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WHO Ministerial meeting in Berlin in 2007

This meeting aimed to:

- Ensure the support of the Member States for the monitoring and follow-up of the Berlin Declaration on Tuberculosis, adopted at the WHO European Ministerial Forum on Tuberculosis in Berlin on 22 October 2007
- Ensure proper visibility on the fight against TB at a policy level
- Present European plans to fight TB
- Increase awareness of high policy administrators in European countries on TB control and elimination.

The TB Europe Coalition is an informal group of European CSOs that, since 2008, has initiated action to raise the profile of global TB within EU institutions. It agreed this meeting would be a good opportunity to:

- Network with policy-makers and other stakeholders across Europe (particularly from East European countries)
- Get CSO visibility
- Help advance lobbying with MEPs to include TB in the European Union (EU) agenda and EC budgetary process.

A CSO statement was prepared and circulated at the meeting to help disseminate its advocacy messages. It urged Ministers of the European Region to raise the standards of care and response to fight TB at national level. It called for special efforts to address MDR/XDR-TB and better integrate TB and HIV/AIDS interventions.

Referring to the recent World Health Assembly Resolution 62.15 on MDR-TB, the statement further called for "countries to develop country indicators and to support monitoring and evaluation of the implementation of the measures outlined in this resolution".

It also asked EU donor countries to support the development of and ensure access to new and more effective tools – drugs, diagnostics and vaccines – for TB control and meet the pledges made in Berlin vis-à-vis sustainable financing by supporting global and regional plans to stop TB 2006–2015.

Finally, the statement reiterated the offer of partnership from civil society to the Ministers of the European Region, presented at the WHO Ministerial meeting in Berlin in 2007. It included specific asks to strengthen CSO engagement in national responses.

Immediate outcomes

The key messages of the CSO statement were echoed in the presentations of different participants during the meeting, including Louise Baker from the Stop TB Partnership.

As a result, there was clear reference to CSOs' requests for:

- the establishment of a mechanism or platform for civil society, NGOs and professional groups' involvement in TB control across the region (similar to the inter-service group on HIV/AIDS, coordinated by EC-SANCO)
- the review of GFATM eligibility criteria for middle-income countries; and
- the EC to explore alternative support to MDR-TB high-burden countries within the WHO/EURO region likely to lose eligibility for GFATM funds.

Civil Society Organizations Statement

At the Meeting on Tuberculosis under the High Patronage of H.R.H the Grand Duchess of Luxembourg, Organized by the European Commission, WHO EURO and European Centre for Disease Prevention and Control (ECDC)

June 30th – July 1st 2009.

Members of European Civil Society Organizations attending the Meeting on Tuberculosis issue this statement calling for the urgent attention of States of the EU Region to call to the facts that:

- **Although TB mortality rates have decreased or remained stable over recent years**, TB - a curable disease - kills nearly two million people per year worldwide, with around 65000 deaths per year in the WHO European Region, so 7 deaths every hour.
- **Despite the decline of TB incidence in the EU, in 2007, a total of 431 518 new cases were registered** in the 53 countries of the WHO European Region. Specifically, in the EU and EEA/EFTA countries substantial increases were observed in Malta and Iceland, and Ireland, Greece, United Kingdom and Sweden saw an increase in new cases.
- **Multi Drug Resistant and extensively drug resistant TB (M/XDR-TB) is on the rise and receiving inadequate or inappropriate responses**. It is alarming that in 2007 within the WHO European region, **some 10% (43,600 cases) of the new TB cases and 43% of re-treated cases were estimated to be MDR-TB cases and 42 300 HIV co-infections were estimated among the new TB cases**. Out of the 27 member states considered with high MDR TB burden, 15 are from Europe and 5 are from EU.
- **Meaningful civil society participation in policy and program development and implementation remains weak**. The contributions and perspectives of civil society in TB prevention and control remains relatively absent in policy and programmes, advocacy and decision making processes.
- **Financial resources and commitments for the TB global response remain insufficient**. The most recent data available on resources allocated to TB programmes ($3 billion in 2009) and research ($483 million in 2007) are insufficient compared to the $5 billion needed for programs in 2009 and the $2 billion for research in 2007. At these funding levels the targets set by The Global Plan to Stop TB (2006-2015) will not be realized by 2015. EU countries and national governments must invest in new diagnostics, vaccines and treatments.

In light of the current state of affairs, we urge Ministers of the European Region to:

- **Raise the standards of care and response to fight TB at national level**. Provide technical assistance to Ministries of Health and CSO engaged in fighting TB at national level, in order to help them restructure their health system to ensure that they can adequately respond to the epidemic by providing comprehensive care and support.
- **Re-emergence of the disease fuelled by the HIV epidemic and the development of MDR TB require renewed efforts** in both control programmes and activities to ensure early diagnoses, availability of appropriate therapy, and completion of treatments. Referring to the recent World Health Assembly Resolution 62.15, we call for “countries to develop country indicators and to support monitoring and evaluation of the implementation of the measures outlined in this resolution”.
- **Special efforts to better integrate TB and HIV/AIDS control plans and implementation programs is needed**.

- **Support the development of and ensure access to new and more effective tools for TB control**, including diagnostic tools that can be used at the point-of-care, treatment regimens that are proven to be effective in children and compatible with HIV medications and new vaccines that will protect against all forms of TB and will be safe for people with HIV.
- National TB programmes to clearly outline the r**ole of civil society in TB control efforts in national plans**. National TB programmes to partner with civil society organizations to actively find TB cases among vulnerable communities.
- Make community based treatment and support, including for MDR TB, and active TB case finding key components of an effective TB response, in order to ensure that all TB patients, including **the most marginalized groups, e.g. migrants and drug users, are able to receive treatment that respects their human rights and ensures treatment success, according to the principles outlined in** *The Patients' Charter for Tuberculosis Care*.
- **Meet the commitments made in Berlin in 2007 vis-à-vis securing sustainable financing by supporting the Global and Regional Plans to Stop TB 2006-2015** and addressing the funding gap between the total resources available and the resources needed to control TB.

We reiterate the offer of partnership from Civil Society to the Ministers of the European Region, presented on 22nd October 2007, at the WHO Ministerial Forum. Now that two years have passed, we strongly urge the European Commission to support civil society involvement in TB national response and strategy by:

- **Urgently creating a European Think Tank co-ordinated by DG SANCO**, with the mandate to relate to TB in the EU and neighbouring countries: exchanging information and contributing to a coordinated approach to combat TB, focusing on the European Union and the neighbouring countries; to facilitate informal consultation between the Commission, the Member States, the Candidate Countries and the EEA Countries.
- This should include **funding and promoting a civil society platform within the WHO Europe region** to facilitate stronger collaboration among civil society organisations, recognising their essential role as partners in national and regional TB control programmes. This process should be initiated as soon as possible, with the aim of a functioning platform by the end of 2009.
- Ensuring that countries within the European region are not adversely affected by the next Global Fund eligibility criteria review. The European Commission and European states should develop together a strategy to **safeguard and sustain successful programs that protect the most vulnerable groups** in European high burden countries and encourages meaningful civil society participation.

↘ Source: Eurosurveillance

Resources / Section 2

Useful links

- The Revised Global Plan to Stop TB: www.stoptb.org/global/plan
- MDR-TB: www.who.int/tb/challenges/mdr/en
- Links with HIV/AIDS: www.advocacypartnership.org/userfiles/files/TB%20and%20HIV-AIDS.pdf
- New TB diagnostic test: www.who.int/tb/features_archive/new_rapid_test/en
- TB and stigma: www.aidsalliance.org/includes/Publication/TB_and_Stigma_May09.pdf

UK Coalition to Stop TB: TB/HIV Working Group Action Plan 2010

Appendix C: TB/HIV and MDR-TB Working Group Action Plan 2010

Members of the Group:

1. (Vacant possible) International AIDS Alliance
2. Alison Grant, London School of Hygiene and Tropical Medicine
3. Denise O'Sullivan, London School of Hygiene and Tropical Medicine
4. Gerri McHugh, Society of Tropical Medicine and Hygiene
5. José Julio Divino, Ely Lilly
6. Louise Holly, RESULTS UK
7. Luciana Brondi, London School of Hygiene and Tropical Medicine
8. Keith Alcorn, NAM
9. Nikki Jeffery, Target TB
10. Pamela Hepple, Médecins Sans Frontières
11. Philipp du Cros, Médecins Sans Frontières
12. Renato Pinto, TB Alert
13. Toby Capstick, UK Clinical Pharmacy Association

Overall Goal:

The TB/HIV and Working Group is aimed at influencing the HIV/AIDS community based in the UK and globally to integrate TB more systematically and effectively into their HIV/AIDS interventions (e.g. in terms of programme and advocacy work).

Objectives:

1. Increase awareness about HIV/TB co-infection issues among civil society organisations, decision-makers, health professionals and community groups, through gathering and dissemination of relevant information and encouraging dialogue among policy-makers, NGOs and other stakeholders.
2. Build the capacity of UK-based HIV/AIDS and health-oriented organisations to address TB/HIV and MDR-TB, in terms of programming and advocacy work.
3. Increase collaboration among TB, HIV/AIDS and health-oriented organisations around HIV/TB issues.

See table on pp. 92 – 93.

Photo courtesy of RESULTS UK

↘ Photo: **Members of the UK parliamentary delegation meet with Indian MPs during a visit to TB programmes in India. Together they sign the Call to Stop TB.**

Objective	Description of activities	Responsible party	Timeframe	Resources needed	Means of verification
1. Raise awareness about HIV/TB co-infection issues in the UK and abroad: identify the needs of UK-based HIV/AIDS and health organizations in terms of TB/HIV co-infection issues (knowledge, programme development within a broader Health Systems Strengthening themes	1.1 Mapping of UK-based HIV/AIDS and health-related organizations working or not on TB/HIV co-infection, main policies, guidelines and best practices on (through electronic search, liaising with BAS on ongoing audit, Stop TB, etc.)	Renato to update the document	March 2010	No costs. Working time	Mapping of TB/ HIV material report done. All to utilize the documents for Policy and lobbying activities
	1.2 Develop calendar of events in the UK and abroad addressing TB/HIV co-infection issues	Belinda	8th Feb 2010	No costs. Working time	Calendar developed upload an updated version 2010
	1.3 Distribute copies of global and national policy and guidelines mapping to UK Coalition members and relevant organizations.	Renato/ Aparna/Keith	Ongoing work	No costs. Working time.	Mapping developed and distributed. Upload on coalition website
	1.4 All working group members to ensure that TB is adequately integrated into AIDS Consortium working groups	TB/HIV working members to join different AIDS Consortium WGs	First quarter of 2010	Membership staff time	As many as possible TB/ HIV working group members to join different consortium working groups
	1.5 Ensure TB information is incorporated in HIV information, education and communication materials vice versa; by regular update through AIDS Consortium working groups	By TB/HIV WG			
	1.6 Support campaign working group to disseminate TB/HIV & messages to decision-makers and public through media and Campaign strategy	All members + media and campaign group members	On-going	No costs. Working time	Reflection of TB/ HIV issues through Campaign strategy

Objective	Description of activities	Responsible party	Timeframe	Resources needed	Means of verification
2. Build the capacity of HIV/AIDS and health-oriented organizations on TB/HIV and MDR-TB	2.1 TB/HIV working group to organize a follow up meeting with AIDS consortium to strategize on best ways to utilize HIV/TB workshop recommendations	Belinda to organize	Feb/March 2010	No cost associated, staff time	Hold a meeting and reach a joint agreement on joint collaboration on TB/HIV within AIDS Consortium
	2.2 Help develop guidelines on TB/HIV collaborative activities for joint applications to the GFTAM	Optional, each Individual organizations to decide on how to proceed with this	As appropriate	No cost associated	Individual organisation to update WG on any developments during WG meetings
3. Increase collaboration among TB, HIV/AIDS and health-oriented organizations around HIV/TB issues.	3.1 Organise joint activities for World AIDS Day 2010: TB/HIV identified as key theme	All members + media group	ongoing work	Organizational budget	TB/HIV materials featured in WAD events and publication
	3.2 Joint APPG AIDS and TB meeting around World AIDS day 2010	APPG TB Coordinator		Organizational budget	Joint event with APPG AIDS and TB
	3.3 Participate in UK Consortium on AIDS and Stop AIDS campaign activities	All members	Pre-Post Election	No cost	

Clarifications on CCM Minimum Requirements, 2005

↘ www.theglobalfund.org/documents/ccm/Clarifications_CCM_Requirements_en.pdf

Differentiating various types of advocacy by their immediate audiences

Type	Immediate Audience	Tactics	Champions	Examples
Indirect				
Research advocacy	Opinion leaders	Politically relevant research Budget & policy analysis Opinion polls	Jeffrey Sachs	Commission on Macroeconomics of Health Global Plan to Stop TB
Coalition advocacy	Multipliers (i.e. bringing new partners or networks into the coalition)	Conventions & partner forums Web-based dissemination Newsletters Sign-on letters		Global Health Council Stop TB Partnership Roll Back Malaria Partnership
Mass advocacy	Sustainers (fundamentally changing social opinions and priorities on an issue)	Internet activism Petitions Mass events Celebrities Electoral processes Cause-related marketing Popular media	Bono Youssou N'Dour Chaka Chaka Rahman	ONE Campaign Make Poverty History
Direct				
Bureaucratic advocacy	Policy enablers	Communiqués Declarations & pledges Targets	Mario Raviglionie Jorge Sampaio Stephen Lewis	United Nations General Assembly Special Session on HIV/AIDS World Health Assembly
Protest advocacy	Political protesters	Marches and demonstrations Boycotts Civil disobedience	Zackie Achmat	ACT-UP TAC
Legal advocacy	Courts	Class action suits & litigation		
Policy advocacy	Decision-makers	Parliamentary/Congressional delegations Editorial board meetings Committee hearings Direct correspondence (e.g. phone calls, letters, etc.) Individual meetings	Winstone Zulu Lucy Chesire Bono Members of Parliament/ Congress	ACTION Bread for the World Friends of the Global Fight

Taken from Best Practices for Advocacy. ACTION Project 2007.
↘ http://c1280432.cdn.cloudfiles.rackspacecloud.com/ACTION-Best-Practices-Guide.pdf

Resources / Section 5

Skill 1: Creating parliamentary champions

Links to documents produced by the APPG on Global TB

- 'APPG on Global TB annual report'.
  www.appg-tb.org.uk/documents/APPG_Annual_Report.pdf
- 'Turning UK TB Policy into Action: the view from the frontline'.
  www.appg-tb.org.uk/documents/RCN_APPG_BTS_report_final.pdf
- 'Scaling up the UK's response to the Global TB Epidemic: An Agenda for Action'.
  www.appg-tb.org.uk/documents/agendaforaction.pdf

Skill 4: Speaking powerfully

Links to media clips

- **Media clip 1:** Marlon Brand, Martin Luther King, Harvey Milk, Ronald Regan.
  www.advocacypartnership.org/userfiles/files/speaking_powerfully_media_clip_1.asf
- **Media clip 2:** Helen Diane Foster, Barak Obama, Stephen Lewis.
  www.advocacypartnership.org/userfiles/files/speaking_powerfully_media_clip_2.asf

Skill 9: Preparing a press release

Sample Press Release

Mary Robinson, Archbishop Desmond Tutu, and Professor Muhammad Yunus Call on Leaders of G8 Countries

WASHINGTON, DC (June 30, 2009) — In an open letter sent today to the leaders of all G8 countries, Desmond M. Tutu, Archbishop Emeritus of Cape Town; Mary Robinson, former president of Ireland; and Professor Muhammad Yunus, founder of Grameen Bank, called on G8 heads of state to renew their commitment to the world's children. The authors of the letter specifically asked the leaders to announce an agreement on the creation of a Global Fund for Education (GFE) at the G8 Summit, which will be held July 8–10 in L'Aquila, Italy.

The letter acknowledges the world's financial climate, but notes that world leaders must "provide the safety net of knowledge to the world's poorest children and save them from paying with their lives for our financial mistakes. Education must be an integral part of the global response to the economic crisis."

Worldwide, 75 million children are unable to attend school, 226 million adolescents are not enrolled in secondary school, and 770 million adults remain illiterate. In over 50 countries, many in sub-Saharan Africa, half of all children never complete primary school. Yet literacy is widely considered a prerequisite for economic development, and education the key to breaking inter-generational cycles of poverty. Despite this, global aid for basic education has been decreasing at an alarming rate.

The authors of the letter stressed the importance of U.S. leadership on this issue, citing President Barack Obama's campaign pledge to make $2 billion available for the launch of the GFE. "Such a bold and ambitious plan should be endorsed by other members of the G8 through a public commitment to such an initiative, which must be launched before the end of the year with full funding," the letter said.

Additional Resources:

- Global Fund for Education Backgrounder
  www.globalaidsalliance.org/page/-/PDFs/GCE_Global_Fund_Education.pdf
- Civil Society letter to President-elect Obama
  www.globalaidsalliance.org/page/-/PDFs/Education_for_All_CSO_Sign_On_Letter.pdf

Skill 10: Writing for the media

Sample OpEd

Old enemy, new challenge: The re-emergence of tuberculosis could reverse a decade of advances in the fight against HIV/Aids

Guardian newspaper, United Kingdom
Monday 9 June 2008 18.30 BST
By **Lucy Chesire**

No one should die from tuberculosis. It can be cured. Yet throughout Africa, TB is the leading killer of people living with HIV.

In the past 10 years, the global community has made tremendous progress in scaling up treatment programmes for

those living with HIV in communities and towns once regarded as too remote to support distribution of antiretroviral drugs.

Yet today that progress is being threatened. An old enemy – tuberculosis – has re-emerged with a vengeance that could reverse a decade of advances in the fight against HIV/Aids.

Across the globe, the deadly combination of HIV and TB – long thought of in Europe as a disease of the past – is fuelling a TB resurgence globally. There are 14 million people co-infected with TB-HIV in the world. In my own country, Kenya, TB is by far the greatest killer of people infected with HIV. Fifty percent of TB patients there are HIV positive.

Because of their compromised immune systems, people like me, living with HIV, are more likely to get TB, more susceptible to active infection and more likely to die unless we receive proper treatment. I spent seven months in a Kenyan hospital battling tuberculosis as it spread from my chest to my lymph nodes to my knees. Only with invasive surgery, antiretroviral therapy and pure chance did I become one of the lucky ones.

This week in New York, the UN general assembly's special session on HIV/Aids is bringing together world leaders and civil society to strengthen action on HIV/Aids.

But without a joint strategy to help the millions of people worldwide living with both TB and HIV receive the treatment and care they need, this cannot succeed.

Every TB patient needs to be screened for HIV, every person living with Aids needs to be tested for TB and there needs to be joint planning between national TB and HIV programmes.
And a strategy will do nothing to help the sick and the dying without strong commitments from rich governments to fund new approaches to TB/HIV co-infection. Furthermore it will not help those at risk unless we invest in new tools for TB prevention.

TB never really disappeared - it was just confined to the poor, the sick, the ignored. But over the last 15 years, the number of new TB cases has more than doubled in countries with the highest rates of HIV infection. The World Health Organisation estimates that globally, one-third of people living with HIV are also infected with TB.

In Kenya, activists and politicians have called for a declaration of a national disaster to confront the twin epidemics. In many African countries, the emergence of multi-drug resistant TB and extensively drug-resistant TB (XDR-TB) has brought a new urgency to treatment, as doctors grapple to save lives without adequate solutions. Reports of an XDR-TB case in Glasgow earlier this year raised the alarm in the United Kingdom – a wake-up call for all of us to think about TB.

The situation will continue to deteriorate unless we have new tools to fight TB. Though now widely available, the drugs we have were invented 40 years ago, must be taken daily for at least six months and, if compliance is not perfect, can continue to breed drug resistance.

The one existing TB vaccine was invented 85 years ago and offers only some protection against a small percentage of severe childhood cases. The frustrating truth is that we cannot accurately diagnose TB. The most commonly used TB diagnostic tool detects only half of new cases and cannot identify drug-resistant disease strains. In HIV-positive patients, it is even less accurate, detecting only 20% of TB infections.

We must maintain efforts to prevent and treat HIV. But we must also transform TB prevention,

diagnostics and treatment with new TB vaccines, new TB tests and new TB medicines. Researchers around the world are committed to this task.

Their success will require sustained support from donor governments. The UK has long been a leader in responding to the global TB epidemic. But much more is needed.

For too long TB has been ignored, simply because it targets the weak – whether those with HIV or the old, young or poor. Through vision, action, new technologies and increased funding, we must prove once and for all that what is good for the world's most vulnerable citizens is, in fact, good for us all.

guardian.co.uk © Guardian News and Media Limited 2010

Sample Letters to the Editor

The World Bank's shameful record

The Guardian, Tuesday 5 May, 2009

The recent report on the World Bank's health investments should be a cause for alarm - especially its shockingly poor performance in the Africa region (World Bank admits most health aid fails, 1 May). In this time of economic crisis, it is crucial that money is spent effectively. The evaluation of the World Bank shows that it has been championing approaches which have often failed to ensure accountability and results. Efforts at health sector reform were among the worst performing. By contrast, 89% of infectious disease programmes targeting diseases such as tuberculosis and malaria were deemed successful but received minimal funding.

With the deadline for the Millennium Development Goals approaching fast, we must ensure that efforts to improve the health of the world's poorest people are not going to waste.
Louise Holly
Deputy Director, Results UK

The Independent Evaluation Group has scrutinised the work of the World Bank in delivering healthcare for the poor over a decade, finding that in Africa 73% of the bank's health, nutrition and population projects failed.

Despite this abysmal performance, the UK government has recently awarded the bank an additional £2bn over three years. And yet, in contrast, the Global Fund to Fight Aids, TB and Malaria, which last month reported that it has saved an estimated 3.5 million lives, is facing a funding shortfall of between £2.7bn and £6.7bn over the next two years. In terms of accountability in Africa, 69% of Global Fund programmes performed at the highest ratings. Where grants were not performing, they have been stopped and reformed.

We are calling on the UK government to increase its funding to the Global Fund by £183.45m for 2009 and 2010 - paying its fair share according to donor income levels. If the World Bank wants to continue in health then it must demonstrate that it is able to commit to delivering results for the poor.

Malaria Consortium
The Stop Aids Campaign
UK Coalition to Stop TB
World Vision UK

Make TB history

The Guardian, Wednesday 24 March 2010

The World Health Organisation reports record levels of multidrug-resistant tuberculosis (Report, 19 March). We urge the UK government to take concerted action now. TB is a major killer, yet it is not being treated as a major priority. Not only is there a rise in TB cases globally, it is on the increase in the UK, with some of the highest rates in western Europe. Today, on World TB Day, the UK Coalition to Stop TB launches a new campaign TB: A disease of the past? Action now. Tuberculosis is not a disease of the past. It should be.

Aaron Oxley Results UK, **Julie Morgan MP** Co-chair, all-party parliamentary group on TB,
Dr Amina Jindani World Without Tuberculosis, **Mike Mandelbaum** TB Alert, **Nikki Jeffrey** Target TB

Urgent action needed to tackle TB

From The Times, March 23, 2009

Challenges ahead: tuberculosis is the single biggest killer of HIV patients worldwide

Sir, Remarks by the Pope (report, Mar 17) that condoms could make the global HIV epidemic worse reflect an attitude that will only serve to hinder progress made to combat this ruthless disease. However, there are greater challenges to HIV/Aids programmes than religious dogma. Tuberculosis is the single biggest killer of HIV patients worldwide, and in sub-Saharan Africa HIV has caused TB incidence to triple since the 1990s. Without proper treatment, it is estimated that 90 per cent of people living with HIV die within months of developing TB.

Data to be released by the World Health Organisation today, World TB Day, are expected to report levels of TB-HIV co-infection significantly higher than originally estimated. Evidence shows that prevention and care for patients are far more effective when TB-HIV services are combined, but sadly insufficient money and resources have been dedicated to developing integrated services. It is critical that this is scaled up as soon as possible; a failure to respond will result in thousands more preventable deaths each year. This, of course, will depend on the response of international donors in the face of the global financial crisis. Despite recent pledges from the US and renewed commitment from the UK, the Global Fund to Fight Aids, TB and Malaria and the Global Plan to Stop TB are still facing serious shortfalls in funding. Through the programmes they support, these institutions have made a real impact on the fight against communicable disease. A drop in funding threatens to halt or even reverse progress made.

With TB-HIV co-infection rates rising rapidly, as well as cases of drug-resistant TB emerging in many countries (including the UK), world leaders attending the forthcoming G20 meeting need to fulfil urgently the promises they have made to avoid potentially devastating effects.

Mike Mandelbaum, Chief Executive, TB Alert
Louise Holly, Deputy Director, Results UK
Sheila Davie, Advocacy Partnership
Paul Thorn, Project Director, the Tuberculosis Survival Project
Nikki Jeffrey, Director, Target Tuberculosis
Gerri Mchugh, Chief Executive, Royal Society of Tropical Medicine and Hygiene
Lara Brehmer, Comdis (Communicable Disease Research Programme Consortium)
Lynn Young, Royal College of Nurses
Toby Capstick, Lead Respiratory Pharmacist, St James University Hospital
Evelyn Harvey, Health Development Networks
Dr Luciana Brondi and Ruth Mcnerney, The London School of Hygiene and Tropical Medicine

Challenges in advocacy M&E

- Causal relationships: The complexity of issues handled by activists makes it difficult to determine cause and effect between NGO advocacy initiatives and outcomes[1] that is, how to attribute a specific change in the law or in more general attitudes and values in society to the advocacy/lobbying efforts of a single NGO or coalition? The influence of external factors is also unpredictable – i.e. the political situation, disasters or opposition tactics may influence outcomes more than anything within the advocate's control.

- Compromise versus outright victory: Absolute victory, in the sense of achieving all the sought-after objectives, is rare – often compromise is necessary, with some objectives being jettisoned or modified. This introduces an element of subjectivity in determining whether gains were significant, or whether small gains were consistent with the wider objectives of the campaign. There are likely to be a variety of opinions among different partners and stakeholders in a campaign. Indeed advocacy may bring together organisations that are not all trying to achieve the same thing.

- A moving target: the objectives of advocacy are moving targets sensitive to external factors. They will change as the environment changes through unrelated factors, as progress is made or when resistance and setbacks are encountered. Thus indicators[2] of success may also need to change: an indicator that was relevant at the start of the campaign may become irrelevant as the campaign widens or changes its focus.

- Advocacy can mean many things and is increasingly collective: Advocacy includes a whole range of tactics such as influencing, lobbying, campaigning, demonstrations, boycotts, etc. Different organisations work in different ways and advocacy increasingly takes place through networks and coalitions. Indeed, positive results may often reflect the sum of a variety of approaches. It may be difficult to assess which approach makes the difference; even harder to isolate the impact of a particular organisation. Claiming or measuring individual attribution may be counterproductive and harm cooperation. It may be more important to improve how organisations are working together for a common purpose.

- Long-term policy work: Furthermore, much advocacy and policy work is long term. This poses a challenge in measuring impact as opposed to outcomes. Measuring policy change may not be sensitive enough to changes in the short term. It is also important to measure implementation of the policy, not only its formulation.

- A conflictive process: Advocacy can be a conflictive process. Engaging in advocacy work can have political consequences in terms of groups' relationships with others.

To learn from experience: advocacy work is often unique to a country (e.g. political, social and cultural) context, rarely repeated or replicated, so that the gradual accumulation of knowledge by repetition does not happen. Reflection on advocacy work is even more important to ensure that lessons are learned throughout the process. Deciding what succeeded or failed is often a case of looking at which mix of strategies worked in a given situation or comparing how different strategies influenced a particular target audience or contributed to the achievement of advocacy efforts. Learning is more effectively built by:

- reflecting regularly on whether expected outcomes have been achieved;
- collecting anecdotal or other evidence for documentation;

Monitoring the external situation in order to recognise and record other factors that may have influenced achievement or not of results. Often it is more useful to focus on why plans need to be changed than to spend time collecting data on pre-determined indicators.

End notes

1. Outcome is the impact or result expected to achieve from outputs (that are the activities undertaken, such as meetings, workshops, production of policy briefs, press conferences etc.). Inputs are the resources used to undertake activities in terms of staff and production costs.
2. Indicators are the evidence to be collected that shows the outcomes have been achieved.

Major indicators (Stop TB and Global Fund)

The WHO Stop TB Department developed a Stop TB Planning Matrix and Framework in order to guide TB proposal development according to the six objectives and 20 sub-components, also called Service Delivery Areas (SDAs) of the Stop TB Strategy.

The matrix lists all Stop TB Strategy objectives, SDAs, and provides a menu of main activities and corresponding indicators. This tool corresponds with the Global Fund M&E and reporting tools.

Please find below indicators related to advocacy only (as opposed to ACSM as a whole), that may help you develop indicators to your advocacy work.

Stop TB Planning Matrix and Framework

Stop TB strategy objective	SDAs	Menu of activities	Programmatic indicators	Data source
Objective 1: Pursue High Quality DOTS Expansion and Enhancement	SDA 1.1 Political commitment with increased and sustained financing	Advocacy component of ACSM Place TB high on the political agenda Foster political will Increase and sustain financial and other resources	Number and/or percentage of funds budgeted by the government for TB control out of the total national health budget	National budget and financial reports Media coverage
Objective 5: Empower People With TB and communities	SDA 5.1 ACSM Advocacy, communication and social mobilization and Patients' Charter for TB Care	5.1.1 General management 5.1.2 Advocacy 5.1.3 Communication 5.1.4 Social mobilization 5.1.5 Patients' charter (e.g. training health care staff and technical assistance) **Additional Advocacy activities** Meeting with policy and decision-makers Raise the profile of TB issues addressed by advocacy campaign in Media Write policy briefs and political statements/manifestos	Population with correct knowledge about TB: mode of transmission, symptoms, treatment and curability (%) People in selected community expressing accepting attitudes towards people with TB (%) Number of meetings with policy and decision-makers held Number of articles addressing advocacy campaign issues Number of documents produced and disseminated	Knowledge, attitude and practice (KAP) study, case studies and focus group discussions Reports and minutes on the meetings Newspapers., case studies Reports to donors

Note: The above are not really exclusive indicators for advocacy but ACSM.
However please note that the Stop TB Matrix refers menu of activities SDA 5.1 for the advocacy component of ACSM.

Case Study: Basanti's story on the TB election asks

Basanti's Story

Basanti Munda is an 18-year-old girl from Jharkhand State, India, where she lives with her mother, father and younger brother and sister. TB is a big public health problem in her village. Basanti's aunt also died from TB. Basanti had symptoms for more than a year before she was finally diagnosed. Basanti initially visited a traditional healer which is common practice in her village. The family paid the equivalent of about £4 for this. When this did not work, her parents took her to private doctors locally but she was still not properly diagnosed.

Finally when Basanti was extremely sick and unable to walk, her parents hired a car and travelled to a private hospital in the adjoining State of Orissa, where hospital facilities are better. She was given an ultra sound and tuberculin skin test and diagnosed with extra-pulmonary TB of the ovaries.

This cost the family the equivalent of over £100 in fees, for which they had to take out loans. Eventually, Basanti was linked to the local health centre so that she could receive free TB treatment through the government health service and her TB treatment be closely monitored by a local health worker.

Source: TB Election Asks, UK Coalition to Stop TB, March 2010 at www.stoptbuk.org

Links to main international funders

- DFID: www.dfid.gov.uk
- Bill and Melinda Gates Foundation: www.gatesfoundation.org
- The Global Fund: www.theglobalfund.org
- The Stop TB Partnership: www.stoptb.org
- USAID: www.usaid.gov

Additional resources

Organisations and websites

Organisations	Websites
ACTION	www.action.org
The Global Fund to Fight AIDS, TB and Malaria	www.theglobalfund.org
Panos	www.panos.org
RESULTS UK	www.results.org.uk
RESULTS USA	www.results.org
Stop TB Partnership	www.stoptb.org
Treatment Action Group (TAG)	www.treatmentactiongroup.org
UK Coalition to Stop TB	www.stoptbuk.org
UNDP	www.undp.org
UNICEF	www.unicef.org
World Health Organization/Stop TB Department	www.who.int/tb
World Health Organization Euro	www.euro.who.int
World Bank	www.worldbank.org