TB program data. Completion of therapy and other important indicators (e.g., the percentage of persons completing preventive therapy) can also be reviewed by demographic group to identify problems of access to services and specific educational needs. The coalition can encourage thorough reviews of clinic practices, including focus groups with patients and high-risk persons, to assess the quality of care and identify barriers to clinic attendance or participation in DOT programs. When specific coalition activities have been carried out, the coalition can help assess their overall impact on the TB program's performance.

Coalitions should share evaluation reports with the appropriate public, private, and community groups, as well as all coalition members. These reports should document the extent and nature of the TB problem in the area, assess the impact and success of coalition activities, and recommend future coalition activities or other improvements in the TB prevention and control program. The coalition should publicize important successes or failures of the coalition in general and of the TB prevention and control program specifically. In certain circumstances requiring public health advocacy (e.g., important lacks of funding or resources, inadequate staffing, outbreaks), the coalition may want to sponsor an outside review of the TB program by experts from, for example, state or local health departments, CDC, or the American Thoracic Society.

Checklist for Coalition Building

Preparation

- ☐ Analyze TB morbidity and demographic data in project area
- ☐ Evaluate current programs and identify gaps in services
- ☐ Evaluate current resources and needs
- ☐ Convene core group of coalition organizers
- ☐ Identify areas of mutual interest for potential partners
- ☐ Determine need for coalition or existing group to intervene
- ☐ Define coalition's purpose or goal
- ☐ Define coalition's scope
- ☐ Gain administrative support
- ☐ Identify potential members

Groundwork

- ☐ Contact and interview potential members
- ☐ Select members and invite to participate
- ☐ Confirm commitment of members
- ☐ Organize and hold initial meeting
- ☐ Clarify purpose or goal
- ☐ Set SMART objectives (see p. 26)

Organization

- ☐ Stress team building and group facilitation
- ☐ Determine schedule and organization of meetings
- ☐ Define structure, responsibilities, and roles of members and leadership
- ☐ Identify leadership
- ☐ Determine ground rules and bylaws
- ☐ Sign charter (if desired)

Maintenance

- ☐ Hold regular meetings
- ☐ Reward and recognize contributions
- ☐ Communicate with members frequently
- ☐ Publicize activities
- ☐ Identify sustainable sources of funding

Evaluation

- ☐ Evaluate progress towards coalition objectives at least annually
- ☐ Evaluate overall TB program performance and the coalition's impact
- ☐ Disseminate results to all members
- ☐ Publicize important successes or failures

What Can a Partnership Accomplish?

Partnerships can help interested individuals, communities, and organizations more effectively use the following strategies to reach the goal of controlling and eventually eliminating TB disease.

- Market TB prevention and control activities, communicate problems, and publicize TB control strategies and successes to policymakers, organizations, high-risk groups and their health care providers, using the media when appropriate.
- Identify and acquire the additional resources needed to fully implement strategies to improve TB prevention and control.
- Use effective community participation strategies to direct high-quality services to high-risk persons and encourage their participation in TB prevention and control activities.

We explore each of these areas further in the following sections, providing concrete examples and ideas for activities. Published documents and other training and education resources pertinent to each of these three areas can be found in appendix B.

Marketing and Media Relations

Marketing is a subject of growing importance to nonprofit organizations, including TB prevention and control partnerships. Marketing can be defined as the skill of knowing how to plan and manage the organization's relationships with its various patrons. A **patron** is any group that has an actual or a potential interest in, or impact on, an organization: people who fund or support an organization, people who make up an organization, or people to whom an organization provides services. Marketing involves

- analyzing the needs of these patrons
- designing appropriate information or services to meet their needs
- using effective communication and distribution to inform, motivate, and gain the participation of these patrons in high-priority activities

Marketing was first developed in connection with products, but it has been broadened in recent years to cover other marketable entities, such as information or services. The objective of nonprofit organizations such as TB partnerships in using marketing to promote TB information or services is not to

manipulate their audiences unscrupulously; rather, TB partnerships can use marketing to influence the decisions of their patrons in ways that will help achieve specific TB prevention and control objectives. At the same time, TB partnerships can use marketing to determine how they can best meet the needs of these patrons. The most successful organizations make every effort to sense, serve, and satisfy the needs and wants of their patrons within the constraints of their budgets; coalitions or partnerships, because they represent many different groups of patrons, can successfully work together to find ways to do this.

The acid test of an organization's responsiveness is the satisfaction it creates and its success in building a lasting relationship with its patrons. Policymakers, elected officials, and the general public are important patrons who need information about the size and scope of the TB problem, the potential for better control and elimination efforts, and the need for adequate staffing and resources. They need to know immediately about emerging TB-related problems (e.g., multidrug resistance, low completion-of-therapy rates, morbidity increases, TB in children) in order to consider appropriate responses (e.g., new appropriations, legislation, or prioritization of activities). Health officials and public health partnerships have a clear responsibility and an obligation to inform policymakers and elected officials about immediate opportunities for preventing the transmission of *M. tuberculosis* and about the long-term potential for the elimination of TB.

According to marketing theory, an organization can attract resources from others only if it can offer them something of value. TB partnerships must ask "What can this organization offer health care providers, community groups, elected officials, the health commissioner, or the general public that they value?" When these questions have been asked and answers are sought, a marketing approach is being used. TB partnerships can use marketing to attract resources and gain organizational support for coalition activities. It is important to present a clear picture of the problems at hand (e.g., number of cases, number of infected persons) and the potential impact of interventions (e.g., number of cases prevented, dollars saved). The potential negative impact of the problem should also be presented (e.g., ongoing transmission, outbreak situations, the development of drug resistance, and negative publicity).

Patients and high-risk persons, who are the clients of TB service delivery, are also a very important group of patrons. For successful TB prevention and control, clients need to use services such as DOT, directly observed preventive therapy (DOPT), and physician appointments for several months at a time. These services must therefore be highly responsive to clients' needs. For-profit

organizations use complaint systems, surveys of satisfaction, surveys of needs and preferences, and customer-oriented personnel to improve their responsiveness. TB service providers have seldom taken a marketing approach like this, but they could be more effective if they did. Members of high-risk groups should have significant input into the planning and evaluation of TB services provided in their communities. Partnerships that bring together client representatives, TB service providers, and other organizations can do much to assess and improve responsiveness to client needs.

Partnerships can take either of two marketing approaches with regard to TB service clients: mass marketing or directed marketing. A mass marketing approach is to offer only one level of services and attempt to satisfy everyone with those services. Directed marketing is based upon the decision to distinguish the groups that make up a market and to develop appropriate services and marketing mixes for each market segment. Organizations today are moving away from mass marketing and toward directed marketing, because the latter is more effective in satisfying the needs of clients and in achieving organizational goals and objectives.

The first step in directed marketing is called market segmentation — dividing a market such as TB service clients into distinct groups who should receive information or services tailored to their needs. For example, client groups — homeless patients, foreign-born persons, working mothers, the elderly — might be more effectively reached by offering special services directed to their needs. Understanding clients' needs, wants, and behavior is the foundation of marketing. Individuals who seek services have a need or desire they want to satisfy. TB coalition members should understand what needs (e.g., symptoms or exposure to an infectious case) trigger interest in TB services and the specific wants (e.g., diagnosis and treatment or tuberculin skin testing) activated by these underlying needs.

Prospective clients must have a certain amount of information (e.g., who offers the service, where, and when) before they can take action. They must also be able to access the services available. When these needs for information and access have been met, clients evaluate their options and establish a preference for one, weighing additional factors such as attitudes and values. Finally, after coming in for services, clients review their experience and decide whether to return for additional services. Special services that might encourage clients to return include convenient hours, interpreters, DOT, or incentives (e.g., transportation, clothing, food, child care, referrals for social or housing assistance).

TB partnerships should help ensure that TB service providers stay in touch with how their clients and potential clients are making these decisions. These efforts might be particularly directed at those patients who fail to keep appointments or who delay seeking treatment. It is important to identify problems that cause patients to discontinue treatment or to seek services irregularly, such as

- lack of information or misinformation
- barriers to access
- lack of motivation to complete treatment
- negative attitudes toward TB program staff

Partnerships can help TB service providers avoid the attitude that people should be grateful for their services and so have no right to criticize; by providing valuable information on the clients' perspective, partnerships can identify potential problems and increase the effectiveness of TB service delivery.

An organization's image — the sum of beliefs, ideas, and impressions about the organization held by a particular person or group of persons — is very important because people respond to what they perceive, not necessarily to what is real. To assess the image of the TB program or of various TB service providers, coalitions or other partnerships should ask their patrons what they think of the organization and its services. An undesirable image can be improved by changing aspects of TB services or of the partnership's membership or structure, or by promoting the value of TB prevention and control through information campaigns among high-risk groups. Good media relations are an important means of improving and maintaining a good public image for TB control in general. (A valuable resource for improving media relations is the booklet *The Media & You: A Basic Survival Guide*, listed in appendix B.)

Sometimes TB partnerships can engage in educational activities by using persuasive communication techniques adapted from advertising and public relations. **Public relations** is a tool used to advance the partnership's goals and improve its public image. The process used for public relations campaigns consists of the following steps.

- Identify the organization's relevant patrons.
- Measure the images and attitudes held by those patrons.
- Establish image and attitude goals for the key patrons.
- Develop cost-effective strategies to improve image and attitudes.

- Implement actions based on those strategies (e.g., public service announcements, phone calls, letter-writing campaigns, personal visits).

- Evaluate results by measuring images and attitudes once more.

For example, partnerships can reach policymakers and elected officials through official channels (e.g., the health department) and through letters, phone calls, and personal visits. TB service clients can be reached through public service announcements, posters and flyers, and personal visits by community leaders and outreach workers. A successful TB partnership should make use of public relations to convey that TB remains an important public health problem, that the TB partnership and TB service providers can effectively combat the problem in affected communities, and what high-risk persons and their health care providers need to do to reduce their risk.

In summary, a marketing approach can make a TB partnership more effective in reaching its objectives by successfully satisfying the needs of its various patrons. By analyzing the needs of persons with a stake in the partnership's success, the partnership's members can design services that are appropriate for the diverse needs of these groups. Marketing will also help TB service providers communicate effectively with these patrons and distribute services and information that can motivate high-risk groups to participate in activities. Although such an approach does not guarantee that the partnership's objectives will be achieved, it does make it more likely that they will be.

Resource Acquisition

TB partnerships in each area need to develop specific plans and strategies for acquiring funds and other resources to support the implementation of TB prevention and control activities. In seeking funding, it is important to remember a lesson from marketing and media relations — people will do something because it serves their interest by attracting support or improving their public image. Most organizations respond positively when asked to become involved with a successful program that has a clear goal; TB partnerships need to present their objectives in such a way as to stress the importance of the goal of TB prevention and control, to demonstrate the value of their services to high-risk communities, and to highlight their successes. The message to potential funders is very important; it must be clear, concise, and positive.

In the following section, we describe different types of funding sources and suggest an approach to acquiring the resources the partnership needs to make its activities a success. (Most of this material is taken directly from a Congressional Research Service report, *Grants and Foundation Support: Selected Sources*

of Information [5]). Before determining whether the best funding source is a government program, a small private fund concerned primarily with local activities, a specialized organization providing grants in a particular subject area, or a broadly based national foundation, it is wise to prepare an analysis of the contemplated project. Any request for funding will require a presentation that describes

1. existing problems to be addressed or resolved by the proposal
2. immediate and long-range goals
3. detailed plans for the implementation, organization, staffing, budget, and evaluation of the activity

A number of research tools are available to help choose which government agency or private foundation may be interested in a particular activity. In deciding on a particular organization to which a TB partnership would like to apply for funding, it is important to know the stated purposes of the funding organization, its grant restrictions and financial capacity, and some history of the activities it has supported. It is also a good idea to know the review and funding cycles of the potential funding organization. Every attempt should be made to identify only those funding sources whose stated purposes are consistent with those of the grant seeker (e.g., health promotion, disease prevention, health service delivery). In the changing environment of health care delivery, it is important to consider the most current information on different funding mechanisms possible (e.g., Medicaid reimbursements, state or local appropriations, federal funding through block grants or cooperative agreements, or private funds from managed care systems, voluntary organizations, or foundations).

Government funds may be sought at the federal, the state, or the local level. A good general source that describes federal programs is the *Catalog of Federal Domestic Assistance* (see appendix B). In addition, congressional offices have access to various congressional databases (Preaward Grants and Postaward Grants) that include data from the *Catalog of Federal Domestic Assistance* and current grants from the *Federal Register*. When state funds are sought, it is important to know about specific legislative budget procedures for that state, including the calendar and periodicity of the legislative session, state budgeting periods (i.e., fiscal years), and the deadline for submission of the governor's budget to the legislature. It also helps to know the amount of time the legislature or the appropriations committee has to consider the budget.

When the partnership is seeking funds from the state, it can often help to identify and recruit a key elected official who is interested in, and supportive of, the TB partnership. Such persons can help the partnership gain needed support from other elected officials. It is often helpful if the communities served by the partnership or members of the partnerships have personal contacts with such persons or are part of their constituency. If possible, identify and develop a group of high-level officials and community leaders who will support the TB prevention and control effort and work with the partnership toward its goals (if possible, as full members).

The staff of elected officials and legislative committees may also be very supportive and helpful in reaching influential but very busy officials. The partnership should ensure that all its supporters are educated about the TB problem, the partnership and its goals, and specific objectives for the funding sought. These persons will then disseminate the partnership's message, which should be kept clear and simple, and repeated as often as possible. Remember that in a competitive funding environment, the partnership will have to make compromises and should be flexible, but firm in its purpose.

Sources of funds for TB prevention and control activities other than federal or state governments include private foundations, voluntary organizations, businesses, and other organizations. These organizations can be either local or national; a good general source of information about private funding is the *Foundation Directory* (see appendix B for more information). The partnership needs to be persistent in seeking out innovative funding sources. Selected sources of information on grants and foundation support can be found in appendix B. Many of these resources are also available as on-line databases and can usually be accessed through a local library for a fee.

The Foundation Center, which publishes the *Foundation Directory* and other useful works, is a nonprofit organization that gathers and disseminates information on foundations. The center's reference libraries in New York City and in Washington, D.C., contain extensive collections of books, documents, and reports about private funding sources and current files on the activities and program interests of approximately 30,000 U.S. foundations; in addition, the Foundation Center has established regional reference collections in Cleveland and San Francisco. A list of the addresses and phone numbers of these collections appears in most of the center's publications.

The Foundation Center's resources are a good starting point for likely funding sources. The next step is to find out more about these foundations by obtaining copies of their annual reports and guidelines. Grant seekers will need to determine whether

- their projected proposals match the foundation's areas of interest and geographic focus
- the proposal is within the foundation's budgetary constraints
- the foundation normally funds the type of activity being considered

On a national level, the Robert Wood Johnson Foundation is an example of a private foundation that has become an invaluable source of funds for TB prevention and control programs; awards have gone to fund innovative projects to promote local partnerships and information sharing. It is generally a good idea to start looking first for foundations close to home; they may have a greater interest in local problems than do larger foundations principally concerned with programs of national significance. (See example, p. 37, of support given by such local foundations.)

Direct corporate giving is another potential funding source. Many companies support local activities in areas where they have their headquarters or plants, or they sponsor activities that somehow enhance their corporate image. These companies and other local businesses may play an active role in prevention activities by providing materials, facilities, or even employees to serve as volunteers. The *National Directory of Corporate Giving* profiles companies making contributions to nonprofit organizations and includes corporate foundations and companies that have direct giving programs. (See appendix B for more information on these resources.)

When a partnership is seeking funds from foundations or corporations, an excellent way to prepare for writing the final grant proposal is to develop a **concept paper** that briefly describes

- the needs a project is to address
- who is to carry out the activity
- what is to be accomplished and its potential impact on the overall problem
- the methods to be used
- how long it will take
- how much it will cost

- how the accomplishments will be measured
- ways the proposal relates to the mission of the funding source

Many governmental agencies and foundations are willing to assess a concept paper before a formal proposal is prepared. If the funding source expresses interest in the concept paper, this is the time to ask for suggestions, criticism, and guidance — before writing the final proposal. It is often a good idea to have the concept paper critically reviewed both by specialists in the field and by those unfamiliar with the project to ensure that it is free of assumptions and jargon before submitting it to the funding source. State and local affiliates of the ALA

Example

The Wetmore Foundation

Since 1950, The New Orleans TB Program has benefited from generous contributions from the Wetmore Foundation, a local private foundation established through a legacy from Mrs. Elizabeth Wetmore, who left a large sum of money for the delivery of services to TB patients in the city of New Orleans, Louisiana. In addition, the Wetmore Foundation donated the building where the TB prevention and control program is currently housed. The Wetmore Foundation is funding two patient programs in New Orleans: the Treatment Incentive Program (TIP) and the Needy Program.

As of May 1, 1995, patients with suspected or confirmed TB disease who live in the greater New Orleans area are eligible for TIP if they are also on DOT. Patients who enroll in TIP and keep all their clinic appointments during a month are eligible to receive a $100 check from the Wetmore Foundation. Patients can receive one check for every month of adherent treatment. It is believed that this incentive program will increase the number of health care providers and patients who participate in DOT and ultimately improve the area's completion-of-therapy rate.

The Needy Program is designed to provide assistance to any TB patient who is determined by the program to be in urgent need of assistance. Qualified patients receive funding for housing, utilities, medication, dental care, car repairs, or other urgent needs when they arise. This plan has successfully helped TB patients overcome situations that may have put them at risk of abandoning treatment. Funds awarded through the Needy Program, as with TIP, are dependent upon the patient's continued adherence to therapy.

can often provide technical assistance on resource acquisition and can be invaluable in identifying funding sources.

Once an award is made, it is important to keep funding sources apprised of the partnership's progress in implementing the funded project. Funding agencies should be invited to participate in press conferences or presentations about the project and in project activities when appropriate. If additional funds are required that were unforeseen in the original grant application, the funding agency is more likely to be supportive if significant progress and an adherence to the proposed plan and time line are evident.

TB prevention and control partnerships can be of enormous value in educating key elected officials, as well as in soliciting funds from private sources. Partners can help attract positive attention to the TB problem and create a sense of urgency by keeping a steady pressure on funding organizations to make a difference. It is important that all members of the partnership know the message being used to solicit funding and which organizations are being solicited during the funding campaign. Volunteers can be asked to circulate petitions, staff phone banks, or write letters in support of the TB partnership's efforts.

In areas where HIV infection has had a big impact on the TB problem, TB partnerships may want to coordinate activities and collaborate with HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) prevention organizations to broaden the impact of their activities and share ideas and resources. TB partnerships should also recognize the value of resources that members already possess — technical assistance, training capacity, access to high-risk clients. These resources can be used to encourage others to become involved in TB prevention and control activities.

Community Participation

A partnership should take a leadership role in training and educating communities at high risk for TB about TB prevention and control strategies. To determine needs for training and education, TB partnerships should monitor the level of knowledge of TB among high-risk groups, their health care providers, policymakers, and other members of the community who provide services to TB patients, such as CBOs, immigration and refugee organizations, social workers, substance abuse counselors, corrections or parole officers, mental health workers, and homeless shelter staff. TB partnerships should help ensure appropriate training and education at regular intervals for the staff of residential facilities or organizations that serve clients at high risk for TB disease. Prior-

ity for skill-based training should be given to the staff of facilities and organizations with the capacity and commitment to providing on-site, cost-effective TB prevention and control services to high-risk clients.

An important function of a partnership is designing and planning activities in high-risk communities; other work done by a partnership should stimulate interest in, and support for, these activities. Successful activities will help a partnership reach its goal (e.g., improved completion of therapy, good participation in contact investigations) and will promote a healthy level of enthusiasm and support among partnership members and community residents.

Planning such activities requires an immediate goal and well-defined objectives, a good estimate of costs, a proven method or strategy (e.g., a referral system for providing DOT), and a list of action steps with an expected date of completion and responsibility assigned for each step. Residents of high-risk communities should be involved directly throughout planning to help ensure that activities are culturally appropriate and responsive to community needs, values, and concerns. TB program and lung association staff should provide technical support and concrete assistance to partnership members; they should also advise the partnership of the potential impact (e.g., in terms of cases prevented or percentage increase in the completion-of-therapy rate) and the priority of proposed activities.

Once a partnership has set its agenda and planned its activities, members should inventory the resources available and assess unmet needs. These needs might include funds, materials, facilities, additional staff or volunteers, and authorization (i.e., a clear mandate to carry out the activity). When needs have been catalogued, the partnership should develop a plan to solicit and secure them. (See Resource Acquisition, p. 33.) It is important to include a specific plan and resources for evaluation from the start; this is a vital component of a well-planned community intervention.

Traditional approaches to expanding the reach, or impact, of TB prevention and control activities have focused on persons at risk for TB disease. Though much has been accomplished in this way, TB partnerships can expand on these efforts and focus on the community level. By focusing on and encouraging community participation, TB partnerships can begin to address the social conditions that contribute to TB morbidity and poor completion-of-therapy rates (e.g., poor access to medical care, lack of knowledge about TB, social stigma attached to TB disease). In addition, community-level interventions can have a longer-term effect than activities directed at the individual, because community residents can share knowledge with others and can reinforce key messages to

high-risk persons. A community approach is the approach best suited to a partnership's activities because it seeks to involve a wide range of local health professionals, health institutions, community groups, and private citizens in a collective attack on TB and the conditions that encourage TB transmission.

The following are among the more substantive arguments for the community's participation in TB prevention and control efforts.

- Access: Most government, and many agency-directed or agency-supported, programs reach only a limited number of people. Partnerships that encourage community participation can involve a greater percentage of the population at risk. Community participation in service delivery planning can extend coverage even further, especially to those in greatest need (i.e., persons at high risk for TB). Community participation will increase the number of potential beneficiaries of services and may attract more public support.

- Efficiency: By coordinating the efforts of a greater number of service points and building on existing contacts in the community, TB partnerships can attain a greater economy of resources, activities, and efforts. This should help prevent the loss of patients to follow-up and improve completion of therapy rates.

- Effectiveness: After there is agreement about priority areas for service provision, the partnership members interested specifically in the relevant areas can pool efforts to determine plans and strategies for action.

- Equity: By participating in community-based efforts, community members can promote equity through sharing responsibility, building solidarity, directing services toward those with the greatest need and at the greatest risk, and seeking to promote better health for community residents who have not had access to the necessary resources and services.

- Self-Reliance: Partnerships that encourage community participation can promote self-awareness and cause residents to examine their problems and to think positively about solutions. Participation at the community level increases people's sense of control over issues affecting their lives and helps them to learn how to respond to health problems in collaboration with their peers.

Partnerships can use community participation to promote TB prevention and control activities if three guiding principles are observed (6).

1. The partnership must develop a clear definition of the community of interest. This process of definition is a necessary step in determining where community members are and how to reach and include them. In general, a community is a system of people with common values and institutions who identify themselves as part of that common system.

2. The partnership must use existing community structures or help build new linkages to reach and include community members. This is based on the need for community members and organizations to define the problems, propose solutions, and make the changes happen, using methods with which they are familiar. The extent to which the partnership enlists help and mobilizes local networks in what they come to see as **their** interests will determine access to resources, enthusiasm, and accepted ways of getting things done. This sense of ownership will minimize resistance to change and speed its diffusion.

3. The partnership's direct involvement at the community level must not be controlling or dictatorial. To be successful in encouraging community participation, a partnership must promote autonomy and provide only a certain level of regular communication and monitoring. This will be possible if, from the beginning, the partnership involves and trains community members and local service providers in such a way that they will be responsible for continuing TB prevention and control activities in the community, evaluating successes or failures, and adjusting for changes in conditions. TB partnerships can be a catalyst, educator, and resource; the community must be responsible for the day-to-day work required for ongoing TB prevention and control activities.

The success of a community participation model hinges on the quality of the community representatives involved (either as paid staff or as volunteers) in local activities and service delivery. These people are the front-line interventionists: making community contacts, providing education and advocacy, implementing strategies, and instilling neighborhood trust in the program. They play multiple roles as educators, counselors, and support group leaders. Given the significance of the roles of these community liaisons, TB partnerships must give careful thought to the recruitment of members and encourage TB service providers to do the same for their own staffing.

TB partnerships should recognize and embrace the many advantages to including persons who belong to high-risk populations in the planning and implementation of TB prevention and control activities:

- ensuring the cultural sensitivity of presentations and educational materials
- facilitating rapport with high-risk group members
- enhancing program legitimacy among high-risk group members
- translating technical information into readily understood concepts
- increasing high-risk group members' concern about TB by appealing to common frames of reference
- selecting TB prevention and control strategies based on a better understanding of shared norms, values, and perspectives
- gaining access to the community grapevine to monitor the adoption and maintenance of TB prevention and control measures
- improving follow-up capabilities for reinforcing desired behaviors (e.g., completion of TB treatment or preventive therapy) as a result of their knowledge and relationship with other social network members (7).

(See example of this approach on p. 43.)

In the long term, participatory efforts such as community-based DOT and screening of high-risk groups will help increase the impact of TB prevention and control activities. A considerable additional investment of time and money in the training, monitoring, and evaluation of outreach activities can therefore be justified. By encouraging such community participation, TB partnerships can more efficiently and more effectively reach high-risk groups and include them in TB prevention and control activities.

The Planned Approach to Community Health (PATCH) is a flexible process that can be used when a community wants to identify and address priority health problems such as TB. Based on the PRECEDE (predisposing, reinforcing, and enabling constructs in education and environmental diagnosis and evaluation) model (8), PATCH has been adapted by more than 500 diverse communities to address various health problems by encouraging partnerships within and beyond the community. The goal of PATCH is to increase the capacity of communities to plan, implement, and evaluate comprehensive, community-based health promotion activities directed toward high-priority health problems. PATCH is carried out in five phases:

1. Mobilizing the community
2. Collecting and organizing data
3. Choosing health priorities

Example

Heart, Body, and Soul Outreach in Baltimore

In Baltimore, a partnership between public health professionals and community leaders was recently awarded a grant from the Robert Wood Johnson Foundation to expand a system for neighborhood-based TB screening and prevention. As part of the program, a CBO called Heart, Body, and Soul recruits community outreach workers through churches in the neighborhood. These neighborhood residents are trained and supervised by local nurses and physicians to provide TB education, screening, and medical referrals for members of the community. During the training, outreach workers learn about high-risk groups in their own communities and the appropriate use of TB prevention and control activities. The community outreach workers also learn about adherence strategies so that they can encourage completion of preventive therapy and help provide DOPT to community residents.

This project, which started out with just four full-time outreach workers to provide TB screening and education, is being used as a model to encourage further community participation and expand efforts in other neighborhoods of the city of Baltimore. One important aspect of this project is that the nurse coordinators who train and supervise the neighborhood workers will also serve as liaisons with the Maryland Division of Corrections, several drug treatment centers, and the Baltimore City Health Department. The goal of this component is to ensure that patients adhere to preventive therapy as they go from these institutions into the community.

4. Developing a comprehensive intervention plan
5. Evaluating PATCH

CDC promotes the use of PATCH in helping achieve the year 2000 national health objectives (9). A resource guide called *PATCH: A Guide for Local Coordinators* contains concept guides, meeting guides, assessment tools, and other materials designed to assist PATCH implementation at the local level. For additional information on PATCH, contact

Community Health Promotion Branch
National Center for Chronic Disease Prevention and Health Promotion
Mailstop K-46
Centers for Disease Control and Prevention
Atlanta, GA 30333
Phone: (770) 488-5426
Fax: (770) 488-5964

Conclusion

Although *Forging Partnerships to Eliminate Tuberculosis* is meant to provide a framework for collaborative efforts, it is not a cookbook of specific steps. Organizations are unique, and solutions must be found on the local level. Forging successful partnerships requires a firm commitment to the goal of TB prevention and control, a strong faith that collaborative effort will help reach goals and objectives, and an enormous amount of elbow grease and patience.

Remember that the partnership's primary goal is to reach its high-risk populations with appropriate and effective activities designed to halt TB transmission and eventually eliminate TB. People will buy into the idea of TB prevention and control and participate more fully if they recognize how TB affects their communities and if they become involved in planning activities and evaluating progress. By working in partnerships, people with a stake in the prevention and control of TB can foster support and participation in activities, find new resources, and help develop community-building skills.

Finally, a partnership should never be too narrowly focused. A successful partnership can build on its efforts to encompass a wide variety of public health problems. It may even be advisable to address other priority problems of a specific high-risk population and use them to promote interest in TB prevention and control activities. For example, if migrant workers want better dental health, why not build a partnership with dental health providers and promote oral health care concurrently with TB prevention efforts? Such a partnership could give a toothbrush as an incentive to participate in tuberculin skin-test screening or a free dental checkup to complete therapy.

However, never forget that it is crucial to have a clear goal and focus. Support for TB prevention and control should be based on the mutual recognition that TB is a legitimate and high-priority health problem. By promoting visibility, fostering support among community groups, and sustaining good relations with all its members and patrons, a TB partnership can gain the momentum necessary for the overall TB elimination effort. By evaluating program performance and the effectiveness of activities as they are carried out, partnerships will stay on track and ensure that support is maintained. Although the needs and objectives of TB partnerships will differ considerably according to the specific problems of each community, the framework we present in *Forging Partnerships to Eliminate Tuberculosis* should be applicable almost anywhere.

Endnotes

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Appendices

Appendix A

Glossary

advisory committee a partnership that brings together a group of experts to advise a specific organization, such as a TB prevention and control program. An advisory committee uses the combined knowledge and skills of its members to review, plan, and evaluate the program's strategies, activities, and impact. Such TB advisory committees should include representatives of health care providers serving high-risk communities.

coalition the most complex type of partnership. It is used to coordinate long-term efforts through joint planning, common objectives, and collaborative action. A formal coalition requires sustainable effort from its members. Tight links between members are needed to set an agenda, solicit funding, implement activities, and evaluate progress jointly.

community in general, a system of people with common values and institutions who identify themselves as part of that common system.

community-based organization (CBO) an organization that is located in a specific community and provides services to, and is managed and directed by, members of that community.

concept paper a brief document written in preparation for the final funding request when seeking funds or other resources from foundations or corporations; this document describes the needs an activity is to address, who is to carry out the activity, what is to be accomplished and its potential impact on the overall problem, the methods to be used, how long it will take, how much it will cost, how the accomplishments will be measured, and ways in which the proposal relates to the mission of the funding source.

directed marketing a marketing approach based upon the decision to distinguish the groups that make up a market and to develop appropriate services and marketing mixes for each specific market segment.

high-risk persons persons at high risk of being exposed to and infected with *M. tuberculosis* (e.g., close contacts; foreign-born persons from high-prevalence areas; the elderly; medically underserved, low-income populations; migrant farm workers; homeless persons; inmates and other residents of long-term facilities; persons who inject drugs) or who are at a particularly high risk for the development of TB disease once infected (e.g., persons with HIV infection, persons recently infected with *M. tuberculosis*,

persons with certain medical conditions, persons who inject drugs, persons with a history of inadequately treated TB).

image the sum of beliefs, ideas, and impressions about the organization held by a particular person or group of persons.

mass marketing a marketing approach that offers only one level of services and attempts to satisfy everyone with those services.

network an informal, loosely associated partnership that unites people or groups with similar interests. Its purpose is usually limited to communication and information sharing between and among its members.

partnership in this document, partnerships forged with high-risk groups, their health care providers, the medical community, and the public that can bring people together to work toward a common goal: TB prevention and control.

patron any group that has an actual or a potential interest in, or impact on, an organization: people who fund or support an organization (e.g., taxpayers, foundations, corporations), people who make up an organization (e.g., the board of health, lung association staff) or people to whom an organization provides services (e.g., patients, high-risk communities).

task force a partnership often used to coordinate an intense, short-term effort that requires input from many diverse groups. Its goal is to complete a specific, well-defined task in a limited time.

Appendix B

Resources

✆ Indicates a publication that can be ordered through the voice information system at 1-888-232-3228

General

✆ American Thoracic Society and CDC. Control of tuberculosis. *Am Rev Respir Dis* 1992;146:1623 – 33.

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Coalition Building

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World Health Organization. *WHO report on the tuberculosis epidemic, 1995.* Geneva: WHO TB Programme, 1995.

Resource Acquisition

Annual register of grant support. Wilmette, IL: National Register Publishing Co. Annual.

Describes government and private programs by fields of interest, giving purpose, types of awards, eligibility requirements, financial data, application and deadline information.

Catalog of federal domestic assistance. Washington, DC: US Government Printing Office. Annual and update vol., loose-leaf.

Describes federal programs that provide funds or nonfinancial assistance to state and local governments, public agencies, organizations, institutions, and individuals. Includes purpose, types of awards, restrictions, eligibility requirements, financial information, application and award procedures, and related programs. Also available in the database Federal Assistance Program Retrieval System (FAPRS).

Directory of research grants. Phoenix, AZ: Oryx Press. Annual.

Provides information about grant, contract, and fellowship support programs available from federal and state governments, private foundations, associations, and corporations for research, training, and "innovative efforts."

Federal register. Washington, DC: US Government Printing Office. Daily.

Daily updates of material on federal domestic assistance.

Foundation Center national data book. New York: Foundation Center Annual, 2 vols. (telephone [800] 424-9836).

Lists more than 24,000 private and community foundations, including thousands of smaller ones not described in other sources. These smaller foundations are especially important as local sources of funding. Overall arrangement is by state, with foundations listed from largest to smallest in terms of grants awarded.

Foundation directory. New York: Foundation Center. Biennial.

Lists more than 4,400 large American foundations, arranged by state. Each entry includes factual and financial data, purpose and activities, and grant application procedures. Available on-line through Dialog.

Foundation grants index. New York: Foundation Center. Annual.

Lists more than 34,000 grants awarded by approximately 460 foundations within the previous year or two. A selective listing, useful for developing an initial list of potential funding sources based on the foundation's actual grants; arranged by state, with foundations listed alphabetically.

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Profiles 1,551 companies that contribute to nonprofit corporate foundations and companies that have direct giving programs. Alphabetically arranged by company name with a general description of the company and its activities and a description of the company's direct giving program or foundation for each entry.

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Appendix C

Charter, Advisory Council for the Elimination of Tuberculosis

Purpose

The Secretary, the Assistant Secretary for Health, and by delegation the Director, Centers for Disease Control and Prevention, are authorized under Sections 301 and 311 of the Public Health Service Act, as amended, 42 U.S.C. 241 and 42 U.S.C. 243, to: (1) conduct, encourage, cooperate with, and assist other appropriate public authorities, scientific institutions, and scientists in the conduct of research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases, and other impairments; and (2) assist States and their political subdivisions in preventing and suppressing communicable diseases and other preventable conditions and in promoting health and well being.

Authority

42 U.S.C. 247b(1). The Council is governed by the provisions of Public Law 92-463, as amended, (5 U.S.C. App. 2), which sets forth standards for the formation and use of advisory committees.

Function

The Advisory Council for the Elimination of Tuberculosis shall provide advice and recommendations regarding the elimination of tuberculosis to the Secretary, the Assistant Secretary for Health, and the Director, Centers for Disease Control and Prevention. The Council shall make recommendations regarding policies, strategies, objectives, and priorities; address the development and application of new technologies; and review the extent to which progress has been made toward eliminating tuberculosis.

Structure

The Council shall consist of ten members including the Chair. Members and the Chair shall be selected by the Secretary from authorities knowledgeable in the fields of public health, epidemiology, immunology, infectious diseases, pulmonary disease, pediatrics, tuberculosis, and microbiology. The Council shall also consist of nine voting ex officio members representing: the Department of Defense; Department of Veterans Affairs; Agency for Health Care Policy and Research; Food and Drug Administration; Health Resources and Services Administration; Indian Health Service; National Institutes of Health; Office of Minority Health, Office of the Assistant Secretary for Health; Substance Abuse and Mental Health Services Administration; and such additional officials of the U.S. Government as the Secretary deems necessary for the Council to effectively carry out its function. The Council shall also include non-voting liaison representatives from the American College of Chest Physicians, the American Lung Association, the American Medical Association, and the American Thoracic Society, and such other representatives from organizations with interests in the prevention and control of tuberculosis as the Secretary deems necessary to carry out the function of the Council.

Members shall be invited to serve for overlapping four-year terms; terms of more than two years are contingent upon the renewal of the Council by appropriate action prior to its termination. Members shall serve after the expiration of their terms until their successors have taken office.

Management and support services shall be provided by the Office of the director, National Center for Prevention Services, Centers for Disease Control and Prevention.

Meetings

Meetings shall be held approximately three times a year at the call of the Chair with the advance approval of a Government official, who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings shall be open to the public except as determined otherwise by the Secretary; notice of all meetings shall be given to the public.

Meetings shall be conducted, records of the proceedings kept, as required by applicable laws and Departmental regulations.

Compensation

Members who are not full-time Federal employees shall be paid at the rate of $188 per day, plus per diem and travel expenses in accordance with Standard Government Travel Regulations.

Annual Cost Estimate

Estimated annual cost for operating the Council, including compensation and travel expenses for members but excluding staff support, is $40,393. Estimate of annual person-years of staff support required is .40, at an estimated annual cost of $31,797.

Reports

An annual report shall be submitted to the Secretary through the Assistant Secretary for Health and the Director, Centers for Disease Control and Prevention, not later than November 15 of each year, which shall contain as a minimum a list of members and their business addresses, the Council's functions, dates and places of meetings, and a summary of Council activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee management officer.

Termination Date

Unless renewed by appropriate action prior to its termination, the Advisory Council for the Elimination of Tuberculosis will terminate on March 15, 1995. [This charter has been renewed.]

Signed by Donna E. Shalala
Secretary
U.S. Department of Health and Human Services
March 26, 1993

Appendix C

National Coalition to Eliminate Tuberculosis

Member Organizations

Action Council

AIDS Action Council

AIDS Coalition to Unleash Power

AIDS/SidAlerte Internationale

American Academy of Family Physicians

American Academy of Pediatrics

American Association for Continuity of Care

American Association for Respiratory Care

American Association for World Health

American College of Chest Physicians

American College of International Physicians

American College of Physicians

American College of Preventive Medicine

American Correctional Health Services Association

American Federation of State, County, and Municipal Employees

American Federation of Teachers

American Geriatrics Society

American Health Care Association

American Hospital Association

American Jail Association

American Lung Association

American Medical Association

American Nurses Association

American Public Health Association

American Society for Microbiology

American Society of Law, Medicine and Ethics

American Thoracic Society

Asian American Health Forum

Association for Professionals in Infection Control and Epidemiology

Association of Asian Pacific Community Health Organizations

Association of Community Health Nursing Educators

Association of State and Territorial Directors of Nursing

Association of State and Territorial Health Officials

Centers for Disease Control and Prevention

Clark Foundation

College of American Pathologists

Congress of National Black Churches

Department of Defense

Department of Veterans Affairs

Drug Strategies

1199 National Health and Human Service Employees Union

Food and Drug Administration

Health Care Finance Administration

Health Care for the Homeless Clinicians' Network

Health Resources & Services Administration

Indian Health Service

Infectious Diseases Society of America

Migrant Clinicians Network

National Association of Community Health Centers, Inc.

National Association of County Health Officials

National Association of Hispanic Nurses

National Black Nurses Association

National Coalition for the Homeless

National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)

National Commission on Correctional Health Care

National Council of La Raza

National Foundation for Infectious Diseases

National Health Care for the Homeless Council

National Heart, Lung, and Blood Institute

National Institute of Allergy and Infectious Diseases

National Institute of Nursing Research
National Leadership Coalition on AIDS
National Migrant Resource Program
National Minority AIDS Council
National Public Health Information Coalition
National Rural Health Association
National Tuberculosis Controllers Association
National Tuberous Sclerosis Association, Inc.
National Urban League
National Women & HIV/AIDS Project
National Women's Health Network
New York Academy of Medicine
New York City Department of Health
Nursing Organization Liaison Forum
Office of Minority Health
Pan American Health Association/World Health Association
Pharmaceutical Manufacturers Association
Service Employees International Union, AFL-CIO
SidAlerte Internationale
Society for Hospital Epidemiology of America
Substance Abuse and Mental Health Services Administration
TB/AIDS Citizen Action Project
UMDNJ New Jersey Medical School
US Agency for International Development
Visiting Nurse Service of New York
Wasatch Homeless Health Care Program

Appendix C

Missouri Advisory Committee for the Elimination of Tuberculosis

Mission

- The Missouri Advisory Committee for the Elimination of Tuberculosis (MACET) strives to eliminate TB though education and advocacy as well as by formulating and recommending policies and procedures to ensure effective TB prevention and control.

Goals

- By the year 2000, no more than 175 new TB cases per year in Missouri.
- To eliminate (one case per million population) TB in Missouri by the year 2010.

Background

- MACET represents the American Lung Associations of Eastern and Western Missouri and was officially organized in 1988.
- In 1989, with the active participation and support of the state's Bureau of TB Control, MACET developed and recommended the implementation of the Strategic Plan for the Elimination of Tuberculosis from Missouri. It was modeled after the CDC's national plan.
- MACET and the Bureau of TB Control developed joint goals for the elimination of TB in Missouri.

Membership

- Executive and program directors of the American Lung Associations of Missouri
- TB controllers and program managers for metropolitan areas
- Laboratory manager and hospital administrator
- Medical staff from hospitals, private practice, and local health departments

- Director of drug treatment center
- Minority health group
- Representatives of state and local government agencies (Corrections, Social Services, and Mental Health)

Operation

- Quarterly meetings held in a central location (Columbia, Missouri)
- Meetings chaired by a medical expert; agendas prepared by MACET leadership, the Bureau of TB Control, and committee members

Accomplishments

- Strategic Plan for the Elimination of Tuberculosis from Missouri
- Annual reports outlining progress toward TB elimination
- Adoption of new rules and regulations formulated by the Bureau of TB Control
- Adoption of the use of a four-drug initial regimen for the treatment of TB in Missouri
- Annual program assessments for local health departments
- Reviewed, modified, and adopted screening and treatment procedures for the Department of Corrections
- Surveyed hospital laboratories on type of services provided
- Issued statement on the use of Mantoux testing as the method of choice in TB screening
- Provided technical assistance to the Bureau of TB Control, local health departments, and the medical community
- Assisted in organizing educational conferences and in-service training on TB
- Recognized by state and local elected officials for commitment to the elimination of TB

Partnership Inventory Worksheet

Potential Partners	Roles								
	Advocacy & Resource Acquisition	Medical or Technical Consultation	Funding	Service Provision	Marketing & Media Relations	Education	Outreach Services	Coordination	Training