



**ENDURING
NEGLECT**

**The World Bank's
Inadequate
Response to
Africa's TB
Emergency**

RESULTS International • September 2006

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The World Bank's Inadequate Support for Africa's TB Emergency

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“It is tragic that this disease has not been brought under control, because I am living proof that TB can be effectively treated and cured. The problem is huge and medical authorities cannot overcome it alone, they need help. A full course of TB drugs that costs 15 dollars will save the lives of TB patients—and in the case of people who are co-infected with HIV, extend their lives by precious years until ARVs become more widely available in Africa.”

Archbishop Desmond Tutu, a survivor of TB, in response to the declaration of a TB Emergency in Africa, Maputo, Mozambique, August 25, 2005

“We cannot win the battle against AIDS if we do not also fight TB. TB is too often a death sentence for people with AIDS. It does not have to be this way. We have known how to cure TB for more than 50 years. What we have lacked is the will and the resources to quickly diagnose people with TB and get them the treatment they need.”

Nelson Mandela at the XV International AIDS Conference in Bangkok, Thailand, July 2004

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RESULTS Educational Fund (REF) (www.results.org)

REF, based in Washington, DC, is a 501(c)3 non-profit citizens' advocacy organization committed to educating the public, the media, and government leaders about issues related to poverty and hunger in the United States and abroad. It organizes public forums, trains ordinary citizens in being active participants in democracy, holds media conference calls to share the latest information, and conducts oversight research to determine the effectiveness of programs meant to address poverty and inequity. REF, together with its sister organization, RESULTS, Inc., a 501(c)4 grassroots advocacy organization, and six international affiliates in Australia, Canada, Germany, Japan, Mexico, and the United Kingdom, combine advocacy efforts for greater impact worldwide.

RESULTS Canada (www.results-resultats.org)

RESULTS Canada is a grassroots advocacy organization committed to generating the awareness and political will necessary to end hunger and the worst aspects of poverty around the world. With its base of grassroots volunteers, RESULTS Canada works to transform knowledge into action through political advocacy, community outreach, and media work. In 2005, then-National Coordinator of RESULTS Canada, Alec Soucy, conducted initial research on World Bank spending for TB. The report presented builds on Dr. Soucy's original methodology and analysis.

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ACRONYMS

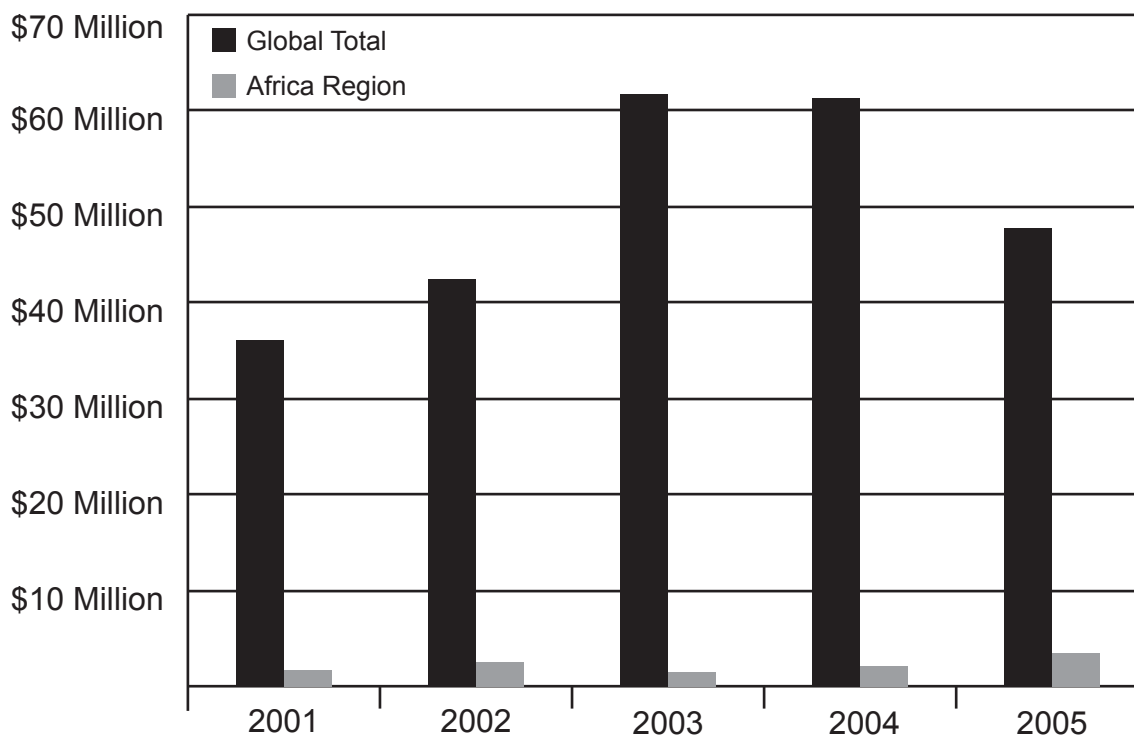
- AIDS:** Acquired Immune Deficiency Syndrome
- DOTS:** Directly Observed Treatment Short-course
- HAMSET:** HIV/AIDS, Malaria and TB Control Project
- HBC:** High [TB] Burden Country
- HIV:** Human Immunodeficiency Virus
- HNP:** Health, Nutrition and Population
- IBRD:** International Bank for Reconstruction and Development
- IDA:** International Development Association
- IMF:** International Monetary Fund
- MAP:** Multi-Country HIV/AIDS Program
- M&E:** Monitoring & Evaluation
- MDG:** Millennium Development Goal
- MDR-TB:** Multi Drug-Resistant Tuberculosis
- PEPFAR:** [United States'] President's Emergency Plan For AIDS Relief
- PLWHA:** People Living With HIV/AIDS
- PRSC:** Poverty Reduction Support Credit
- PRSP:** Poverty Reduction Strategy Paper
- RESULTS:** Responsibility for Ending Starvation Using Legislation, Trimming and Support
- RNTCP:** [India's] Revised National Tuberculosis Control Programme
- SWAp:** [Health] Sector Wide Approach
- TB:** Tuberculosis
- UK:** United Kingdom
- US:** United States
- WHO:** World Health Organization
- XDR-TB:** Extremely/Extensively Drug-Resistant Tuberculosis

EXECUTIVE SUMMARY

In light of Africa's escalating tuberculosis (TB) emergency, World Bank financing for TB programming on the continent is inadequate. In 2005, the Bank provided Africa a total of US\$585 million in health-sector financing, of which just US\$3.5 million (0.6%) was explicitly directed to TB control. Thus, in a region accounting for more than a third of the world's TB deaths, less than one penny for every dollar of the Bank's health financing was spent to control the disease. While the Bank provides the equivalent of roughly US\$9.33 in TB funding per estimated TB case outside Africa, it provides a mere US\$0.83 in funding per TB case within Africa.

The Bank has established dedicated financing initiatives for both HIV/AIDS and malaria, two other major infectious killers in the Africa region. The Bank has provided some US\$1.2 billion in multi-sectoral financing for HIV/AIDS in 29 African countries via its Multi-Country HIV/AIDS Program (MAP) since 2000. In 2005, the Bank launched its "Booster Program for Malaria in Africa" and has so far committed US\$167 million for eight projects with an additional US\$260 million and seven projects in the pipeline. While morbidity and mortality due to TB are increasing in Africa—despite TB being curable, and treatment highly cost-effective and pro-poor—no World Bank initiative of similar scope exists for TB. This under-funding is a sign of neglect and a missed opportunity.

Figure 1. World Bank Financing for TB (FY2001-2005): Global & Africa Region



Source: Data from World Bank, "Can funding for TB be sustainable and flexible?" (PowerPoint presentation given at the Stop TB Partnership's Steering Committee for the Global Plan to Stop TB 2006–2015 Meeting, Addis Ababa, Ethiopia, May 2, 2005).

TB kills nearly 590,000 Africans a year, despite being treatable with drugs costing roughly US\$16 per standard course. Of the world's 22 countries with the highest TB burdens (HBCs), nine are in Africa.¹ Since 1990, incidence of TB on the continent has tripled, while the number of people dying annually from the disease has doubled. In fact, Africa is the world's only region where the annual number of new TB cases continues to rise, increasing by some 5 percent each year. On August 25, 2005, TB's devastating impact on the continent spurred Africa's Ministers of Health and the World Health Organization (WHO) to declare TB a continent-wide emergency. One year later, too little has been done to counter the continued escalation of disease and death.

Such trends are especially troubling considering TB's lethal alliance with HIV. TB is the leading killer of people living with HIV/AIDS (PLWHA), responsible for up to one third of AIDS-related deaths worldwide and more than half in some African countries. Globally, one third of the more than 40 million people with HIV/AIDS are co-infected with TB. In lockstep with HIV/AIDS, TB has cut short the lives of millions, destroying communities and draining economies.

While World Bank-supported TB-specific control efforts are near-absent in Africa, the Bank does have a history of funding successful, large-scale TB control projects in other regions of the world. In China, where TB is the leading infectious cause of death, a Bank-supported Ministry of Health (MOH) program treated over 1.5 million TB cases in 10 years, achieving a cure rate of 95 percent and averting 30,000 TB deaths each year. The project helped achieve a 37 percent decrease in TB prevalence in China, while yielding a US\$60 return for each dollar invested. Bank support for India's Revised National Tuberculosis Control Programme (RNTCP) has been crucial to scaling up efforts to curb the disease. Since 1997, the RNTCP has achieved countrywide Directly Observed Treatment Short-course (DOTS)² coverage, trained 600,000 new healthcare workers and equipped 11,500 new TB diagnostic laboratories. With Bank support, India's program has treated over 5 million patients, saved over a million lives and exceeded global targets for TB case detection and treatment success. The World Bank's challenge is now to support countries in Africa to replicate such accomplishments.

The World Bank's current stated mission is to help developing countries achieve the Millennium Development Goals (MDGs) by working to alleviate poverty. Sustained global action to address TB is crucial to reaching MDG 6, which calls for halting and reversing the incidence of HIV/AIDS, malaria and TB by 2015. As Africa is the world's only continent where net TB incidence continues to rise, curtailing the epidemic in the region is a central step toward reaching global TB targets. Moreover, the Bank itself has acknowledged that TB control can yield tremendous returns for every dollar invested and can contribute to long-term sustainability and equitable growth. Therefore, to significantly increase support for TB control in Africa is not only consistent with the Bank's mission, it is necessary for achieving it.

Compounding the societal burden that TB levies by its sheer prevalence and lethality is the fact that the disease disproportionately afflicts the poor and specifically those in their most economically

1 HBCs comprise 22 countries that the World Health Organization has identified as containing 80% of the world's annual new TB cases. The nine African HBCs are: Nigeria, South Africa, Ethiopia, Kenya, Democratic Republic of the Congo, United Republic of Tanzania, Uganda, Mozambique and Zimbabwe.

2 DOTS is the centerpiece of the World Health Organization's (WHO) Stop TB Strategy (see Box 1).

productive years. Because of TB's particular impact on poor people who are income-earners and parents, expanded access to free, high-quality TB services is an important, targeted pro-poor strategy. The spread of TB and other diseases of poverty is exacerbated by insufficient national and international responses—a key reason why the poor remain poor.

While the World Bank provides broad budget and health-sector support to countries throughout Africa, this support is not necessarily tracked to specific TB activities nor measured against meaningful, TB-specific indicators. It is, therefore, difficult to substantiate the impact this support has on TB control. Furthermore, to be effective, such broad support assumes that sound, strategic national TB control plans are in place. Budget and sector support are also distributed across a number of competing government priorities, and are, thus, less likely to specifically target the very poor. As TB disproportionately affects the poor, to invest directly in TB control is an important and cost-effective, pro-poor strategy directly in line with the Bank's mission.

The Bank is currently revising its Health, Nutrition and Population (HNP) strategy, in which health systems strengthening is expected to play a key part, along with: 1) a shift to greater multi-sectorality and greater inclusion of all relevant stakeholders in discussions with the Bank at the country-level; and 2) increased monitoring and evaluation (M&E) of indicators and outcomes of health lending related to the MDGs. This increased multi-sectoral approach and outcome-linked focus should be strongly encouraged. In relation to this, efforts to strengthen overall health systems should be viewed as complementary to, and reinforcing of, disease-specific investments and not divert much needed resources from proven, high-impact interventions, such as DOTS. TB control is not only highly cost-effective, but it can help to ensure positive impact on the poor. Furthermore, the Bank's HNP strategy should be flexible to allow the Bank to make rapid investments to address urgent health crises, including the TB emergency in Africa.

Achieving a World Bank response to TB in Africa commensurate with that of AIDS and malaria, and proportionate with the burden of disease, would save lives and assist governments and civil society to meet the MDGs. Finally, the broader benefits and externalities of effective TB control are crucial to the Bank's stated vision of a world free of poverty.

In light of the above, this report recommends that the World Bank:

1 Increase funding (prioritizing the Bank's International Development Association [IDA])³ grant funding) to not less than US\$1 billion for TB and TB-HIV specific efforts in Africa over the next decade, beginning with an immediate annual increase to at least US\$100 million in 2007 and reaching US\$150 million by 2015;

2 Proactively engage African countries in policy dialogue to ensure that action is taken and appropriate financial resources mobilized to address the TB emergency from the ground up, with a goal of free, universal access to quality TB treatment;

³ IDA provides interest-free loans and some grant financing to many of the world's poorest countries.

3 Build on the Bank's past successes in supporting TB-specific programming in India, China and elsewhere, to achieve leadership on TB financing in Africa;

4 Foster a favorable policy environment by ensuring that the Bank's new HNP strategy supports leadership on TB programming in Africa, and around the world, and, in particular, supports a required major scale up in investment for TB control in Africa. This includes actively engaging with the International Monetary Fund (IMF) to ensure that increased investments needed by the Bank and other donors in TB and health systems strengthening are not limited by inflexible fiscal and monetary policies, including wage bill and budget ceilings;

5 Ensure that civil society, especially affected populations, have an explicit role in the development of Bank health policies and Bank-supported projects; and

6 Take a lead role in galvanizing high-level support for, and participation in, a Ministerial conference on TB in Africa in early 2007, as called for in the 2005 G8 Summit communiqué.

In addition, African governments are urged to: 1) prioritize TB investments with IDA resources, especially grant resources; 2) develop national TB emergency plans and proactively seek additional external resources to address their TB emergencies; and 3) invest more of their own resources, wherever possible, to fight TB.

BACKGROUND

Africa's TB Emergency

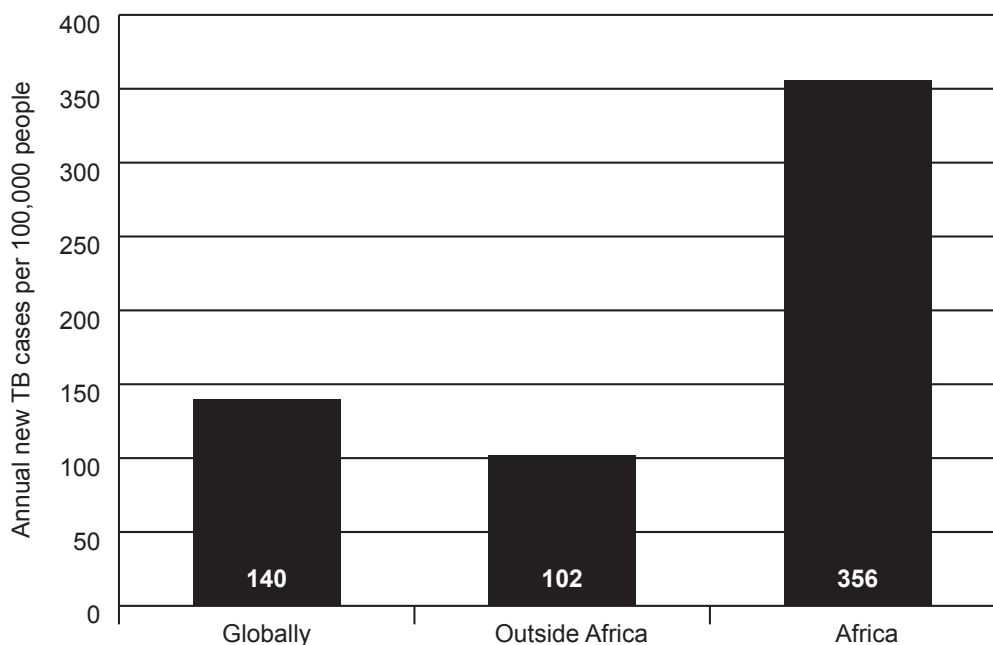
Africa's TB pandemic is so severe that in 2005, Africa's Ministers of Health and WHO declared TB a continent-wide emergency. To support country-led efforts to fight the disease, the Stop TB Partnership developed a "Blueprint for TB Control in Africa." Global recognition of and political commitment to address the TB crisis in Africa have increased through key statements in the 2005 Commission for Africa Report, communiqués from the G8 Summits in Gleneagles (2005) and St. Petersburg (2006) and the political declaration from United Nations General Assembly Special Session on HIV/AIDS this past May. The reasons for this are clear: the continent has the highest rates of TB globally (Figure 2). Fueled by HIV/AIDS and ubiquitous poverty, the number of Africans becoming sick with TB each year has tripled since 1990. Despite progress, African TB programs have been fighting an uphill battle, swamped by an enormous number of TB cases and hampered by weak infrastructure, too few resources and increasing co-infection with HIV/AIDS.

The region's annual increase in TB incidence is great enough to offset the stabilization or decrease of the disease in each of the world's other regions. In 2004 alone, the region saw 2.6 million new cases of TB and suffered nearly 590,000 deaths from this curable disease—an increase of 10 percent from 2003 (WHO 2006a).

Africa's rapid escalation of TB is fueled by the HIV/AIDS epidemic. Figure 3 shows TB incidence increasing alongside an increase in HIV prevalence between 1990 and 2002 in 18 high-HIV/AIDS-prevalent African countries.⁴ In Swaziland, 81 percent of new adult TB cases are also HIV-positive; Botswana, 77 percent; Zimbabwe, 68 percent; and South Africa, 60 percent (WHO 2006a). Among the 31 countries supported by the World Bank's MAP, the average HIV prevalence among adult incident TB cases is 22 percent with a range of 4.4 percent in Mauritania to 54 percent in Zambia.⁵

A recent outbreak of a strain of “extremely” or “extensively” drug resistant TB, (XDR-TB) in KwaZulu-Natal, South Africa, is an alarming development that illustrates the growing emergency and the consequent need to strengthen and scale up existing DOTS programs (see Box 1 for an explanation of the DOTS framework as the foundation of TB control) and related efforts to combat TB-HIV and multidrug-resistant TB (MDR-TB). XDR-TB is both deadly and potentially untreatable, being unresponsive to at least isoniazid and rifampin (two first-line anti-TB drugs) plus at least three classifications of second-line drugs. In the KwaZulu-Natal outbreak, 53 patients were diagnosed with a strain of TB resistant to all drugs for which susceptibility was tested (Gandhi 2006). Of these 53 patients, 52 (98%) died within a median of 25 days and 47 (89%) were HIV positive (Gandhi 2006).

Figure 2. TB Incidence Rate (2004): Global, Outside Africa & Africa

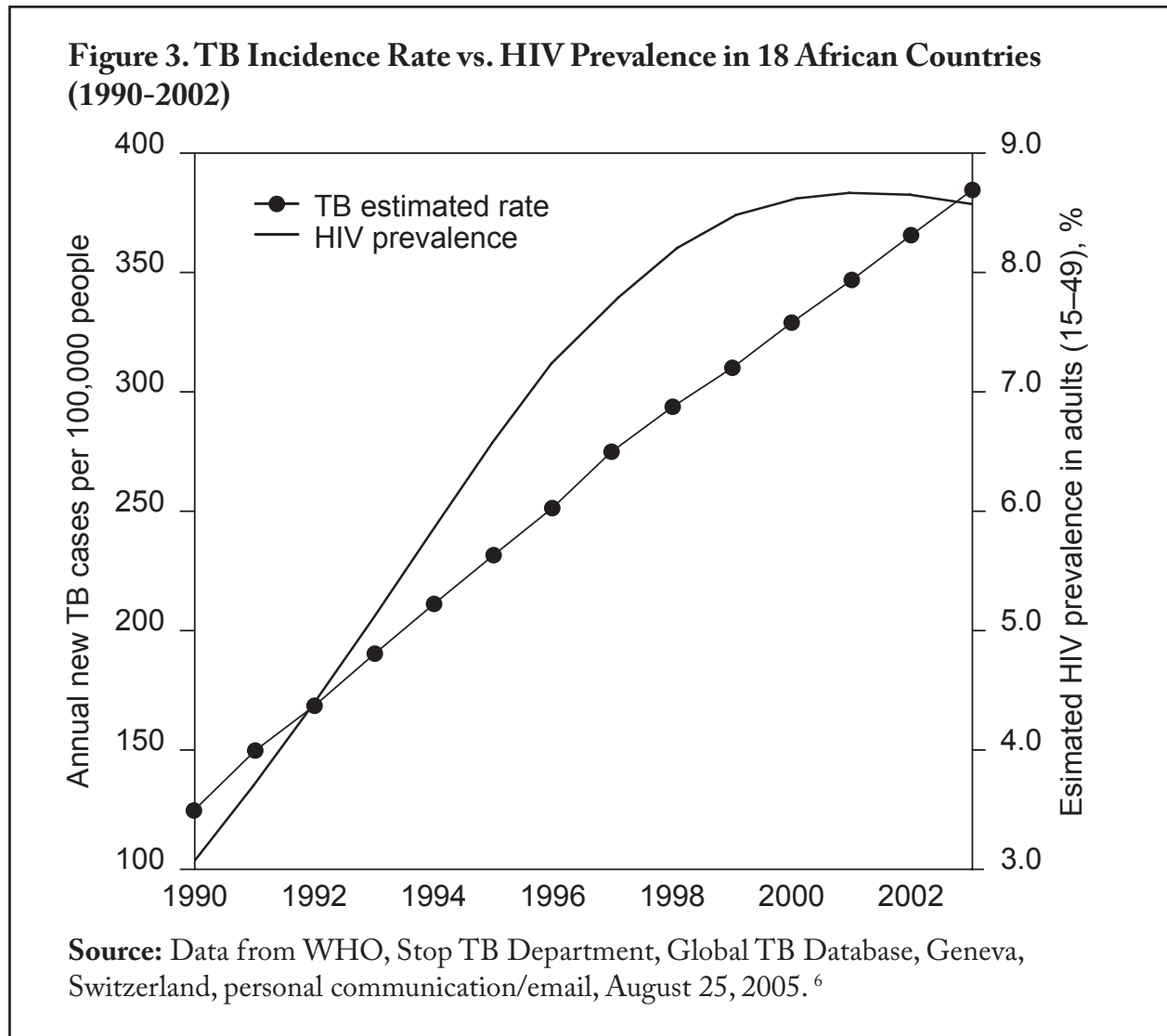


Source: Data from WHO, Global Tuberculosis Control: Surveillance, Planning, Financing; WHO Report 2006 (Geneva: World Health Organization, 2006 (WHO/HTM/TB/2006.362)).

4 Botswana, Burundi, Cameroon, Central African Republic, Republic of the Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Lesotho, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Uganda and Zimbabwe.

5 See Appendix A for a list of MAP countries and corresponding TB-HIV country data.

Globally, one-third of the approximately 40 million people with HIV/AIDS are co-infected with TB (WHO 2005). A person infected with TB bacillus typically has a 10 percent lifetime chance of becoming sick with active disease, as most latent TB infections are kept in check by healthy immune systems (WHO 2006b). For PLWHA who are co-infected with TB, however, the annual risk of developing TB disease is 5 to 15 percent (WHO 2006c). TB likewise accelerates the progression of HIV infection, making people sick sooner (WHO 2006d). When someone with AIDS is diagnosed with TB disease, life expectancy is often mere weeks (Mukadi et al. 2001).



The Funding Shortfall

Along with the highest rates of TB mortality and disease, Africa faces the largest gaps between needed and available financing as projected by the Stop TB Partnership’s *Global Plan to Stop TB*:

⁶ Countries are listed in footnote 4. Together these countries bear 75% of Africa’s TB burden.

2006–2015. Launched at the 2006 World Economic Forum by entrepreneur and philanthropist Bill Gates, UK Chancellor of the Exchequer Gordon Brown, and Nigerian President Olusegun Obasanjo, the Global Plan is a 10-year comprehensive business plan for combating TB worldwide and reaching MDG 6. No plan like it exists for any other major disease. Endorsed by more than 500 international partners including the World Bank itself, the Global Plan calls for an 8-fold increase in donor financing for TB in order to save 14 million lives, treat 50 million people, and begin to reverse the global incidence of TB by 2015. To accomplish these goals will require an estimated US\$56 billion in funding over the next decade, of which US\$47.2 billion will support country-level expansion of DOTS, DOTS-Plus for MDR-TB⁷ and TB-HIV programs and US\$9 billion will fund efforts to develop new TB diagnostics, drugs and a new vaccine.

According to the Global Plan, “Since the largest gap in funding needs for country-level implementation is in Africa, a particular focus on this region is necessary” (Stop TB Partnership and WHO 2006, 62). The Global Plan projects that Africa will require US\$19.4 billion for country-level TB control efforts through 2015, representing nearly 44 percent of the global total needed for country implementation. Based on anticipated contributions by African country governments, the remaining funding gap for Africa that will need to be filled by donors, including the World Bank, stands at nearly US\$5 billion over the next decade (Table 2).

The Need for World Bank Financing and Leadership

MDG 6 will not be met in Africa unless donors, including the World Bank, and affected countries themselves significantly increase funding and support for TB control. As a permanent member of the Stop TB Partnership’s Coordinating Board and administrator of the Partnership’s Trust Fund, the Bank needs to demonstrate greater leadership in supporting implementation of the Global Plan and in helping to close the TB financing gap. The Bank has committed to fight TB through financing instruments, policy dialogue and advice, analytic work and participation in global partnerships (World Bank 2006b). These mechanisms can and should be engaged to better support national TB efforts in Africa. Part of the Bank’s comparative advantage includes Monitoring & Evaluation (M&E), for which capacity remains weak in many African countries. Support for strengthening systems to collect and analyze data on treatment access and the effectiveness of service delivery would be very beneficial, as would assessing where gaps still remain in the capacity to conduct effective M&E.

The Bank’s successful track record in supporting TB programs in India and China illustrates its important role in financing the fight against TB. Because it was a serious threat to health and development, TB was placed at the center of India’s and China’s public health agendas in the early 1990s. It is well documented that the Bank’s strategic support proved crucial to the control of TB in both countries. Given its successful track record in enabling India and China to massively expand DOTS and save millions of lives from this disease, the Bank should extend the same leadership to Africa.

⁷ To control MDR-TB requires the implementation of DOTS-Plus, a comprehensive strategy that includes the administration of second-line TB drugs and other specific components in addition to the standard DOTS strategy.

Box 1. Key Components of WHO's Stop TB Strategy

DOTS is the centerpiece of WHO's Stop TB Strategy, which aims to reduce global TB incidence by 2015 in line with the Millennium Development Goals.

1. Pursue high-quality DOTS expansion and enhancement
 - Political commitment with increased and sustained financing
 - Case detection through quality-assured bacteriology
 - Standardized treatment with supervision and patient support
 - An effective drug supply and management system
 - Monitoring and evaluation system, and impact measurement
2. Address TB-HIV, MDR-TB and other challenges
 - Implement collaborative TB-HIV activities
 - Prevent and control MDR-TB
 - Address prisoners, refugees and other high-risk groups and special situations
3. Contribute to health system strengthening
 - Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems
 - Share innovations that strengthen systems, including the Practical Approach to Lung Health
 - Adapt innovations from other fields
4. Engage all care providers
 - Public-Public and Public-Private Mix approaches
 - International Standards for Tuberculosis Care
5. Empower people with TB, and communities
 - Advocacy, communication and social mobilization
 - Community participation in TB care
 - Patients' Charter for Tuberculosis Care
6. Enable and promote research
 - Programme-based operational research
 - Research to develop new diagnostics, drugs and vaccines

Source: WHO. 2006. The Stop TB Strategy. Online at www.who.int/tb/features_archive/stop_tb_strategy/en/index.html. Accessed September 11, 2006.

Because Africa endures such high rates of TB-HIV co-infection—up to 60 or 70 percent of TB patients are HIV-positive in some high-HIV-incidence countries (WHO 2006a)—TB programs can serve as efficient and cost-effective entry points for providing people with access to HIV

counseling, testing and care services. In Kenya and Malawi, large numbers of PLWHA have been identified and either provided or referred to HIV services through TB clinics. As most PLWHA are unaware of their status (UNAIDS 2006), expanding TB treatment programs to include HIV testing and referral is an ideal way to identify those with HIV, increase access to antiretroviral treatment, and therefore make progress in the fight against AIDS.

The World Bank acknowledges DOTS as one of the most cost-effective public health investments (World Bank 1993). Increasing World Bank resources targeted at TB and TB-HIV project investments in Africa, and strengthening DOTS capacity in the region, would prevent mortality, support delivery of both TB and HIV services and strengthen Africa's health systems. TB treatment is also the key to prevention, as each person with TB infects an estimated 10 to 15 others every year, even in low-HIV settings (WHO 2006b).

A number of important new health financing mechanisms have emerged in recent years, including The Global Fund to Fight AIDS, Tuberculosis and Malaria, the US President's Emergency Plan For AIDS Relief (PEPFAR) and The Bill & Melinda Gates Foundation. However, it is important to emphasize that these mechanisms, especially the Global Fund, were never intended to offset

Box 2. Tuberculosis—The Global Picture

- Despite being fully curable and cost-effective to treat, TB remains one of the leading infectious killers in the world. In 2004, 8.9 million people developed and 1.7 million people died of TB (WHO 2006a).
- Nearly two million people needlessly die from TB and nine million become sick every year from this preventable and curable disease. In 2004, there were 590,000 TB deaths in Africa alone.
- Up to half of people living with HIV/AIDS develop active TB. TB is the number one killer of people with AIDS. About 80 percent of TB-HIV deaths occur in Africa.
- Without treatment, the life expectancy of an HIV-infected person who develops active TB is measured in weeks. TB treatment extends life by years.
- Just over half of those sick with infectious TB in Africa have access to life-saving anti-TB drugs, which cost just US\$16 for one full six-month standard treatment. Many millions more with less easily detectable forms of TB go undiagnosed and untreated.
- MDG 6 will not be met for Africa unless donors, including the World Bank, and affected countries themselves significantly increase funding and support for TB control.

existing funding streams from sources such as the World Bank. They were meant to complement existing streams and provide additional financing, so that affected countries might have the capacity to reverse major health emergencies. Although the Global Fund has come to play an enormously important role in TB control and has become the major source of external funding for global TB to emphasize that these mechanisms, especially the Global Fund, were never intended to offset existing funding streams from sources such as the World Bank. They were meant to complement efforts (currently providing two-thirds of external resources), the Global Plan targets will never be met without a substantial increase in financing from other sources as well. This includes World Bank resources, particularly in the form of grant financing available through IDA for Africa. Long-time donors, including the Bank, must expand their support to address the TB epidemic in line with dedicated and increased responses to HIV/AIDS and malaria.

It is worth noting that efforts are ongoing within Bank-financed HIV/AIDS projects to increasingly support implementation of the key activities defined in the WHO/Stop TB Partnership's *Interim Policy on Collaborative TB-HIV Activities*. Furthermore, multi-year HIV/AIDS, Malaria and Tuberculosis Control (HAMSET) projects approved by the Bank's Board in the last year for Angola and Eritrea do include dedicated funds for TB that will help to strengthen the capacity of Ministries of Health to prevent, detect and treat TB and to monitor outcomes. These projects demonstrate that the Bank is starting to take action, but much more needs to be done.

Table 1. World Bank Financing for TB (FY2001-2005): Global & Africa Region

Fiscal Year	Global (US\$)	Africa Region (US\$)	% of Global Directed to Africa
2001	36,093,000	1,700,000	4.71
2002	42,463,000	2,600,000	6.12
2003	61,683,000	1,500,000	2.43
2004	61,308,820	2,125,820	3.47
2005	47,777,153	3,514,153	7.36
TOTAL	249,324,973	11,439,973	4.59
<i>Average/Year</i>	<i>49,864,995</i>	<i>2,287,995</i>	<i>4.82</i>

Source: Data from World Bank, Washington, DC, personal communication/email, July 31, 2006.⁸ (Data are illustrated in Figure 1)

⁸ Figures do not capture financing through overall budget support and other overall health sector funding arrangements (mainly SWAPs and PRSCs) that may contribute to TB control.

EVIDENCE OF INADEQUATE WORLD BANK INVESTMENT IN TB IN AFRICA

In light of Africa's need and the World Bank's capacity to help meet it, the Bank significantly under-funds TB control in the region. In 2004, the most recent year for which data are available, 2.6 million Africans became sick with and nearly 590,000 thousand died of TB (WHO 2006a). In 2005, the same year in which Africa's TB emergency was declared, the World Bank provided the region with US\$3.9 billion in total lending through the International Bank for Reconstruction and Development (IBRD)⁹ and IDA, of which US\$585 million (15%) was directed to the health sector (World Bank 2006a, Figure 2.2). From that lending, estimated TB-specific financing for Africa totaled a mere US\$3.5 million (Table 1) or less than 1 percent of total World Bank health-sector financing for the continent.

Although the biggest gap in World Bank support for TB control is in Africa, the institution also under-funds TB efforts at the global level. In 2005, the Bank provided a total of US\$2.23 billion in total IBRD/IDA health-sector lending worldwide (or 10% of total lending) (World Bank 2006a, Figure 3.3), of which an estimated US\$48 million was specifically targeted for TB control (Table 1). In other words, a mere 2 percent of the World Bank's global health lending in 2005 was invested directly in the fight against TB, an "MDG disease" second only to HIV/AIDS as the world's leading infectious cause of death among adults (Dye and Floyd 2006).

As Table 1 shows, over the past five years Africa received a fraction of the Bank's estimated total financing for TB. The US\$11.4 million it provided for TB-specific efforts in African countries from 2001 to 2005 represents just 4.6 percent of total TB financing. The Bank's failure to support the Africa region is even more apparent when its TB financing for 2004 is analyzed in relation to TB incidence rates and broken down on an estimated per-case basis (Figure 4) (Incidence rates from WHO 2006a). These low levels of funding show an inadequate response to the region's escalating TB incidence.

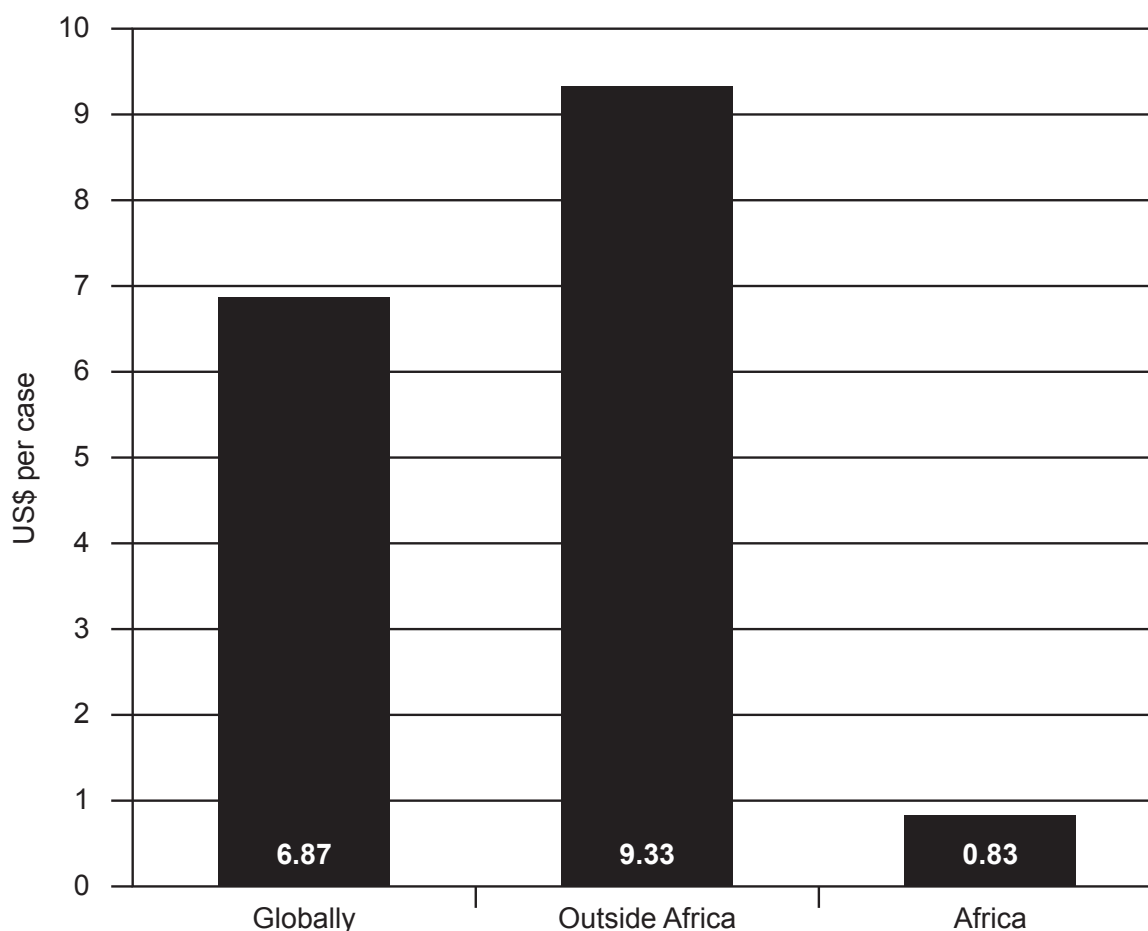
An analysis conducted using data from the Bank's publicly available Projects Database¹⁰ shows that of 32 ongoing projects that include a specific TB component, none operates within a HBC in Africa. The nine projects that do operate in Africa are found in countries that collectively represent just 8 percent of Africa's population and 5 percent of its TB burden (see Appendix B for list of 32 projects with a TB component).

The Bank, however, does have an ongoing record of support for large-scale, comprehensive TB projects in a number of key countries, particularly in Asia, and these have achieved impressive results (see section, "What Needs to Happen"). A recently approved project agreement with the Government of India, for example, will commit US\$170 million over five years to support the country's RNTCP. This loan follows on an initial nine-year loan, which was critical to the

⁹ IBRD provides loans, generally to middle-income countries, at near-market terms, but with longer-term repayment schedules than commercial banks.

¹⁰ Based on the results of a search for "TB" and "tuberculosis" in the World Bank's Projects Database (<http://www.worldbank.org>) conducted on July 22, 2006.

Figure 4: World Bank Investment in TB Per Case (2004): Global, Outside Africa & Africa



Sources: Based on authors' calculations using incidence data from WHO, Global Tuberculosis Control: Surveillance, Planning, Financing; WHO Report 2006 (Geneva: World Health Organization, 2006 (WHO/HTM/TB/2006.362)).

unprecedented scale up of India's DOTS program and its impressive increase in both case detection and cure rates. The World Bank should be commended for its support for India's RNTCP, as this ongoing collaboration comprises the world's largest, and arguably most successful, DOTS-expansion effort in history.

Predictably, such impressive achievements result from substantial, targeted investment: the Bank's financing for this single TB project is 15 times greater than financing for TB within all of Africa over the last five years. The World Bank will clearly not leverage similar successes in Africa without comparable financing for TB within the region.

WHAT NEEDS TO HAPPEN: GREATER LEADERSHIP BY THE WORLD BANK IN THE FIGHT AGAINST TB IN AFRICA

In the face of a continent-wide emergency, the World Bank needs to do its part by significantly ramping up investment in TB control for Africa if millions of deaths from this curable disease are to be prevented in the next decade, global trends in TB incidence are to be reversed and the MDGs, particularly MDG 6, are to be met by 2015. To achieve these goals, this report recommends that four key actions take place simultaneously.

Table 2. External TB Funding Gap to be Filled by Donor Sources (2006–2015): Global, Outside Africa & Africa Region (in US\$ millions)

Year	Global	OUTSIDE AFRICA		AFRICA	
	External TB Funding Gap	External TB Funding Gap	Gap as % of Global	External TB Funding Gap	Gap as % of Global
2006	549	204	37.2	345	62.8
2007	595	216	36.3	379	63.7
2008	649	233	35.9	416	64.1
2009	705	251	35.6	454	64.4
2010	759	266	35.0	493	65.0
2011	782	273	34.9	509	65.1
2012	807	277	34.3	530	65.7
2013	830	278	33.5	552	66.5
2014	854	279	32.7	575	67.3
2015	884	283	32.0	601	68.0
TOTAL	7,414	2,560	34.5	4,854	65.5

Source: Data from WHO, Stop TB Department, Geneva, Switzerland, personal communication/email, March 28, 2006.

1. World Bank funding for TB control in Africa must be drastically scaled up, with priority given to countries suffering high TB burdens and high rates of TB-HIV co-infection.

The World Bank can and should play a leading role in the fight against one of Africa's largest killers and drivers of poverty. While other health financing mechanisms have emerged in recent years, the need to scale up country-level TB control efforts over the long term is considerable, and these

Table 3. Recommended Minimum TB Financing Targets for Africa Based on 23.3% World Bank Estimated Share of the TB Funding Gap (2006–2015) (in US\$ millions)

Year	External TB Funding Gap	TB Financing Target	TB Financing Target, Adjusted*
2006	345	80	3.5**
2007	379	88	97
2008	416	97	105
2009	454	106	114
2010	493	115	123
2011	509	119	127
2012	530	123	132
2013	552	129	137
2014	575	134	142
2015	601	140	149
TOTAL	4,854	1,131	1,131

Source for column 2: WHO, Stop TB Department, Geneva, Switzerland, personal communication/email, March 28, 2006.

* Adjusted figures are calculated by taking the US\$80 million TB financing target for 2006 (column 3, row 2) minus the US\$3.5 million (column 4, row 2) which equals US\$76.5 million and then evenly distributing this amount (US\$8.5 million) across the remaining nine years (2007–2015). For example, for 2007, US\$88 million plus US\$8.5 million equals an adjusted TB financing target of US\$96.5 million or rounded to the nearest whole number, US\$97 million.

** The adjusted figure listed for 2006 assumes that the Bank will be providing at minimum the level it contributed for TB in Africa in 2005 of US\$3.5 million (Table 1) and that no new financing will be contributed for TB in Africa for the rest of 2006.

new mechanisms were intended to supplement existing financing—not supplant it. Important donors, including the World Bank, need to contribute their part by increasing financing for DOTS and coordinated TB-HIV activities in the face of a growing epidemic and its impact on the poor.

The Global Plan projects that Africa will require US\$19.4 billion over the next decade to sufficiently expand TB case detection and treatment interventions. Given available funding from all sources, Africa still faces an approximate gap of US\$11 billion over 10 years, of which nearly US\$5 billion must be met by external donors including the World Bank (Table 2). The annual external funding gap faced by Africa is expected to scale up over time from US\$345 million in 2006 to US\$601 million in 2015 (Table 2).

What portion of this external funding gap for Africa should the World Bank be expected to meet?

In regions outside Africa, the World Bank is currently providing financing for TB equivalent to an estimated 23.3 percent of the total external funding gap.¹¹ The World Bank should provide African countries with a level of TB financing, preferably grant financing, at least at the same level it provides countries outside Africa. To accomplish this, the Bank would need to increase its TB investment on the continent to the annual levels shown in Table 3—a total of US\$1.1 billion from 2007 to 2015.

The World Bank's Projects Database shows no TB-specific projects currently in the pipeline. Given the timetable required for developing and approving new projects, an adjusted ramp-up schedule in the last column of Table 3 assumes the same level of financing for TB in Africa for 2006 as was contributed in 2005 and suggests a timetable of TB financing targets for the Bank starting in 2007 and extending to 2015.

While this scenario proposes a substantial increase in financing for TB in Africa, it represents only a small percentage of the funding that is needed to fill Africa's TB funding gap. Given the demonstrable need to close this gap in order to mount an effective response to the TB emergency and make progress toward achieving MDG 6, the proposed figures listed in Table 3 are recommended as a minimum contribution to be made by the Bank. This scenario also emphasizes the need for Bank funding to complement other TB funding mechanisms, including the Global Fund and key bilateral donor initiatives in particular, which also need to be supported and scaled up robustly.

The Africa MAP, housed organizationally within the World Bank's Africa region, currently supports 31 countries on the continent and three regional initiatives and provides a natural base from which to expand support for TB-HIV in the region. However, the Bank's Africa region overall should also seek to increase its investment, particularly grant financing, for TB. This is especially relevant and necessary for countries with high TB burdens and high TB-HIV co-infection rates. Finally, the Bank should ensure that TB is prioritized as part of the *HIV/AIDS Agenda for Action in Sub-Saharan Africa (2007-2011)*, which is currently under development.

¹¹ The estimated percentage (23.3%) of the TB funding gap for countries outside Africa provided by current World Bank TB financing (which then provides a minimum target for Bank TB financing for Africa), is calculated by taking the Bank's 2005 contribution to TB in countries outside Africa from Table 1 (US\$47.58 million) divided by the estimated 2006 external TB funding gap for countries outside Africa from Table 2 (US\$204 million).

2. The World Bank needs to engage more proactively in policy dialogue with African governments.

No TB-control effort supported by the World Bank or any other donor agency will be effective unless African countries themselves accord priority to these programs. Indeed, the Global Plan lays out clearly that increased country investment and policy priority will be critical to achieving global TB targets. In this regard, the Bank can play an important role by encouraging greater prioritization of TB with IDA resources, particularly grant resources.

The Bank can proactively support African countries in developing more robust assessments of where and how support for TB and TB-HIV control is needed, and how IDA resources can be used effectively for this effort. The Poverty Reduction Strategy Paper (PRSP) process¹² could serve as an important channel for enhancing dialogue with governments and civil society in order to develop and promote a pro-poor agenda. This should include addressing TB, TB-HIV and other infectious diseases that disproportionately impact the poor, in ways that measurably benefit those living in poverty.

3. The World Bank should mobilize existing TB expertise and know-how.

The Bank has a strong track record in supporting the development and expansion of major national TB control programs in India, China and Russia. India and China have overseen the largest DOTS expansions in history. Lessons learned from these HBCs could inform efforts to expand effective TB programs in Africa, with priority placed on the nine African HBCs and other countries suffering from high rates of TB-HIV co-infection. To date, however, the Bank has largely failed to help expand strategic TB efforts in Africa the way it has in other regions, or to leverage best practices from its successful TB projects to adapt for TB projects in Africa.

India

India is home to 20 percent of the world's TB burden—the highest percentage of any country. The World Bank is the leading source of external financing for India's RNTCP, providing over US\$140 million from 1997 to 2005 through the Bank's National Tuberculosis Project. This project supported the most rapidly expanding DOTS program in the world, achieving 100 percent population DOTS coverage by March 23, 2006 (TBC India 2006a). Treatment success and case detection of new sputum smear-positive cases¹³ exceed the global target levels of 85 percent and 70 percent, respectively. In addition, the TB death rate currently stands at just 4 percent of registered cases (TBC India 2006b). The RNTCP reports that each day an average of 15,000 patients are examined, 3,200 are placed on treatment and more than 2,500 are cured (TBC India 2006b). Furthermore, 600,000 health care workers have been trained under the RNTCP scale up since the beginning of

¹² A process led by government involving the participation of other domestic stakeholders and external partners in the preparation of a strategy paper that describes a country's priorities and programs to reduce poverty over several years, including the financing needed to achieve these priorities.

¹³ Sputum smear-positive refers to the visual detection of TB bacilli upon microscopic examination of sputum produced by the patient. Sputum is saliva mixed with mucous or pus that has been coughed up from the lungs and is a common symptom of TB.

the program and more than 11,500 laboratory microscopy centers have been upgraded. A World Bank five-year Phase II TB loan of US\$170 million was approved in August 2006 and will support the RNTCP to work toward 100 percent case detection and treatment success.

China

In 1991, the World Bank approved a 10-year loan to China to control infectious diseases. TB was the first of three components covered by this project. By 2000, the project had treated and cured nearly 1.2 million TB patients. Moreover, patients within Bank-supported project areas were treated at less cost (US\$537 per patient) than those served by the Ministry of Health (US\$760) or in non-DOTS areas (US\$1432). As outcomes of the project, treatment success increased from 52 to 95.6 percent, case detection increased from 35 to 50 percent and prevalence declined 4.1 percent annually (World Bank 2002b). Moreover, the World Bank cited political commitment to fighting TB as one of the project's major successes, evidenced by government action to significantly expand DOTS and strengthen referrals to TB clinics. The incentives provided to healthcare workers to treat TB at the local and dispensary levels "fostered a stronger health system" and were considered "a valuable practice that should be replicated on a larger scale" (World Bank 2002a). According to the Bank's project completion report, the project's impact on health-sector policies and institutions was an "important success, leading to changes in diagnostic methods, the standardization of treatment, supervision of therapy, the establishment of new laboratories, and monitoring and reporting." Health promotion was "enhanced considerably," and operational research informed the project's implementation. To build on these successes, China's original multi-year loan was renewed in 2002 for over US\$100 million. The new project extends through 2010.

Russian Federation

The World Bank initiated the first nationwide Russian TB-HIV/AIDS project, providing a loan of US\$150 million from 2003 to 2008 to support successful scale up from pilot projects to a national-level TB program. As an initial project outcome, TB control overall has been improved in the Russian Federation through adoption of effective TB policies grounded in the DOTS framework and rapid scale up of TB services in the country. World Bank funding is continuing to support efforts to: 1) enhance TB policies, strategies and protocols; 2) strengthen surveillance, monitoring, quality control and quality assurance; 3) improve case detection and diagnosis; and 4) improve treatment and case management (World Bank 2002c). The project also includes efforts to curb the rise of MDR-TB, as WHO has identified the Russian Federation and the surrounding republics as MDR-TB hotspots. Regarding research and development, collaboration between the Bank and Russian pharmaceutical companies has improved the quality of anti-TB drugs and the process by which they are manufactured.

4. The World Bank's new HNP strategy needs to be supportive of the required major scale up of investment in TB control.

The World Bank is revising its Health, Nutrition and Population (HNP) strategy for the first time since 1997, with a new strategy expected to be finalized in December 2006. Three major shifts

are proposed: 1) encouraging greater multi-sectorality in the Bank's dealings with countries; 2) linking lending to results and outcomes related to the MDGs; and 3) emphasizing health systems strengthening over single-disease efforts. The first two shifts are consistent with the necessary scale up of TB financing for Africa, while the third is potentially problematic. This new HNP strategy has significant implications for future directions of the Bank in its overall design and implementation of health sector lending, including for TB.

Multi-sectorality

The World Bank's move to extend country-level collaboration beyond the Ministry of Finance is a positive one. Enabling the Ministries of Health, Education and other social sectors to participate alongside the Ministry of Finance in consultations with the Bank is fundamental to a more inclusive, effective process. Such a process can serve to empower social-sector ministries to put forward adequate budgets, provide a forum for discussion on budget-setting and potential impact of budget ceilings on social sectors and increase cross-sector communication and collaboration. Inclusion of non-governmental sectors, particularly civil society, is also critical for ensuring equity, access and quality of health services.

Financing linked to clear, measurable outcomes in line with the MDGs

To assess the impact of its efforts, it is vital that the Bank link all health lending and policies to clear, measurable outputs and outcomes, especially for the poor. A shift to greater accountability through specific measuring of indicators and reporting on outcomes is strongly encouraged and welcomed.

According to Raviglione and Pio, health sector reform in the 1970s and 1980s saw critical and specialized supervisory functions for TB control broadly integrated into those for primary health (2002). This negatively impacted many countries' abilities to effectively implement TB programs and to conduct program M&E. This provides an important lesson: as the Bank revises its HNP strategy to engage in broader health systems strengthening, it must also strengthen capacity to conduct M&E to ensure that investments and policies are actually improving health outcomes for the poor and not unintentionally worsening them.

Finally, budget support and other general health financing efforts must ensure that M&E features centrally in their design, and that financing can be tracked to increased access to priority health services, especially for the very poor, and ultimately to improved health outcomes.

Health systems strengthening and targeted efforts to address diseases of poverty

Health systems strengthening and disease-specific efforts are complementary. The problems associated with weak health systems in African countries have been recognized by the donor community, activists, broader civil society and affected country governments for many years. More recently, the donor community, including the Bank, has shifted greater attention to the issue of health systems strengthening. For several donors, discussions around how and where donor funding can

help to build and improve health systems has shifted preferences and priorities away from single-disease efforts in favor of this broader agenda. The challenge arises when broad health systems strengthening is pursued to the point of diverting resources away from proven interventions that address specific diseases of poverty. Health systems strengthening should not supersede, but rather complement comprehensive, disease-specific interventions.

TB-specific investments in Africa within general health sector financing will help ensure cost-effectiveness of resources and a pro-poor reach. The World Bank's own data show DOTS to be among the world's most cost-effective health interventions or a "best buy in public health" (Jamison et al. 1993). The World Bank has found in China, for example, that US\$15 to US\$20 invested in DOTS was sufficient to save one healthy life-year, equaling a US\$60 return for each dollar invested (World Bank 2002b). Targeted TB investment is more likely to benefit the very poor because the disease disproportionately affects the poor. Hence funding TB programs is not only a proven high-impact health investment, but also a step toward ensuring that overall health financing by the Bank benefits the most vulnerable.

Focus on health systems strengthening should not supplant urgent responses to major epidemics. Action to address the TB emergency in Africa is needed now. TB was declared an emergency in Africa in 2005 by African Ministers of Health and WHO. Despite its "emergency" status, international donors and African countries have been slow to deliver with no major announcements targeted to address the TB emergency since it was declared. The Bank's new HNP strategy should allow flexibility for the Bank to take action to address specific health emergencies, such as TB in Africa, to save lives now and help support countries to ramp up their capacity to prevent future emergencies.

KEY RECOMMENDATIONS FOR ACTION

1 *The World Bank should invest a minimum total of US\$1 billion over the next 10 years to contribute to filling the external funding gap in Africa to reach MDG 6 by 2015. Priority should be on providing grant funding.*¹⁴

Major specific initiatives with dedicated resources have been launched by the Bank for HIV/AIDS and malaria. Given the global burden of TB, especially in Africa, and the fact that TB is curable through DOTS, one of the world's most cost-effective and pro-poor strategies, the Bank has shown neglect in not providing the same level of attention and resources to TB. The Bank has an obligation and an opportunity to demonstrate leadership in helping to close the TB financing gap for Africa. At a minimum, over the next decade the Bank should provide TB financing for Africa proportional to the level it provides for regions outside Africa, and at a level commensurate to the Bank's response to HIV/AIDS and malaria.

¹⁴ See Table 3 for a breakdown of recommended minimum annual World Bank TB financing targets for Africa from 2007 to 2015.

2 The World Bank should be proactive in reaching out to African countries to encourage demand for support in controlling their TB crises.

The Bank should take proactive steps to assist African countries to develop more robust assessments of where and how support for TB/TB-HIV control is needed and how IDA resources, particularly grant resources, can be used effectively to achieve free universal access to quality TB treatment. The PRSP process could serve as one important channel through which to enhance dialogue with governments and civil society in their efforts to set the minimum components of a pro-poor agenda that ensures TB and other infectious diseases that disproportionately impact the poor are addressed in ways that measurably benefit those living in poverty.

3 The World Bank should adapt TB expertise and know-how from its experiences in India and China and other models to expand support for TB in Africa.

Given the magnitude of the TB epidemic in Africa, it is critical that the Bank demonstrates the same level of support and leadership that was significant in the success of TB control in India and China, two of the most comprehensive scale ups in public health ever implemented. The Bank should also consider adapting other successful models from PEPFAR, the Global Fund and WHO to help support African countries to expand TB control and address TB-HIV.

4 The World Bank's new HNP strategy needs to allow for major scale up of financing for comprehensive TB control efforts.

The Bank's potential shift to: 1) multi-sectorality or greater inclusion of other relevant stakeholders; and 2) linking investments to clear, measurable outcomes, is positive. However, in the context of the HNP strategy, health systems strengthening and single-disease efforts should not be seen as conflicting choices, but rather as necessary and valuable complements. It should be recognized that TB-specific investments in Africa within general health sector financing can help ensure cost-effectiveness of resources and a pro-poor reach. Action is needed now to save lives and should not be superseded by a focus on longer-term health systems strengthening. Furthermore, the Bank's new HNP strategy should include recognition of the role of the IMF in policy-setting in countries. The Bank should maintain active engagement with the IMF and Ministries of Finance to ensure that increased investment in TB control and health systems strengthening is not limited by wage bill and overall budget ceilings, in particular, and other IMF-advised fiscal and monetary policies that may restrict countries' ability to increase their capacity to effectively deliver health services.

5 The World Bank should ensure that civil society, especially affected populations, have an explicit role in the development of Bank health policies and Bank-supported health projects.

To date, the Bank has engaged a number of civil society partners in discussions around its new HNP strategy, as well as its *HIV/AIDS Agenda for Action in Sub-Saharan Africa (2007-2011)*. Substantive engagement of civil society, especially in affected countries, is critical to shaping policies and developing projects that help rather than adversely affect the poor.

6 The World Bank should take a lead role in galvanizing high-level support for and participation in a Ministerial conference on TB in Africa in early 2007, as called for in the 2005 G8 Summit communiqué.

The 2005 Gleneagles Summit called for a Ministerial meeting on TB financing this year. Given the Bank's engagement with Heads of State, Ministries of Finance and Health, and its role in convening meetings on HIV/AIDS and malaria, the Bank should take a similar lead in a summit on TB financing in early 2007, with a particular focus on addressing the TB crisis in Africa.

Finally, African governments should prioritize TB investments with IDA resources, especially grant resources; develop national TB emergency plans and demand additional external resources to address their TB emergencies; and, wherever possible, invest more of their own resources to fight TB.

While the Bank should do more to address TB, African governments themselves need to take high-level action to address their TB emergencies, including prioritizing TB within their available IDA resources. African governments, particularly Ministries of Finance and Health, need to work more closely together to develop initiatives—including national TB emergency response plans—and prioritize TB as part of their overall health portfolios. Where financing gaps exist, African governments should be proactive in seeking additional resources from the Bank and other donors to tackle TB, and, wherever possible, mobilize additional internal resources.

APPENDICES

APPENDIX A. Listing of World Bank MAP Countries and Corresponding TB-HIV Data

On average, 22 percent of adults with TB in MAP countries are co-infected with HIV, compared to a global average in adults of roughly 13 percent (WHO 2006a). In seven countries, HIV prevalence in people with active TB surpasses 30 percent. Malawi and Zambia face a particular burden, with greater than half of those with TB also suffering from HIV. In eight MAP countries, more than a third of TB deaths are AIDS-related. Such high rates of TB-HIV co-infection and mortality in MAP countries show that MAPs will be most effective by addressing HIV/AIDS in the context of its co-epidemic with TB.

Table A.1: 31 MAP Countries and Corresponding TB-HIV Data (2004)

MAP country	HIV prevalence in adult incident TB cases (%)	TB incidence rate, all forms HIV+	TB prevalence rate, all forms HIV+	TB mortality rate, all forms HIV+
Angola	17	29	14	7
Benin	9.3	5	3	2
Burkina Faso	24	32	16	16
Burundi	30	74	37	33
Cameroon	31	39	20	12
Cape Verde	2.8	3	2	1
Central African Republic	48	110	55	58
Chad	22	43	21	22
Republic of the Congo	23	61	31	18
Côte d'Ivoire	30	83	41	37
Democratic Republic of the Congo	21	54	27	21
Eritrea	15	26	13	9
Ethiopia	21	53	26	19
Gambia	5.1	8	4	2
Ghana	16	21	11	10
Guinea	17	27	13	12
Guinea-Bissau	19	25	12	9
Kenya	29	125	63	43
Madagascar	10	14	7	6
Malawi	52	152	76	49
Mali	12	22	11	11
Mauritania	4.4	8	4	3
Mozambique	48	158	79	67
Niger	6.8	7	3	3
Nigeria	27	55	27	27
Rwanda	26	69	34	33
Senegal	4.7	7	4	3
Sierra Leone	9.9	28	14	13
Uganda	19	54	27	22
United Republic of Tanzania	36	89	44	31
Zambia	54	261	130	68
AVERAGE	22	56	28	22

Source: Data from WHO, Global Tuberculosis Control: Surveillance, Planning, Financing; WHO Report 2006 (Geneva: World Health Organization, 2006 (WHO/HTM/TB/2006.362)).

APPENDIX B. Listing of World Bank Projects with a TB Component

The list of the following projects was derived by searching for “tuberculosis” or “TB” within the World Bank’s Projects Database. Of the 32 projects listed, only nine are in the Bank’s Africa region. These nine countries collectively represent only 8 percent of the region’s population and 5 percent of its TB burden (WHO 2006a). None of the Bank’s projects in Africa with a TB component operate in Africa’s nine HBCs.

Table B.1: World Bank Projects Containing a TB Component

Project #	Title	Location	Duration	Allocation (US\$ millions)
1) TB Projects				
P078539	Second National Tuberculosis Control Project	India	pipeline	\$ 165.0
P071147	Tuberculosis Control	China	3/02-3/10	\$ 104.0
Subtotal:				\$ 269.0
2) TB-HIV Projects				
P064237	Tuberculosis & AIDS Control Project	Russian Fed.	4/03-12/08	\$ 150.0
P069857	Tuberculosis & HIV/AIDS Control Project	Ukraine	12/02-6/07	\$ 60.0
Subtotal:				\$ 210.0
3) AIDS, TB, & Malaria Projects				
P094694	HIV/AIDS/STI, TB, Malaria & Reproductive Health Project (HAMSET II)	Eritrea	6/05-6/10	\$ 24.0
P073603	HIV/AIDS, Malaria & Tuberculosis Control Project	Djibouti	5/03-9/08	\$ 12.0
P083180	HIV/AIDS, Malaria & TB Control Project (HAMSET)	Angola	12/04-6/10	\$ 21.0
Subtotal:				\$ 57.0
4) Other Projects				
P003566	BASIC HEALTH (HLTH8)	China	5/98-6/07	\$ 85.0
P004838	National Health Support	Vietnam	1/96-10/06	\$ 101.2
P051174	Health Investment Fund Project	Moldova	8/00-8/06	\$ 10.0
P051741	Second Health Sector Support Project	Madagascar	12/99-12/06	\$ 40.0
P055482	Public Health Surveillance & Disease Control Project (VIGIA)	Argentina	10/99-5/06	\$ 52.5

Project #	Title	Location	Duration	Allocation (US\$ millions)
P069916	2nd Social Expenditure Management	Philippines	6/02-12/05	\$ 100.0
P070542	Health Sector Support Project	Cambodia	12/02-12/07	\$ 27.0
P073442	HIV/AIDS Global Mitigation Support Project	Guinea-Bissau	6/04-12/07	\$ 7.0
P071505	HIV/AIDS Prevention & Control Project	Dominican Republic	6/01-12/06	\$ 25.0
P071612	Multi-Sector STI/HIV/AIDS Support Project	Niger	4/03-6/08	\$ 25.0
P073525	Multi-Sectoral HIV/AIDS Project	Central African Rep	12/01-6/06	\$ 17.0
P073651	Integrated Disease Surveillance Project	India	7/04-3/10	\$ 68.0
P073883	HIV/AIDS Response Project	Sierra Leone	3/02-12/06	\$ 15.0
P074122	AIDS Control Project	Moldova	6/03-7/08	\$ 5.5
P074128	Health Sector Reconstruction & Development Project	Sierra Leone	2/03-02/08	\$ 20.0
P074730	National HIV/AIDS Prevention Project	Sri Lanka	12/02-6/08	\$ 12.6
P074841	Health Nutrition & Population Sector Program	Bangladesh	4/05-12/10	\$ 300.0
P075220	Caribbean HIV/AIDS I	Barbados	6/01-12/06	\$ 15.2
P076715	HIV/AIDS Prevention & Control	Grenada	7/02-6/07	\$ 6.0
P076722	HIV/AIDS Prevention & Control Project	Guyana	3/04-6/09	\$ 10.0
P080721	Pan-Caribbean Partnership Against HIV/AIDS	Caribbean	3/04-12/07	\$ 9.0
P08223	Healthcare System Improvement Project	Montenegro	6/04-2/09	\$ 7.0
P08333	Emergency Multi-Sector Recovery Program	Angola	2/05-12/07	\$ 50.7
P087003	AIDS Control Project	Central Asia	3/05-12/07	\$ 25.0
P087843	HIV & AIDS Capacity Building & Technical Assistance Project	Lesotho	7/04-12/08	\$ 5.0
Subtotal:				\$ 1,008.7
Total				\$ 1,574.70

Source: World Bank, Project Database, <http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/0,,menuPK:115635~pagePK:64020917~piPK:64021009~theSitePK:40941,00.html>. Accessed May 8, 2006.

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