

# World Bank's Multi-Country HIV/AIDS Program for Africa

## KEY FINDINGS

- ▶ An analysis of publicly available documents suggests that the Africa MAP's efforts to address TB-HIV have been inconsistent and poorly tracked; neither a comprehensive strategy nor M&E framework for TB-HIV has guided activities within the program.
- ▶ Though TB-HIV activities are eligible for MAP funding, from public documents it is impossible to determine how much funding, if any, has been provided to support TB-HIV programming.
- ▶ MAP projects have not tracked the numbers of PLWHA screened for TB or provided with appropriate follow-up services. The MAP's new M&E framework includes no required indicators to track activities relating to TB-HIV or even opportunistic infections (OI) generally.
- ▶ Compared to first-generation MAP projects, second-generation projects demonstrate limited progress toward carving out space for TB-HIV efforts. A few projects from among the sample analyzed monitor TB-HIV indicators and discuss TB as the OI most likely to kill PLWHA, but it remains impossible to determine the extent to which these projects support TB-HIV activities.

## OVERVIEW

Launched in 2000, the World Bank's Multi-Country HIV/AIDS Program for Africa (MAP) provides a "central mechanism" for implementing the Bank's reformulated HIV/AIDS strategy, aiming to significantly increase access to HIV prevention, care, and treatment through comprehensive support for national HIV/AIDS programs (The World Bank 2007). The MAP was envisioned as a 12 to 15 year program, to be implemented in three phases by way of individual multi-year funding commitments.

To date, MAP efforts have focused on developing national capacity for planning and coordination, strengthening the health system to improve the delivery of HIV/AIDS services, and expanding stakeholder involvement in the provision of HIV/AIDS services. Future phases of the MAP will aim to scale up successful intervention models and expand service delivery to the hardest-to-reach populations, ultimately helping to achieve universal access. Countries in which MAP projects were first implemented have begun to focus on these second-level objectives, but most MAP projects continue to concentrate on capacity building and health system strengthening.

The MAP's conceptual document recognized the Bank's role in seeing that national policies include HIV/AIDS as an important issue in the control of sexually transmitted infections (STIs) and TB. This document, however, narrowly saw TB as one among a number of OIs requiring treatment — though an important one (World Bank 2000). The Bank's *HIV/AIDS Agenda for Action, 2007-2011* identifies lessons learned from this narrow approach

and calls for the fuller integration of HIV/AIDS and TB efforts. In later MAP project documents, however, TB-HIV activities still appear to be inconsistently implemented and poorly tracked, with no comprehensive strategy or M&E framework to guide and report on TB-HIV integration.

To ensure its HIV/AIDS portfolio in the Africa region impacts those with TB-HIV, the MAP should develop a comprehensive TB-HIV strategy and work more proactively with recipient countries to ensure that TB-HIV activities, indicators, and outcome targets appropriate to the country context are included during project design. To complement MAP resources, the Bank should also scale-up its concomitant investment in basic TB control in the region.

## POLICIES

Though MAP project resources can be used to address TB-HIV if a country's epidemiological context calls for it, MAPs are not required to implement or monitor TB-HIV activities (The World Bank 2006). The extent to which MAP projects address TB-HIV depends on decisions made by the various in-country stakeholders involved in MAP project planning and implementation, and on the degree to which TB-HIV collaboration is incorporated into a country's national HIV/AIDS strategic plan (The World Bank 2000; The World Bank 2008a). Bank staff are heavily involved in the MAP project design process, and local staff maintain the Bank's involvement during project implementation by participating in ongoing project supervision (The World Bank 2000).

The Bank is also a lead organization providing technical support for national HIV/AIDS strategic plans (UNAIDS 2005). The MAP's project appraisal document (PAD)<sup>1</sup> suggests it would work to integrate national efforts against TB and HIV/AIDS, stating the Bank "is playing a rapidly growing role in bringing into country policies the importance of HIV/AIDS in addressing opportunistic diseases such as STIs and TB" (World Bank 2000). Since its inception, MAP resources have been available to finance "essential expenditures to strengthen HIV/AIDS prevention, care, treatment, and impact mitigation," including "the treatment of ... opportunistic infections — notably tuberculosis." Further, the MAP's log frame includes several "STI/TB/OI" outcomes toward which the MAP would contribute (The World Bank 2000).<sup>2</sup>

In addressing TB as one among a number of OIs and STIs — albeit an important one — the MAP PAD glossed over TB's uniquely devastating impact on PLWHA and the full range of integrated activities needed to reduce TB-HIV co-infection. Reflecting current WHO policy recommendations, *The World Bank's Commitment To HIV/AIDS In Africa: Our Agenda For Action, 2007 – 2011*, calls for a more integrated approach to TB and HIV/AIDS, asserting that "[t]

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1. Project Appraisal Documents (PADs) summarize the operations of the proposed project and provide the basis for the Bank's appraisal and approval of project commencement. In this case, the PAD refers to the entire MAP program. Each individual project implemented under the MAP also has its own PAD.

2. These include: 1) Increase in percent of population receiving quality HIV/AIDS/STI/TB case management, 2) Increase in percent of adults with access to quality STI/TB/OI case management, 3) Percent decrease in reported STI/TB/OI prevalence, 4) Percent increase in number of facilities implementing and evaluating STI/TB diagnosis and treatment activities

reating HIV/AIDS as a single disease has been a significant deficiency in national HIV/AIDS programs” (The World Bank 2008b). It recognizes that the number of new TB cases in Africa has tripled since 1990, and that “the complexity of the interactions between TB and HIV have magnified” with the emergence of drug-resistant TB (The World Bank 2008b). The first pillar of the *Agenda for Action* — Focus the Response through Evidence-Based and Prioritized HIV/AIDS Strategies — states the Bank’s intent to “recognize the crucial links [of HIV/AIDS] with the health system as well as TB, malaria, reproductive health, and nutrition; and help integrate these considerations into the HIV/AIDS agenda” (The World Bank 2008b). Stating that strengthening the links between TB and HIV/AIDS services will “take on greater priority,” the document lists the need to integrate TB and HIV/AIDS services as one of a number of “key lessons going forward from the MAP experience.” It recognizes that “the frequency of co-infection with TB (and the emerging Extensively Drug Resistant TB) and other opportunistic diseases, require providers to offer integrated services” (The World Bank 2008b).

## PROGRAMMING

The ACTION project analyzed first- and second-generation MAP project documents for seven countries: Burkino Faso, Burundi, Ethiopia, Kenya, Madagascar, Rwanda, and Tanzania. In 2006, all seven countries were in the top quintile of TB incidence rates, with varying levels of TB-HIV co-infection. All countries except Tanzania have completed an initial MAP project, and all countries except for Rwanda and Tanzania have begun to implement a second-generation project.

Most of the project documents for these countries recognize TB as a burden among people with HIV, and they show that the MAP is providing some support for TB-HIV integration — how much support, however, is unknown because the documents do not provide detailed budget information and M&E does not effectively track TB-HIV outputs. Even in the absence of concrete data, project planning documents, project completion reports, and program-wide evaluations carried out by the Bank provide some evidence that TB treatment was frequently considered as part of the MAP’s efforts to scale up HIV/AIDS services. However, these documents also suggest that the actual implementation of TB treatment in MAP projects, as well as support for the other recommended collaborative TB-HIV activities, has been limited.

### **First Generation MAP Projects**

Of the first-generation MAP projects analyzed, only Ethiopia, Burundi, and Rwanda included plans to implement TB-HIV activities (Table 12). The focus of these activities, however, tended to be narrow. For example, Burundi’s and Ethiopia’s PADs were limited to treating TB among PLWHA. The Rwanda MAP’s PAD discussed a “promising strategy” for integrating TB and HIV/AIDS services as part of an expansion in the number of VCT sites in the country, complementing one of Rwanda’s early Global Fund grant applications, but the inclusion of this level of strategic thinking around TB-HIV in early MAP planning documents was an exception (The World Bank 2003a). In Tanzania and Burkina Faso, TB activities were described as eligible for funding but not as planned project outputs. Tanzania’s PAD, for example, includes “better diagnosis and treatment of tuberculosis and other opportunistic infections and improved nutrition” in a list of anticipated “benefits and target population,” but does not include related activities as part of the project’s planned outputs.

Table 13. TB activities described in a sample of first generation MAP project PADs

Country	Fiscal Year Approved	2006 HIV Prevalence in TB Incident Cases (%)	TB-specific activities described as eligible for MAP support	No TB activities described	Planned TB-specific interventions described	General Discussion of TB-HIV
Madagascar	2002	0.4		X		
Ethiopia	2001	6.3			X	
Burundi	2002	7.6			X	
Burkina Faso	2002	17	X			X
Tanzania	2004	18	X			X
Rwanda	2003	41			X	X
Kenya	2001	52		X		

Within the PADs analyzed, there was little discussion of efforts to screen PLWHA for TB. In almost all countries, identifying and treating TB-HIV co-infection by integrating HIV/AIDS testing and treatment services into TB clinics was similarly not considered, with Ethiopia providing the sole exception among the PADs reviewed.

Planning documents alone cannot rule out the possibility that early MAP projects supported more robust TB-HIV programming during implementation than was originally described. However, though only a handful of MAP projects have closed, available information from project completion reports and other outcome documents suggests that efforts to treat TB may have played a more limited role in these projects than was originally expected.<sup>3</sup>

Even though the PAD for Burkina Faso's first MAP project included an OI-related indicator that would be tracked during project implementation, the Implementation Completion Report (ICR) stated that the OI indicator had no baseline data, that no targets for the indicator had been set, and that the indicator was ultimately eliminated in 2005 following Rwanda's request for a supplemental credit from the Bank. Nothing else in Burkina Faso's ICR suggested that OIs, or TB in particular, had been addressed through the MAP.

The ICR for Ethiopia's first MAP included a single TB-related indicator, which tracked the number of antenatal, TB, and sexually transmitted infection (STI) clinics into which affordable VCT services were incorporated. The ICR reports that the number of VCT sites in Ethiopia expanded from 17 to 658 over the course of the project, but it provides no information on how many new VCT sites were established in TB clinics. Given the scale of this expansion of VCT services, even a relatively small reach into TB clinics would mean a substantial increase in access to VCT among those with TB. However, TB is mentioned only once in the narrative of the ICR, in regard to the expansion of a TB hospital's HIV/AIDS ward, and without disaggregating the outcomes that are included

3. Data on specific project outcomes is only released after the project has closed and the Bank has completed its review and assessment, compiled in an Implementation Completion and Results Report (ICR). For the MAP projects reviewed, the Bank has published an ICR for only Burkina Faso, Ethiopia, Kenya, and Madagascar.

in the VCT indicator, it is impossible to estimate the full extent to which the project expanded access to critical TB-HIV services.

Several Bank-led reviews of MAP activities provide little further clarity on the TB-HIV integration being supported by first-generation MAP projects. An evaluation of the Bank's full portfolio of HIV/AIDS assistance, conducted by the independent Operations Evaluation Department (OED)<sup>4</sup> in 2005, reported that 13 of 18 MAP projects<sup>5</sup> were providing support for at least one TB activity (The World Bank 2004, World Bank Operations Evaluation Department 2005). The evaluation noted that about a third of MAP projects supported prophylaxis for TB and other opportunistic infections, but provided no other information on the type or volume of TB activities that were supported and discussed TB-HIV's role in the MAP in no other context. A 2004 interim review<sup>6</sup> of the MAP included no discussion of TB, TB-HIV, or OIs whatsoever, and a 2007 Bank assessment of MAP activities during the period 2000-2006 provided no information on TB-HIV activities or outcomes and was almost completely lacking in references to TB in general. This 2007 assessment identified TB activities only in Eritrea's MAP project, but Eritrea's MAP was designed to address malaria and TB in addition to HIV/AIDS, and there was no information regarding TB-HIV integration.

## **Second Generation MAP Projects**

The first of the MAP projects closed in 2005, and several countries have entered or are currently negotiating a second round of MAP funding. Considering lessons learned and the policy commitments outlined in the Bank's *Agenda for Action*, the MAP is in a position to strengthen its support for TB-HIV as several countries' MAP projects come up for renewal.

A Bank report on the progress of TB-HIV integration in several African countries identifies one strategy by which the MAP could more effectively address TB-HIV. The report outlines a number of "critical support system preconditions" that in-country stakeholders in Tanzania and Ethiopia agreed would need to be met before making further progress in the implementation of targeted TB-HIV activities (The World Bank 2008a). These preconditions primarily revolved around improvements in the systems and processes involved in TB-HIV service delivery,<sup>7</sup> and there was general agreement among stakeholders that the Bank was well positioned to provide for these preconditions. Tanzanian stakeholders believe that the preconditions constituted "areas in which the WB was particularly strong" (The World Bank 2008a). In Ethiopia, stakeholders believe that the "structure [of Ethiopia's second MAP project] appears to enable the inclusion of proposals that address TBHIV ... [specifically] the TBHIV-related preconditions" (The World Bank 2008a).

Despite the opportunities identified above for MAPs to address TB-HIV, and despite the commitments made by the Bank in its *Agenda for Action*, it appears that few second-generation MAP projects have planned to implement robust efforts to address co-infection. In fact, based on the limited information available, second-generation MAP projects appear to be performing more poorly on TB-HIV than first-generation projects.

The PAD for Kenya's second MAP identifies the threat TB poses to PLWHA and procures TB drugs to counter this threat. Similarly, though Burkina Faso's second MAP project does not explicitly identify plans to provide TB

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4. Now the Independent Evaluation Group.

5. At the time of the survey, there were 24 active MAP projects, only 18 of which responded.

6. The interim review was carried out by a team of representatives from the World Bank, DIFD, UNAIDS, and MAP International, and included site visits to MAP projects in Benin, Burkina Faso, Ghana, Malawi, Mozambique, and Sierra Leone.

7. Improvements to physical infrastructure, human resource development, financial management capacity-building, etc.

treatment to PLWHA, it tracks TB cure rates as part of the M&E framework for the project's HIV/AIDS treatment and care component. None of the PADs reviewed included more comprehensive efforts to combat TB-HIV than were found in first-generation MAP projects, however. Likewise, none addressed the "support system preconditions" described above nor the commitments to TB-HIV integration articulated in the *Agenda for Action*.

Table 14. TB activities described in second generation MAP project PADs

Country	Fiscal Year Approved	2006 HIV Prevalence in TB Incident Cases (%)	TB-specific activities described as eligible for MAP support.	No TB activities described.	Planned TB-specific interventions described.	General Discussion of TB-HIV
Madagascar	2006	0.4		X <sup>a</sup>		
Ethiopia	2007	6.3			X	
Burundi	2008	7.6		X		
Burkina Faso	2006	17		X <sup>b</sup>		
Kenya	2007	52			X	X

a The PAD for Madagascar's second MAP project identified the treatment of OI in PLWHA as a planned activity, but TB was never referenced, either as part of or separate from OIs generally.

b The provision of TB treatment for PLWHA was not specifically identified as a planned activity or eligible expenditure in Burkina Faso's PAD. However, the project tracks TB cure rates as an outcome and results indicator, suggesting that TB treatment for PLWHA may be a planned, if unstated, activity.

## FUNDING

To date, the MAP has committed almost \$1.6 billion to combat HIV/AIDS in Africa, with over \$1 billion disbursed among 40 country-specific projects and five regional initiatives.<sup>8</sup> Additional funding has been leveraged from development agencies like DFID and the Netherlands' Ministry of Foreign Affairs, both of which provide co-financing for specific MAP projects in accordance with each agency's development priorities.

In addition to dedicated funding to support MAP project management and M&E, a typical MAP project features three primary mechanisms for distributing funds to project implementers:

1. For institutional strengthening and capacity building, funds are provided directly to national, regional, and local HIV/AIDS coordinating bodies.
2. To expand multisectoral involvement in HIV/AIDS control, a fund is established to which government ministries (e.g. Ministries of Health, Education, Labor, Justice, etc.) can apply to support comprehensive, sector-specific HIV/AIDS strategies.

8. MAP funding is provided as a mixture of IDA credits and grant funding. The specific financing instrument used in each MAP country is determined by the applicable Bank policies associated with different IDA replenishment rounds and by country-specific circumstances. The IDA is funded primarily by contributions from donor countries, who meet every three years to replenish IDA funds and review IDA policies.

3. To stimulate greater community involvement, a fund is established to which local government and civil society/community-based organizations can apply to support the implementation of HIV/AIDS prevention, treatment, and care projects at the local level.

MAP projects do provide financing for TB-HIV activities. As discussed above, Kenya's second generation MAP project includes a budget line for TB activities, and the OED MAP evaluation indicates that some specific TB-HIV programming was carried out in the early years of the program. Furthermore, though outcome documents provide little information regarding how many MAP projects actually provided TB treatment and in what volume, TB treatment was routinely considered as an eligible MAP expenditure in planning documents, and treating TB was identified as a planned activity in a number of MAP projects.

It is impossible to tell from publicly available documents, however, how much funding the MAP has provided for TB-HIV activities. Project documents generally lack budget lines for specific activities, comprehensive MAP evaluations provide little specific information regarding TB-HIV activities, and almost all indicators used in MAP M&E do not effectively track the TB-HIV outputs to which MAP funding may have contributed (discussed below).

## MONITORING & EVALUATION

In order to proceed quickly from project planning to implementation, the MAP cut planning time and aimed to compensate with a more robust M&E (The World Bank 2007). Despite the greater importance placed on M&E within MAP projects, however, according to the first MAP evaluation, "the overall record of the Africa MAP in implementing strong M&E to improve 'learning by doing' [was] weak," at least early during the early years of the program (World Bank Operations Evaluation Department 2005).

The Bank relies heavily on each MAP country's own health information systems to collect M&E data. As such, MAP projects budget substantial resources to improve or implement strategic information systems for HIV/AIDS in each country. Through 2006, however, the MAP's actual performance in strengthening endemic country M&E systems had been inadequate and under-funded,<sup>9</sup> hampering efforts to collect information that could be used to evaluate and improve MAP performance (The World Bank 2004; The World Bank 2007; World Bank Operations Evaluation Department 2005). Ethiopia's first MAP project provides an illustrative example: at project-end, there was no "reliable information on access to treatment" for OIs (The World Bank 2006). "[L]arge quantities" of OI drugs had been procured and distributed during the MAPs duration, but no hard data could be reported (The World Bank 2006).

In consultation with Bank staff, each country's national HIV/AIDS coordinating body has typically been responsible for choosing M&E indicators. Operating under this arrangement, the MAP projects analyzed for this report only sporadically included TB-HIV indicators. Burundi and Ethiopia's second MAP, Kenya's first MAP, Tanzania's only MAP, and both Madagascar's first and second MAP did not include any TB-HIV indicators. Burundi's first MAP noted that the measurement of project impact would focus on patterns of OI prevalence, but included no specific indicators or hard targets.

TB-HIV indicators that were included tended to have limited utility, often suffering from one of the following weaknesses: (1) TB-related activities are tracked as a component of a broader activity category (e.g. OIs), for

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9. Through 2006, only 4 percent of committed MAP funds were directed toward M&E strengthening instead of the 5-10 percent envisioned in MAP concept documents.

which the TB portion is not disaggregated, or (2) the indicator tracked TB or TB-HIV activities, but the information tracked does not easily allow for evaluating the MAP’s impact on the co-epidemic. In the Rwanda MAP, process and outcome indicators are not aligned, making it difficult to assess what impact project activities had on the outcomes achieved (Table 13).

Table 15. TB-HIV Indicators Identified in MAP Project Documents

Country	Process Indicators	Outcome Indicators
Burkina Faso I	No Indicators.	Increase in the number of infected people treated for OIs in participating provinces. <sup>a</sup>
Burkina Faso II	No Indicators.	Improvement in TB cure rate.
Ethiopia I	The number of affordable VCT services incorporated into antenatal, TB, and STI clinics.	Increase in access to treatment for opportunistic infections. <sup>b</sup>  Proportion of health institutions in participating Woredas in which drugs for the treatment of STDs, TB, and OIs are available at project end.
Kenya II	Number of TB drugs distributed.	No Indicators.
Rwanda I	The number of health center attendees referred for VCT services. <sup>c</sup>  The number of clients who bring partners for VCT services. <sup>d</sup>	Proportion of reported tuberculosis cases who are appropriately diagnosed and treated according to national guidelines. <sup>e</sup>

a The PAD for Burkina Faso’s first MAP project distinguished between OIs generally and TB in particular, suggesting that this indicator might not track increases in the number of people treated for TB.

b Increases in access to TB treatment is not disaggregated.

c This indicator disaggregates both OI and TB patients from the total number health center attendees.

d This indicator disaggregates TB patients from the total number of clients.

e Another indicator tracks the proportion of OI cases treated according to national guidelines.

In 2007, the World Bank proposed a new “Generic Results Framework” for M&E that laid out a set of key indicators that all Bank-financed HIV/AIDS projects would be required to report. The new framework was created to improve the Bank’s centralized data collection process, help guide the selection of appropriate and effective indicators within country projects, and harmonize indicators with international standards. No required indicators related to TB, TB-HIV, or even OIs generally were included in the framework.

## RECOMMENDATIONS

Given the high rates of co-infection found in most African countries, all MAP projects should incorporate robust activities to reduce the burden and transmission of TB among people with HIV/AIDS. Toward this end:

- ▶ The MAP should articulate a comprehensive strategy by which it plans to address TB-HIV co-infection in countries receiving its resources.
- ▶ The MAP should provide explicit resources for collaborative TB-HIV activities.
- ▶ The MAP program policy should require countries to account for and take measures to implement the three I's as part of HIV/AIDS service scale-up in settings with high rates of both diseases.
- ▶ The MAP's M&E framework should include standard TB-HIV outcome indicators, including, at minimum:
  - Numbers of TB patients provided VCT and appropriate follow-up treatment and care
  - Numbers of PLWHA screened for TB and provided appropriate treatment and care, including IPT
  - Numbers of treatment sites upgraded and personnel trained to implement standard infection control procedures.
- ▶ The World Bank should apply lessons learned from large-scale, successful TB control projects in countries such as India, China and Russia, to expand and improve basic TB control in countries in the Africa region.