

UK Department for International Development

KEY FINDINGS

- ▶ Despite a strong policy commitment to TB-HIV, DFID has provided little evidence with which to measure the scale or impact of its support for collaborative TB-HIV activities on the ground. DFID's HIV/AIDS strategy does not outline what specific measures the agency will take to implement its TB-HIV recommendations.
- ▶ Half of DFID country offices responding to a survey identified insufficient TB-HIV collaboration as a challenge to addressing TB. Sixty-three percent of country offices anticipated an increase in TB-HIV co-infection rates over the next five years.
- ▶ DFID does not track or disaggregate what proportion of its bilateral funding goes to support TB-HIV activities, which may fall under HIV, TB, or broader health budget lines. A survey of DFID country offices demonstrated that they were unable to report how much funding support they have provided for TB-HIV in their respective host countries.

BACKGROUND

The UK is a leader in the global effort to tackle HIV/AIDS and has stated its commitment to scaling up toward the goal of universal access to comprehensive HIV prevention, treatment, care and support. Until recently, the UK Department for International Development (DFID) had overlooked the need to address TB-HIV co-infection as a key component of its AIDS response, with its efforts to address TB and HIV/AIDS remaining largely separate. In June 2008, DFID launched an updated AIDS strategy, *Achieving Universal Access*, which recognizes the need to scale up TB-HIV activities over the next seven years.

In 2008, the UK's All-Party Parliamentary Group (APPG) on Global TB asked DFID to carry out a survey to gather information about its response to TB at the country level. The survey was completed by 24 country offices (Table 1). According to WHO estimates for 2006, all 24 countries have a high TB incidence rate of at least 99 per 100,000 people, and more than half have an incidence rate of over 300 per 100,000 people. In seven of the African countries — Kenya, Malawi, Mozambique, Rwanda, South Africa, Zambia and Zimbabwe — 30 percent or more of TB patients are co-infected with HIV.

In responses to the APPG survey, 12 of 24 (50 percent) DFID country offices identified insufficient collaboration between TB and HIV programs as one of the challenges faced by their host country in addressing the TB epidemic (DFID, 2008e). Fifteen out of 24 (62.5 percent) offices said that they expected to see a rise in the number of TB-HIV cases in their host country over the next five years (DFID, 2008e).

Table 12. TB-HIV Co-infection Rates and TB-HIV Activities in DFID Survey Countries

Country	TB rates – all forms (per 100,000)	HIV prevalence in incident TB cases (%)	Insufficient TB-HIV Collaboration a Challenge To Addressing the TB Epidemic	Expect TB-HIV Rates To Rise Over Next 5 Years
Bangladesh	225	≤ 0.05		x
China	99	0.3	X	X
Pakistan	181	0.3		X
Kyrgyzstan	130	0.5		
Indonesia	234	0.6	X	X
India	168	1.2		X
Nepal	176	1.4	X	X
Burma	171	2.6		X
Sudan	242	4.6		X
Sierra Leone	517	5.2		
Ethiopia	378	6.3		
Ghana	203	7		
DR Congo	392	9.2	X	
Cambodia	500	9.6		X
Nigeria	311	10		
Uganda	355	16	X	X
UR Tanzania	312	18	X	
Mozambique	443	30	X	X
Zambia	553	37	X	X
Rwanda	397	41		X
Zimbabwe	557	43	X	X
South Africa	940	44	X	
Kenya	384	52	X	X
Malawi	377	70	X	

Despite strong policy recommendations on TB-HIV, DFID provides little evidence to measure the scale or impact of its collaborative TB-HIV activities on the ground. DFID's increasing focus on health system strengthening (HSS) and sector-wide approaches (SWAs) to health has resulted in a reduction in support for targeted disease-control programs and presents challenges for the accurate monitoring and evaluation of its impact on TB-HIV.

POLICIES

DFID policies are developed by the organization as a whole, including inputs from DFID country offices. Numerous DFID policy and practice papers have acknowledged that HIV is the most important factor behind the dramatic increase in TB in many parts of the world (DFID 2005, 2008a). Despite the overlapping epidemiology of the two diseases, however, DFID's efforts to support partner countries tackling TB and HIV were

not always integrated. In *HIV and AIDS Treatment and Care Policy*, published in 2004, DFID advocates for a comprehensive approach to treatment and care for PLWHA, including the provision of diagnosis and treatment for opportunistic diseases such as TB (DFID 2004a). The document also calls for increased collaboration between TB and HIV/AIDS programs, especially in the delivery of ART and other services. However, these policy recommendations were not reflected in the UK's 2004 AIDS strategy, *Taking Action*, which made no reference to TB or TB-HIV co-infection.

DFID's recently updated AIDS strategy for the period 2008-2012, *Achieving Universal Access*, does address TB and TB-HIV. It states:

In particular, in hyper-endemic countries, TB and HIV are fuelling each other and the need for integration is made more urgent by the steep rise in drug resistant TB infections. In places where the TB burden is high, progress has been made on screening for TB and HIV and on treating both diseases, but more needs to be done to make these services more accessible (DFID 2008a).

Within the updated AIDS strategy, DFID pledges to support progress toward a number of areas where it is believed that priority action is needed to achieve the goal of halting and reversing the spread of HIV. TB-HIV is included as a priority within DFID's commitment to support "the integration of HIV and AIDS with TB, malaria and SRHR [sexual and reproductive health and rights], including MNCH [maternal, newborn, and child health], services."

Achieving Universal Access does not outline what specific measures DFID will take to implement its recommendations on TB-HIV. Increasingly, DFID is moving away from funding targeted interventions that address specific diseases in favour of supporting the broader health sector plans of developing country governments. DFID has also been instrumental in the development of the International Health Partnership (IHP+)¹ and other initiatives that encourage donors to provide coordinated assistance aligned to national government plans and systems. Through such efforts, DFID hopes to help build the capacity of health systems and to improve the way health services diagnose and treat major illnesses, including TB and TB-HIV.

Achieving Universal Access recognizes that epidemics within and across countries and regions may have different characteristics to which responses to AIDS and to TB-HIV must be tailored. At the country level, Country Assistance Plans (CAPs) lay out the framework of cooperation between DFID and partner countries as part of the effort to support their poverty reduction strategy papers (PRSPs). TB-HIV co-infection was not specifically mentioned in any of the CAPs for the 24 countries that responded to the APPG survey.²

PROGRAMMING

DFID's strategic priorities are carried forward through decentralized bilateral country programs as well as through some regional programs. Working in line with the UK's AIDS strategy and other policy directives, country offices are responsible for the design and delivery of HIV/AIDS and TB responses as agreed in negotiation

1. IHP+ is a global compact between donor countries and international agencies, designed to improve coordination between actors, to strengthen health systems for health outcomes, to build momentum at a national level for improving existing country-led health plans, and to support countries seeking to scale-up work to improve the health-related MDGs.

2. Based on analysis of CAPs available on the DFID website on 09 February 2009. It should be noted that a number of the CAPs that were available online were out of date and many are currently being updated.

with the host government and other key stakeholders, taking into account the local context, domestic commitment, and DFID's overall financial framework.

It is difficult to measure the number of TB-HIV programs directly supported by DFID countries, because UK investment in health is increasingly channeled through instruments such as budget support, SWAps, and basket funding. This shift is intended to increase the capacity of recipient governments to develop and implement effective health services. This does not, however, preclude specific project support where DFID feels it is appropriate at country level.

Examples of TB-HIV programs that DFID supports include:

- ▶ In India, DFID supports both the Government of India's Revised National TB Control Program and its National AIDS Control Program to improve collaboration. DFID also supports operational research into TB and HIV and provides technical assistance through WHO to specifically improve programs addressing TB-HIV co-infection.
- ▶ In Burma, DFID has joined five other donors in establishing the Three Disease Fund (3DF) to help reduce the burden of AIDS, TB, and malaria in response to the suspension of grants by GFATM. One of the activities of the 3DF is to strengthen and expand TB-HIV collaboration and intervention with the National AIDS Programme and partners.
- ▶ Under its Multisectoral HIV and AIDS Programme, DFID South Africa has funded eleven projects aimed at strengthening the South African Government's response to TB. In operational research, studies were undertaken on VCT uptake for TB patients by the University of the Free State, the impact of highly active antiretroviral therapy (HAART) and IPT in TB patients by the Perinatal Research Unit and a novel method for collecting sputa from HIV positive TB patients by the University of KwaZulu Natal.
- ▶ DFID Kenya is supporting collaborative TB-HIV activities through their HIV programs. For example, DFID support has helped to develop a model system of cross referral between HIV and TB diagnostic and clinical services to ensure that patients with combined TB-HIV co-infection receive appropriate management for both conditions at both health facility and community levels.

A number of DFID country offices state that they are not supporting specific TB-HIV interventions to avoid duplicating the efforts of the Global Fund or another agency that they consider to already be taking a lead on this issue. For DFID in Cambodia, for example, "TB and TB-HIV co-infection have not been selected as priority areas ... as donor funding is currently being provided by GFATM, USAID, JICA and World Bank, allowing DFID to prioritise other health issues such as reproductive and maternal health" (DFID, 2008e).

FUNDING

The UK is the second largest bilateral donor of HIV/AIDS-related assistance, providing nine percent of total bilateral disbursements for HIV/AIDS in 2006 (UNAIDS 2008). DFID's statistics department provided ACTION with a summary of its bilateral expenditures on health over the last several years, and from this information a number of observations can be made (DFID 2008b).

DFID's total bilateral health expenditures have increased annually over the last several years, from £385 million in FY04/05 to £591.3 million in FY07/08. A breakdown of these expenditures, however, reveals a slight reduction in the proportion spent on HIV/AIDS and STD prevention, from 25 percent in FY04/05 (£96.7 million) to

23 percent in FY07/08 (£134.2 million)³, and a similar trend can be observed with regards to infectious disease control programs, which saw their share fall from 24 percent to 17 percent over the same period (£92.5 million to £99.7 million). In contrast, available data on DFID's bilateral support for TB control (which includes support for UNITAID, the Stop TB Partnership, WHO, and the Global TB Drug Alliance)⁴ indicates that there was, from FY04/05 to FY05/06, a dramatic increase in expenditures on TB as a portion of total infectious disease spending (£8.8 million to £17.94 million). Though there was no significant increase in TB spending in the two subsequent years (£19 million in FY06/07 and £18.2 million in FY07/08), the proportion of infectious disease spending attributed to TB still nearly doubled between FY04/05 and FY07/08, from 9.5 percent to 18.3 percent.

As the proportion of health spending dedicated to disease-specific interventions has fallen, the proportion of total health expenditures channeled through budget support for government health programs has increased, from 16 to 31 percent during the period FY04/05 to FY07/08 (£63.1 million to £182.6 million). As a signal that the proportion of health expenditures spent on targeted disease-specific programs will likely continue to fall, *Achieving Universal Access* outlines a plan to spend £6 billion on health systems and services by 2015, which DFID argues will help maximise progress on HIV/AIDS through the closer integration of HIV/AIDS, TB and other services. In comparison, the previous AIDS strategy, *Taking Action*, committed £1.5 billion over three years specifically for HIV/AIDS programmes.

DFID's current monitoring mechanisms have not allowed, and continue to prevent, the proportion of bilateral funding that is going to support TB-HIV activities to be clearly measured; TB-HIV activities may fall under HIV/AIDS, TB, or broader health budget lines and cannot be disaggregated from broader TB, HIV/AIDS, and/or HSS spending. In response to the 2008 APPG survey, individual DFID country offices were unable to identify the total amount spent on combating TB-HIV in their particular country. This information-gap is likely to become only more entrenched in the future, as DFID increasingly focuses on monitoring key national health outcome indicators in favor of attributing funding that is directed toward HSS to specific diseases.

MONITORING & EVALUATION

The UK House of Commons International Development Committee found DFID's updated AIDS strategy "to be strong on rhetoric but weak in communicating how DFID will implement it." They argued that there "are few measurable targets or indicators of how the Strategy's effectiveness will be assessed [and it] fails to explain how the high-level funding commitments will be broken down by country or sector, making it difficult to understand how implementation will occur on the ground" (House of Commons IDC, 2008).

The International Development Committee is "not convinced that DFID is taking sufficient steps to ensure that the specific challenge of interaction between the two diseases is tackled. Nor has DFID set out how it will measure the effectiveness of its Strategy in addressing the interaction."

3. These figures include only direct expenditure on HIV; cross-cutting activities and multilateral expenditure are not included.

4. Figures taken from list of bilateral projects on infectious disease control provided by DFID. Only includes direct expenditure on TB, cross cutting activities are not included.

In a letter to the APPG on Global TB, a DFID Minister reinforced that “[t]racking how these resources [channeled through budget support] deliver TB outcomes is critical, so DFID country offices work with governments to ensure that health programmes that we support include TB outcomes as part of their monitoring frameworks” (DFID, 2008d).

On TB-HIV specifically, the International Development Committee said that they were “not convinced that DFID is taking sufficient steps to ensure that the specific challenge of interaction between the two diseases is tackled. Nor has DFID set out how it will measure the effectiveness of its Strategy in addressing the interaction.”

In the M&E methodology document for the AIDS strategy — published at the same time as the International Development Committee’s report — DFID states that:

Monitoring the performance and evaluating the impact of UK activities to halt and reverse the spread of HIV in the developing world is seen as a central part of DFID’s corporate performance systems. Keeping track of the inputs, processes, outputs, outcomes and impacts of DFID funded bilateral and multilateral programmes ... is key to ensuring that the UK responds quickly to fill gaps in performance as well as ensuring transparency and accountability (DFID, 2008c).

It also notes that “DFID operates a decentralised structure and decisions about programmes and support are taken at the country level.” As a result, *Achieving Universal Access* does not contain any specific, quantitative indicators that could measure progress toward improving treatment, and reducing the incidence, prevalence, and deaths related to TB-HIV co-infection. Rather, overviews of the AIDS response from DFID staff in country offices and London will be collated every two years to provide information on progress against the priorities for action set out in the strategy.

Two of the questions relevant to TB-HIV that DFID country offices and regional divisions may choose to report on are:

- ▶ What is DFID doing in relation to supporting national and community-level strategies for care (including palliative care, cotrimoxazole, and TB and HIV co-infection)?
- ▶ What is DFID doing to support the integration of HIV and AIDS with TB, malaria, and SRHR, including maternal, newborn and child health services? (DFID, 2008c)

Despite the apparent specificity of these questions, serious challenges remain for the accurate monitoring and evaluation of DFID’s impact on TB-HIV. Where results are available on the ground on collaborative TB-HIV activities it may not be possible to attribute these outcomes to DFID, because DFID does not seek to attribute its financing toward specific diseases in all settings. Furthermore, it is not yet clear what kind of qualitative information the M&E framework for the AIDS strategy will generate since the questions are subject to the respondent’s interpretation. DFID country offices will not be required to respond to all of the questions in the M&E framework, so the amount of information that will be provided about TB-HIV activities is also unknown.

RECOMMENDATIONS

DFID has clearly stated that addressing TB-HIV co-infection is a priority and has committed to do more to support the integration of HIV/AIDS and TB services. This political rhetoric must now be translated into action by all DFID offices working in countries affected by the two diseases.

Given the UK Government's leadership on HIV/AIDS and health issues in the developing world, the following recommendations highlight the three areas in which DFID should accelerate progress in the fight against TB-HIV co-infection:

- ▶ DFID should incorporate TB-HIV into its Country Assistance Plans, including specific targets and indicators to effectively address TB and TB-HIV co-infection in countries with high disease burden. DFID should also work with partners to ensure that the IHP+ and other health initiatives are sufficiently addressing TB-HIV in their planning and implementation.
- ▶ DFID should explain how it will implement TB-HIV recommendations outlined in the updated AIDS strategy and how TB-HIV outcomes will be measured. In countries with a high burden of TB-HIV, and in those anticipating an increase in TB-HIV cases over the next five years, DFID offices should consult with the national government and other development partners in order to define what actions it is best placed to take to support the integration of TB and HIV programming.
- ▶ DFID should work with partners to develop M&E frameworks that include TB and TB-HIV indicators. Country offices should be encouraged to report every two years on what measures they have taken to address TB-HIV as part of the evaluation of *Achieving Universal Access*.
- ▶ DFID should disaggregate data on its bilateral expenditure on TB-HIV. In particular, DFID should explain how its £6 billion commitment to strengthen health systems will be broken down by year, by country, and how much will support the fight against HIV/AIDS, TB, and TB-HIV.