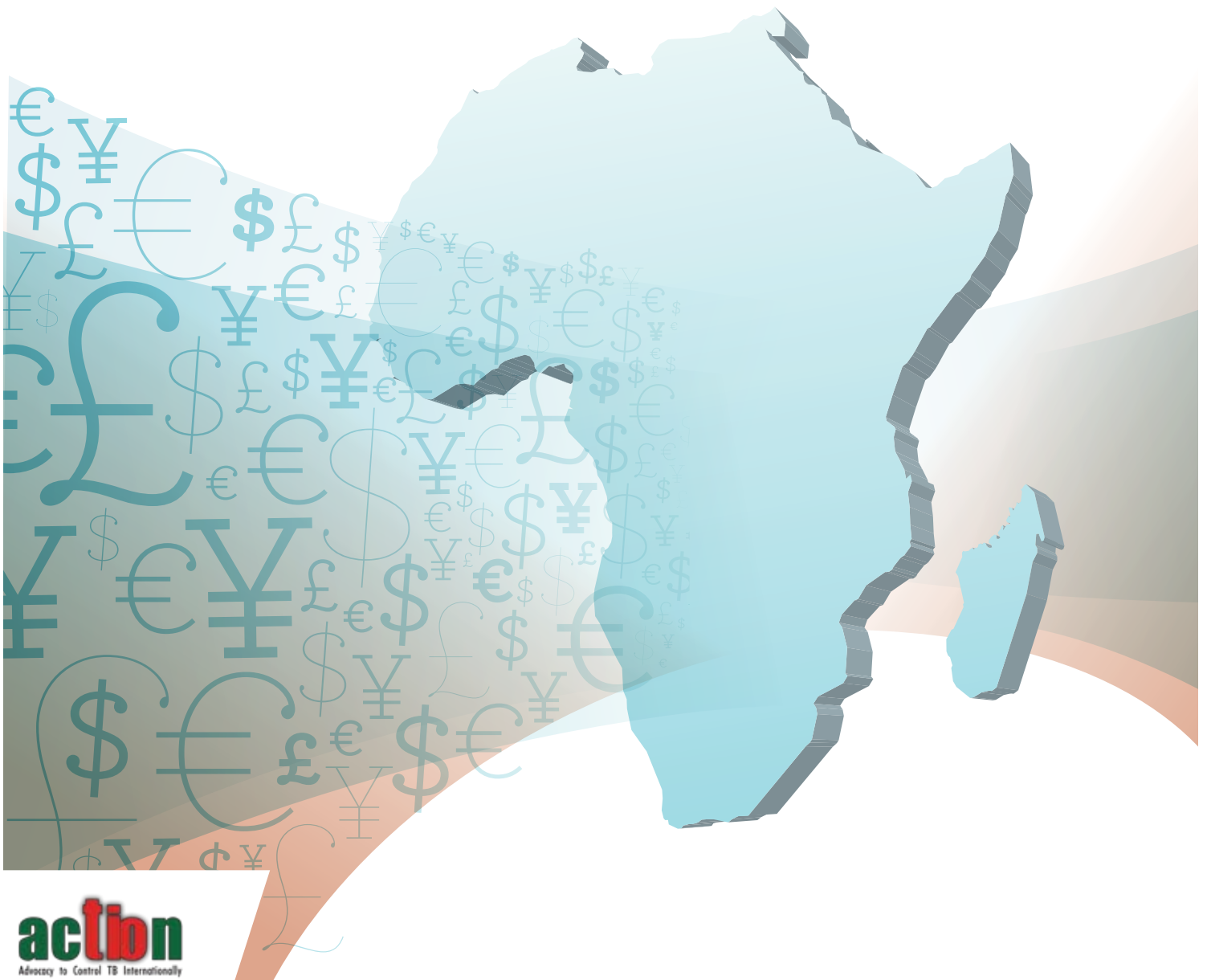


AID WITHOUT IMPACT

How the World Bank and Development Partners
Are Failing to Improve Health Through SWApS



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Are Failing to Improve Health Through SWApS**

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The “Broad Sector Approach” is concerned above all things with improving the results on the ground of investment lending, in particular by assuring the consistency and coherence of policy and investments, and of the interventions of all the different actors, by the farmers, government officials, donors, special interest groups or World Bank staff. ...We view this as the only sure way of increasing the impact and sustainability of our assistance, and of the country’s own resources.

—Kevin Cleaver, Director, World Bank Africa Technical Department, in the Foreword to “The Broad Sector Approach to Investment Lending,” The World Bank, 1995.

About ACTION

ACTION (Advocacy to Control Tuberculosis Internationally) is an international partnership of advocates working to mobilize resources to treat and prevent the spread of TB, an airborne infectious disease that kills one person every 20 seconds. ACTION's underlying premise is that more rapid progress can be made against the global TB epidemic by building support for effective TB control among key policy-makers and other opinion leaders in both donor countries and high-burden countries.

With support from the Bill & Melinda Gates Foundation and other donors, ACTION employs cutting-edge advocacy strategies to support both country-specific and global solutions for the control of TB. In six donor countries — Australia, Canada, France, Japan, the United Kingdom and the United States — ACTION is working to secure the political will needed to eliminate TB as a public health threat worldwide, by improving the policies of foreign assistance programs, and by increasing public resources directed to TB programs and research and development. In two high-burden countries — India and Kenya — ACTION is working with civil society and with national governments to mobilize greater investment in TB control, and to overcome policy constraints toward achieving universal access to TB treatment and care.

ACTION also works to expand and transfer skills for effective advocacy to additional donor and high-burden countries.

Finally, ACTION engages multilateral agencies such as the World Bank; the World Health Organization; and the Global Fund to Fight AIDS, Tuberculosis and Malaria, toward increasing funding and improving policies for global TB control.

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PREFACE

This report is the latest in a series that has analyzed the responses of key international development donors to tuberculosis (TB) in sub-Saharan Africa.

In 2006, *Enduring Neglect: The World Bank's Inadequate Response to Africa's TB Emergency* showed that less than one percent of the Bank's health lending to African countries supported TB control projects. Six percent of the Bank's total financial support for TB control went to countries in sub-Saharan Africa. This meant that on a per-case basis, the Bank was providing roughly 11 times more funding to fight TB outside Africa than within it — despite the fact that TB is epidemic on the continent.

In response, the World Bank asserted that the institution was addressing TB in Africa not through specific TB projects, but rather through its HIV/AIDS program as well as through its support to strengthen health systems.¹

In 2008, *Living With HIV, Dying of TB: A Critique of the Response of Global AIDS Donors To the Co-epidemic* looked at how the World Bank's flagship Multi-Country HIV/AIDS Program for Africa (the Africa MAP) was addressing TB. Even though TB is the most common infection that kills people with HIV in Africa, we found that the Africa MAP did not require its projects to address TB-HIV co-infection or to monitor and evaluate the effectiveness of TB-HIV activities. Moreover, on a project-by-project basis, we found little evidence that the Africa MAP was financing activities intended to keep people with AIDS from dying of TB. Our findings were later confirmed by the World Bank's Independent Evaluation Group, which found that "almost none of the MAP HIV/AIDS projects in Africa contain specific financial support for tuberculosis control."²

This report brings our analysis full circle. Within the pages that follow, we examine the World Bank's claims that it is fighting TB through its efforts to strengthen health systems — particularly through health sector-wide approaches (SWAps). But this report is slightly more ambitious than that. While researching, it became clear that we could not entirely single out the Bank among donors as the focus of our analysis, because World Bank SWAp projects involve multiple sources of financing. Moreover, because SWAps are intended to improve health conditions systemically, our concerns about improving TB outcomes are equally as relevant to other deadly illnesses.

This report therefore has implications for all donors and recipient countries that engage in SWAps, and we hope it leads others to more closely examine whether SWAps are fulfilling their promise to improve a range of disease outcomes. Most importantly, we hope that this report leads to tangible changes in how SWAps are implemented, so that they can be shown to consistently and effectively improve the health of people.

Paul Jensen
Global Research Coordinator
ACTION

1 See, for example, "More Financing Is Urged to Fight TB In Africa," *The New York Times*, September 13, 2006 and "World Bank is faulted on its tuberculosis aid efforts," *The Boston Globe*, September 13, 2006.

2 World Bank Independent Evaluation Group. (2009c). *The Stop Tuberculosis Partnership. Global Program Review Volume 4 Issue 1*. Washington, D.C., The World Bank Group.

EXECUTIVE SUMMARY

BACKGROUND

As the world's leading infectious killer after HIV/AIDS, tuberculosis (TB) remains a disease of exceptional public health importance. TB most heavily impacts the poor in low- and middle-income countries as well as people living with HIV, and it impedes development in areas with a high burden of the disease. The need to address TB has become more urgent in recent years, as HIV/AIDS has driven a resurgence of the disease across much of Africa and as a growing share of TB has become resistant to one or more of the standard drugs used to treat it. Some important progress has been made in global TB control over the last decade, but the world is still far off track toward meeting the Stop TB Partnership's 2015 targets of reducing global TB prevalence and mortality rates to half the levels that were seen in 1990 (World Health Organization 2009b).

There were 9.4 million new cases of TB in 2008, as well as 1.8 million TB deaths. Approximately 44 percent of all TB deaths occurred in Africa, including over 80 percent of all TB deaths among people living with HIV/AIDS. Most people with TB disease in sub-Saharan Africa go undiagnosed, and fewer than 12 percent of the estimated number of multidrug-resistant TB cases in the region in 2008 were identified (World Health Organization 2009b; World Health Organization 2010a; World Health Organization 2010b).¹

While the World Bank has successfully supported national efforts to control TB in China and India through large-scale TB-specific investments, the Bank is largely pursuing a different strategy against TB in the Africa region. Rather than supporting TB-specific projects, the Bank's latest Health, Nutrition, and Population (HNP) strategy seeks to address TB through support to recipient governments for health sector development more broadly (World Bank 2007). This approach emerged in the late 1990s in response to certain limitations that were observed in the project-based approach to health in some settings. The sector-wide approach (SWAp) then evolved as a way to coordinate donor financing for

health sector development. Development assistance channeled toward broad health sector support increased from approximately \$2 million in 1998 to \$937 million in 2007, and in 2006 funding for health sector support exceeded for the first time both TB- and malaria-specific funding (Institute for Health Metrics and Evaluation 2009).

FOCUS OF THIS REPORT

This report seeks to assess the efforts of the World Bank and its development partners to address TB in sub-Saharan Africa through SWAPs. Moreover, because SWAPs are intended to improve public health more generally, the research yielded evidence regarding their performance against other priority health interventions.

As it examines the support provided by the World Bank for TB control, this report seeks to answer four questions for the period 2001 to 2008 for low-income countries in sub-Saharan Africa:

- To what extent did the World Bank, working with its development partners, support TB control through "health sector development projects," including those carried out through SWAPs?²
- To what extent were SWAPs associated with improvements in TB case detection and treatment success rates?
- To what extent do SWAPs appear to be associated with improvements in health outcomes more generally?
- How could the World Bank, its development partners, and countries with a substantial TB burden strengthen the impact of SWAPs on TB case detection and treatment success?

¹ South Africa accounted for over 80 percent of all notified MDR-TB cases in the Africa region. Excluding South Africa, fewer than three percent of MDR-TB cases in Africa were identified in 2008.

² "Health sector development projects" are investment projects in the health sector that generally support the strengthening of key health systems functions as well as various programs within the health sector. This type of operation is to be contrasted with a health project that focuses on a narrow range of investments, such as a project focused on TB control, or HIV/AIDS control, or nutrition.

METHODOLOGY AND LIMITATIONS

This report is based on a review of selected project data, a literature review, and key informant interviews. First, ACTION reviewed 15 World Bank-assisted health sector development projects for countries in sub-Saharan Africa that were approved between 2001 and 2008. Second, ACTION reviewed considerable literature on program-based approaches to development assistance, SWApS in health, and SWApS in education.³ ACTION then carried out 28 key informant interviews with people with expertise in development assistance for health, including for TB control and for health sector development.

This review is not meant to be exhaustive or to compare TB outcomes associated with SWApS with TB outcomes associated with development projects that have a specific TB focus. In addition, ACTION did not examine the extent to which countries implemented the TB component of their SWAp “program of work” (PoW). Rather, this review is concerned with health outcomes — including the extent to which SWApS appear to be associated with improvements in TB case detection and treatment success.

The World Bank and its development partners need to see the failure of SWApS to consistently promote better health outcomes as a potentially lethal breakdown in their development assistance programs for health.

FINDINGS

There is an unacceptable dearth of scientific assessment that demonstrates the impact of SWApS on health outcomes, despite the billions of dollars that have been invested in this approach since the mid-1990s.

Information collected through 28 key informant interviews, as well as a review of the available literature, suggests that the World Bank and its development partners urgently need to adjust their approach to SWApS if SWApS are to effectively and efficiently produce better health outcomes. Within the available literature on SWApS, it was difficult to find evidence that SWApS were enabling improvements in health outcomes. Moreover, while all of the individuals ACTION interviewed for this report expressed that the SWAp is an essential approach to development assistance for health in low-income countries in sub-Saharan Africa, almost all of them noted that in most countries SWApS are not yet being implemented in a way that has led to improvements in health outcomes in effective, efficient, measurable, or sustainable ways.

The findings of a World Bank Independent Evaluation Group (IEG) evaluation of SWApS in the health sector were consistent with this review’s findings, identifying major flaws in the approach the Bank and its development partners are taking to SWApS. These flaws included, among others:

- A general lack of attention to results
- Insufficient attention to ensuring that SWApS are technically sound
- A general failure to monitor country expenditures to be sure they focus on the highest-priority investments
- Very weak monitoring and evaluation of the health programs that SWApS are supporting

The IEG review found that SWApS are associated with mixed results at best (World Bank Independent Evaluation Group 2009a).

³ “Program-based approaches” was a term used more often during the early conceptual phase of SWApS. It is meant to differentiate between aid directed to discrete projects and aid directed to broadly support a sector plan.

The World Bank and its development partners are not addressing TB adequately or appropriately through SWAPs in sub-Saharan Africa.

Only three of the 15 projects reviewed (20 percent) included indicators for improving both TB case detection and treatment success. Programs in three countries with high TB burdens included no TB indicators at all, despite the fact that these programs were oriented toward broad “health sector development.” Little evidence from project documents or 28 key informant interviews suggested that the World Bank and its development partners gave TB the rigorous and priority attention that it should be given in countries with a high TB burden.

Key informant interviews also did not identify any successful impacts on TB that might have been driven by SWAPs. Rather, the most pertinent comments made by key informants suggested that improving TB control in the presence of a SWAP occurs most in those countries that “ring fence” their TB program from the SWAP and continue, often with financing separate from the SWAP, to pay focused attention to improving both case detection and treatment success.

RECOMMENDATIONS

The World Bank and its development partners need to see the failure of SWAPs to consistently promote better health outcomes as a potentially lethal breakdown in their development assistance programs for health. They urgently need to reduce the emphasis in SWAPs on *process* and increase the emphasis on *outcomes*. They must also view SWAPs as a means to achieve better health outcomes rather than as an end in themselves. While efforts to strengthen health systems are important, and while they might be *necessary* conditions for the achievement of health outcomes in some settings, they will rarely be *sufficient* conditions for such achievement. Reducing morbidity and mortality will almost always require well-focused, continuous technical engagement with countries in high-priority areas, regardless of the approach to development assistance being taken by the development partners active in that country.

For SWAPs to promote improvements in health outcomes, the following measures should be taken with urgency:

The World Bank and other development partners must look beyond the process of coordinating aid and toward measuring and improving health outcomes.

Management within these institutions must provide stronger incentives for staff to focus on achieving results. If development partners are made to tie their disbursements to results, this adjustment should help turn their attention, as well as the attention of recipient governments, to improving health outcomes. Moreover, evaluation must be adequately funded and integral to all development-assistance efforts in health. These are findings that the World Bank and others have repeatedly come to themselves, but have failed to sufficiently act on. Absent such changes, established initiatives will fail to improve health outcomes. Moreover, new initiatives such as the International Health Partnership and related initiatives (IHP+) will risk becoming another process-oriented effort that fails to improve health outcomes.

To better ensure accountability for improving health outcomes within SWAPs:

- **Health programs should be reviewed at least once every two years by a truly independent technical team that assesses the impact of program implementation compared to stated objectives, publicly reports on findings, and makes recommendations for improving performance.** Despite the best efforts of stakeholders, the current arrangements for project oversight generally do not produce uncompromised, publicly available information on the status of development investments, as the World Bank itself has noted (World Bank Independent Evaluation Group 2009b).
- **The World Bank and other development agencies should make public, at a minimum, the Annual Joint Program Reviews that cover the health projects they support.** Public oversight of key development investments in low-income settings is critical to the success of these investments. Recent revisions to the World Bank’s policy on transparency could be a valuable step in this direction.⁴

- **SWAps must be more rigorously monitored and evaluated to determine what is working and what is not.** The World Bank and its development partners should invest more resources in monitoring and evaluation to better determine what is working and what is not within the implementation of SWAps. They should disseminate this information widely among all stakeholders, and the results of such research should be used to improve the implementation of SWAps over time.

The World Bank and other development institutions must ensure that the development assistance they provide is appropriate to country capacity.

SWAps were conceived for application in countries exhibiting strong financial accountability, a coherent policy framework, and substantial country capacity for effective program implementation. In practice, however, SWAps have generally been implemented in contexts that do not fit this model. In part for this reason, the aims of SWAps have often exceeded available country capacity and have failed to pay sufficient attention to priority health interventions (World Bank Independent Evaluation Group 2009a). Development partners must better assess risk before developing SWAps. In addition, funds should flow on a large scale only to those SWAps that evidence shows are helping to achieve improvements in health outcomes, particularly for the poor, women and girls, and other marginalized groups. This will encourage greater attention to appropriate design of SWAps.

The assistance that the World Bank and other development partners provide for TB through SWAps must lead to improvements in TB case finding and treatment success.

SWAps in countries where TB is a disease of public-health consequence should include indicators for tracking the progress being made to improve TB case detection and treatment success. Targets for improvements in these indicators should be established, performance of the SWAp should be consistently measured against these benchmarks, and staff should be held accountable for meeting these targeted outcomes.

⁴ In December 2009, the Board of Directors of the World Bank approved a new disclosure policy that will greatly increase the number of World Bank project documents that are made publicly available.

INTRODUCTION

As the world's leading infectious killer after HIV/AIDS, TB remains a disease of exceptional public health importance. TB most heavily impacts the poor in low- and middle-income countries and people living with HIV, and it impedes development in areas with a high burden of the disease. HIV has driven a resurgence of TB across sub-Saharan Africa, and a growing proportion of TB is resistant to the most effective anti-TB drugs. Extensively drug-resistant TB (XDR-TB), resistant to a number of both first-line and second-line drugs, has been reported in 58 countries so far.⁵

There were 9.4 million new cases of TB in 2008, of which 4.3 million were sputum-smear positive (SS+).⁶ The World Health Organization (WHO) estimates that in 2008 only 61 percent of new SS+ cases were detected and treated in DOTS programs, compared to the global target of 70 percent (World Health Organization 2009b).⁷ In 2008 there were an estimated 0.44 million cases of multidrug-resistant TB (MDR-TB), with 27 countries bearing 85 percent of the burden of MDR-TB.⁸ Fewer than an estimated 12 percent of these MDR-TB cases were detected, and only one percent were treated in Green Light Committee-approved projects.⁹ In other words, over 90 percent of the MDR-TB cases in the world are not detected, not treated at all, or treated improperly (World Health Organization 2010a).

Though home to only 15 percent of the world's population, sub-Saharan Africa accounts for over 30 percent of all new TB cases, 44 percent of all TB deaths, and 80 percent of TB deaths among people living with HIV/AIDS.

Despite these sobering numbers, some important progress has been made against TB in the last decade. The number of annual new TB cases is now falling in all regions except sub-Saharan Africa, and worldwide TB case detection and treatment success rates continue to improve. However, the number of people in Africa who annually develop TB has been great enough to offset decreases in TB incidence in other regions, and 1.8 million people continue to die of TB each year. Overall, the world is still far off track toward meeting the Stop TB Partnership's targets of halving 1990 prevalence and mortality rates by 2015, and there remains a large unfinished agenda for TB control in low- and middle-income countries (World Health Organization 2009b).

The importance of addressing TB-HIV co-infection also cannot be overstated. TB is the leading cause of death of people living with HIV in low-income countries, with one in four HIV deaths caused by TB (World Health Organization 2009a). Of the estimated 1.8 million TB deaths in 2008, 0.52 million (30 percent) were among people infected with HIV (World Health Organization 2009b). People who are HIV-positive and infected with the TB bacillus are 20- to 30-times more likely to develop active TB disease than people who are HIV-negative, and TB is much harder to diagnose in people with HIV, as HIV is associated with extra-pulmonary TB (TB that occurs outside the lungs) and sputum-smear negative TB, which the standard diagnostic test for TB fails to detect (World Health Organization 2009c).

In order to understand why TB is so important to the global burden of disease and to the well-being of poor people in low- and middle-income countries, it is important to place TB within a broader global health context. Table 1 shows the number of deaths worldwide in 2008 from HIV/AIDS, TB, and malaria in sub-Saharan Africa and globally.

5 XDR-TB is defined as TB that is resistant to at least rifampicin and isoniazid (two key first-line drugs, the resistance to which defines multidrug resistance), at least one drug from the family of quinolones, and at least one of the following second-line injectable drugs: amikacin, capriomycin, or kanamycin.

6 SS+ TB is a case of TB where sputum produced by the patient contains enough TB bacilli that it can be seen by a technician looking at the sputum through a light microscope. It is considered the most contagious form of TB.

7 DOTS stands for "Directly Observed Therapy, Short-course" and is the linchpin of the internationally sanctioned strategy for TB control. DOTS is an approach in which patients are supervised as they take their drugs in order to ensure proper treatment. DOTS also requires political will for addressing TB, case detection through approved bacteriological methods, a properly managed drug supply, and quality monitoring and evaluation.

8 MDR-TB is a form of TB resistant to at least isoniazid and rifampicin, which are the two most potent anti-TB drugs included in the standard TB treatment regimen. MDR-TB treatment is much more toxic than standard TB treatment, and overall management of MDR-TB is much more expensive than drug-sensitive TB.

9 The Green Light Committee is a WHO initiative that assesses a country's capacity to effectively treat cases of drug-resistant TB and provides technical assistance around the management of TB drug resistance.

TABLE 1. Estimated Mortality of HIV/AIDS, TB, and Malaria in Africa and Globally, 2008

Region	HIV/AIDS	TB	HIV-associated TB	Malaria
Sub-Saharan Africa	1.4 million	805,000	420,000	767,000
Global	2 million	1.8 million	520,000	863,000

Source: Joint United Nations Programme on HIV/AIDS and World Health Organization 2009; World Health Organization 2009b; World Health Organization 2009d; World Health Organization 2010b

Twenty-two countries account for 80 percent of new TB cases each year and are classified by WHO as “high-burden countries,” and nine of these 22 countries are in sub-Saharan Africa (Table 2) (World Health Organization 2009b). Though home to only 15 percent of the world’s population, sub-Saharan Africa accounts for over 30 percent of all new TB cases, 44 percent of all TB deaths, and 80 percent of TB deaths among people living with HIV/AIDS.

TABLE 2. 22 High TB Burden Countries

	High TB Burden Countries	2008 Estimated Incident TB Cases
1	India	1,982,628
2	China	1,301,322
3	South Africa	476,732
4	Nigeria	457,675
5	Indonesia	429,730
6	Pakistan	409,392
7	Bangladesh	359,671
8	Ethiopia	297,337
9	Philippines	257,317
10	Congo, Democratic Republic of	245,162
11	Myanmar	200,060
12	Vietnam	174,593
13	Russian Federation	150,898
14	Kenya	127,014
15	Uganda	98,356
16	Zimbabwe	94,940
17	Mozambique	94,045
18	Thailand	92,087
19	Brazil	89,210
20	Tanzania	80,653
21	Cambodia	71,382
20	Afghanistan	51,456

Source: World Health Organization 2009b

THE FOCUS OF THIS REPORT

This report is the third in a series that RESULTS Educational Fund (REF) and ACTION (Advocacy to Control Tuberculosis Internationally) have produced that have focused on the role of the World Bank in global TB control.¹⁰ The first, *Enduring Neglect: The World Bank’s Inadequate Response to Africa’s TB Emergency*, examined the World Bank’s response to the TB emergency in Africa. This report noted that Bank financing for TB projects in sub-Saharan Africa accounted for only 0.6 percent of its total health financing in the region. It also showed that on a per-case basis, the Bank was providing 11 times more financing for TB projects outside Africa than within it (RESULTS International 2006). *Enduring Neglect* recommended that the Bank:

- Ensure high-level strategic support for TB in its own work, and enable increased investments in TB control in sub-Saharan Africa
- Build on its work on TB in India and China and become a leader in financing TB control in Africa
- Increase funding for TB- and TB-HIV-specific activities
- Proactively engage with African countries to enhance the place of TB in their national plans and ensure free and universal treatment for TB
- Ensure an explicit role for civil society in the Bank’s work in health
- Take the lead in galvanizing high-level support for a ministerial conference on TB in Africa that was scheduled for 2007

Enduring Neglect also recommended that countries in Africa develop national TB emergency plans and seek financing to support their implementation; invest more of their own resources, whenever possible, to fight TB; and give greater priority to using the World Bank’s International Development Association resources to fill gaps in financing for TB control.

ACTION then examined the extent to which the World Bank’s Multi-Country HIV/AIDS Program for Africa (MAP), the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and the U.K. Department for International Development (DFID) were addressing TB-HIV. This analysis, found within *Living with HIV, Dying of TB: A Critique of the*

10 ACTION is a project of RESULTS Educational Fund.

Response of Global AIDS Donors to the Co-epidemic, concluded that donors had pursued inconsistent, inadequate, or superficial responses to TB-HIV co-infection, and that they needed to improve and scale up their responses to TB-HIV as a matter of urgency (ACTION 2009). The report also noted that a failure to do so, in conjunction with a failure to support appropriate infection control in clinical settings, risked undermining the global response to HIV/AIDS and could actually contribute to the spread of TB in some settings.

A number of members of civil society expressed their concern in writing to the World Bank, DFID, PEPFAR, and the Global Fund regarding the findings of *Living with HIV, Dying of TB*. The World Bank and DFID offered no formal response to the findings of this report or to the communications of civil society. PEPFAR responded by saying that it was scaling up TB-HIV activities through partnerships with in-country authorities. The Global Fund responded by noting that it would encourage more attention to the programmatic management of TB-HIV by requiring that all TB and HIV proposals in the future include TB-HIV efforts. The Global Fund also indicated specific steps that it would take to encourage attention to TB-HIV within its next round of proposal submissions.

After examining the World Bank's support for TB projects and TB-HIV activities within HIV/AIDS projects, ACTION decided to examine the extent to which the World Bank and its development partners were advancing TB control through broader health sector investments. This report therefore seeks to answer four additional questions:

- To what extent did the World Bank, working with its development partners, support TB control through “health sector development projects,” including those carried out through SWAPS?¹¹
- To what extent were SWAPS associated with improvements in TB case detection and treatment success rates?
- To what extent do SWAPS appear to be associated with improvements in health outcomes more generally?
- How could the World Bank, its development partners, and countries with a substantial TB burden strengthen the impact of SWAPS on TB case detection and treatment success?

METHODOLOGY

This review was carried out using both quantitative and qualitative techniques. Resources analyzed include:

- Recent documents on global TB efforts, including WHO's 2009 Global Tuberculosis Control report and subsequent update (World Health Organization 2009a; World Health Organization 2009b) and its latest surveillance report on drug-resistant TB (World Health Organization 2010a)
- Journal articles and documents from a number of organizations concerning SWAPS in health and education
- A World Bank Independent Evaluation Group (IEG) evaluation of World Bank operations in Health, Nutrition, and Population (HNP) from 1997 to 2007 (World Bank Independent Evaluation Group 2009a), as well as a background paper that examined in greater detail six health SWAPS that the Bank supported over the period in review (World Bank Independent Evaluation Group 2009b)
- Documents and resources concerning the International Health Partnership and related initiatives (IHP+)
- World Bank project documents for “health sector development projects” for which Bank financing was approved between 2001 and 2008. These projects generally focused on health-systems development and the strengthening of a broad array of health programs in each of the 15 countries receiving this Bank support. Support for some of these projects was provided in conjunction with other development partners.

To conduct this last phase of the study, ACTION reviewed World Bank project appraisal reports for 15 projects, as well as the proposals for supplemental financing for six of these projects. Only projects that had not been examined in the earlier reports produced by RESULTS International and ACTION were included in this sample. The sole exception was a project in Burkina Faso that was included in an earlier study, but only to examine the extent to which its MAP component provided support for TB-HIV, without consideration of the extent to which its health sector component supported TB

¹¹ “Health sector development projects” are investment projects in the health sector that generally support the strengthening of key health systems functions, as well as various programs within the health sector. This type of operation is to be contrasted with a health project that focuses on a narrow range of investments, such as a project focused on TB control, or HIV/AIDS control, or nutrition.

more broadly as a program-oriented operation. Emergency operations in Liberia and Sudan, a technical-assistance loan in Somalia, and projects in Burundi and Madagascar for which documents were not publicly available were excluded from this sample. In the instances where additional financing for existing projects was approved between 2001 and 2008, both the original project and the additional financing were included, whether or not the original project was approved during the period of review.

Finally, ACTION conducted 28 key informant interviews. Key informants included specialists from the World Bank and other development agencies, technical experts from WHO, and a number of people involved in the implementation of TB programs in low-income countries in sub-Saharan Africa. Key informants were identified through a “snowball” technique. Early interviews were sought with World Bank staff who were involved with support for health in Africa, with relevant staff of WHO’s Stop TB Department, and with selected national TB program managers in Africa. These individuals were asked to identify others who could provide thoughtful and evidence-based comments on the questions that this review seeks to answer. Persons interviewed are shown in Annex 1.

Each section of this report includes some additional comments on methodology specific to that section.

APPROACH TO THE REPORT AND ITS LIMITATIONS

This review is not meant to be exhaustive, nor does it examine in depth the implementation of TB control efforts in the SWAps that were reviewed. For example, the report does not examine the extent to which countries implemented the TB component of their SWAps “program of work” (PoW). First, this was beyond the means of this study. Second, the report’s foremost concern is with outcomes — in particular, the extent to which SWAp appear to be associated with improvements in TB case finding and treatment success — not with whether programs of work were implemented.

The following assumptions guided this review:

- The World Bank, its development partners, and affected countries in sub-Saharan Africa must treat TB as a high priority in their efforts to improve health conditions.
- The validity, in principle, of SWAps is not in question. It is presumed that development partners will continue to support health in sub-Saharan

African countries largely through such approaches.

- The objective of development assistance for health must be to reduce excess morbidity and mortality, particularly for the poor, as quickly as possible, at the least-possible cost, and in a sustainable way.
- Health SWAps are a means with which to work with countries to enhance their health circumstances. The value of a SWAp can only be seen in the extent to which it promotes the achievement of better health outcomes, particularly for the poor, even if the SWAp confers other types of benefits, such as reducing the transaction costs of a country’s working with its development partners or improving program efficiency. A SWAp is a means to other ends, not an end in itself.
- As with SWAps, “health systems strengthening” is a means to other ends, not an end in itself. It is a means to reduce morbidity and mortality and to protect people from financial stress due to ill health.
- Health systems strengthening may be a necessary condition to improving health in some settings. However, in low-income and low-capacity countries, it is unlikely to be sufficient to effectively and efficiently address key health conditions. Rather, addressing these conditions will almost certainly require considerable in-depth technical assistance and continuous, well-focused engagements around specific health programs at a variety of different levels of the health system.

KEY CONCEPTS

Before proceeding further, it is critical to understand some of the key concepts involved in development assistance for health and the SWAp approach.

Prior to the mid-1990s, most development assistance for health focused on supporting projects. A *project* is a discrete set of activities, usually fairly narrow in scope, which tries to strengthen one or more parts of a country’s health program and one or more areas of institutional capacity. Prior to the late 1990s, a number of development agencies supported projects that focused specifically or largely on TB control, such as the China Infectious Diseases Control Project and the first and second National TB Control Projects in India. World Bank-assisted projects generally disburse funds by re-

imbursing a percentage of the government's expenditure on an agreed set of activities. This could include, for example, construction of facilities, the procurement of laboratory supplies and materials, drugs, or the salaries of staff associated with new activities.

Concerns arose in the mid-1990s, however, over a number of aspects of project-based support. These included notions that:

- Projects were “pushed” on countries by their partners, and there was insufficient local ownership of project design and implementation.
- Projects, by definition, were “islands” that could not address broader sector issues.
- Projects distorted the health sector, because specific measures were taken during project implementation that were not embedded in the sector as a whole, such as compensating project staff at a level higher than the normal civil-service wages.
- Projects were not sustainable, because they were not carried out within a clear medium-term expenditure framework.
- The project approach was exceptionally heavy in transaction costs for beneficiary governments, as each donor dealt with the government in different and uncoordinated ways.
- The lack of coordination between donors undermined sector development by fragmenting it.
- The creation of individual project units would weaken, rather than strengthen, government capacity (Harrold and World Bank 1995).

These concerns spawned a new approach to development assistance, initially called the “Broad Sector Approach to

A SWAp is a means to other ends, not an end in itself.

Investment Lending.” This approach was to be based on a number of principles:

- Development assistance should be sector-wide in scope and all sector expenditures should be included therein.
- Development assistance should be based on a clear sector strategy and policy framework.

- Government and other local stakeholders should “be in the driver’s seat” for these efforts.
- Implementation arrangements should be common to all development partners.
- Local capacity should be relied on for carrying out the project.
- Before a sector-wide program could be introduced, developing countries would need to have achieved a certain level of macroeconomic stability and to have demonstrated a minimum level of government capacity for planning and implementing the sector programs under consideration (Harrold and World Bank 1995).

The sector-wide approach (SWAp) to health evolved to address the above concerns. The principles that underlie a SWAp hold that:

- Governments would “be in the driver’s seat” on planned investments.
- Development agencies would contribute to funding the sector as a whole.
- Development agencies would work in partnership with each other and with governments to jointly support the government’s sectoral plans.
- The focus of dialogue between donors and governments would be on the overall policy, institutional, and financial framework for the sector.
- Sectoral performance would be assessed against an agreed set of commonly used performance indicators.

Ideally, in a SWAp the donors would pool their resources in what is generally called a “basket.” Donors would then disburse this basket funding by financing a share of the government’s overall budget for the health sector as certain performance triggers are met (Cassels and Janovsky 1998). In practice, however, donors can finance a SWAp in a variety of ways that do not involve contributing to a pooled funding basket.

Early thinking about SWAPs in the health sector suggested that moving toward country-led health SWAPs in some settings would have to be an incremental process. The move toward SWAPs would require an extended transition period, during which increasing responsibility for planning and implementing a SWAp would be transferred to developing-country governments as government and health-system capacity increased (Cassels and Janovsky 1998).

ANALYSIS OF SWAPs AND HEALTH OUTCOMES

SUMMARY

Evidence suggests that support provided by the World Bank, in conjunction with its development partners through health sector development projects and SWAPs, does not address TB control in a rigorous manner or as a high priority.

Broad-based, programmatic approaches to development assistance, especially SWAPs, are a preferred instrument for a number of donors for delivering development assistance for health in low-income countries in sub-Saharan Africa. However, it appears from the available evidence that SWAPs, as they are now designed, implemented, monitored, and evaluated, are not on track to help deliver better health outcomes for the poor in efficient, effective, or sustainable ways. In fact, there is growing evidence that:

- SWAPs focus excessively on the process of coordinating aid delivery, to the detriment of substance and a focus on improving health outcomes.
- Donors have made the coordination of SWAPs an inadvertent end in itself rather than a means by which to achieve better health outcomes.

It is unacceptable, more than ten years after the first SWAP was put in place, for the evidence base for SWAPs to be so bare and for development agencies to continue, nonetheless, to follow an approach that does not appear to be sufficiently or consistently associated with improvements in health outcomes.

- Donors are taking an approach that may be necessary for development assistance to be more effective in some cases, but which is unlikely to be sufficient to help countries achieve their key development goals in health.

- A level and duration of technical engagement that is often lacking in SWAPs will be required if SWAPs are to better enable improvements in health outcomes.

If development assistance is to promote the achievement of better outcomes in TB and in other health areas, then SWAPs will need to be much more focused on the achievement of results.

Enhancing the results focus of health SWAPs will require the Bank to implement the recommendations of the 2009 IEG review of the Bank's work in the health sector. It will also require development agency managers to get their staff to focus more on achieving tangible results. Greater transparency of information about projects and regular independent evaluations of SWAP operations will also be necessary to enable more effective implementation and to hold countries and their development partners more accountable for achieving results. In the longer run, countries and development agencies must improve their evaluation of the SWAP process and of outcomes achieved under SWAPs. It is unacceptable, more than ten years after the first SWAP was put in place, for the evidence base for SWAPs to be so bare and for development agencies to continue, nonetheless, to follow an approach that does not appear to be sufficiently or consistently associated with improvements in health outcomes.

INTRODUCTION

This section examines the extent to which World Bank support for health sector development contributed to TB control in low-income countries in sub-Saharan Africa from 2001 to 2008. Particular attention is paid to support provided as part of a SWAP.

WHAT IS A SECTOR-WIDE APPROACH (SWAp)? ▶

The World Bank defines “**SWAp**” as an approach to a locally-owned program for a coherent sector in a comprehensive and coordinated manner, moving toward the use of country systems. SWApS represent a shift in the focus, relationship, and behavior of donors and governments. They involve high levels of donor and country coordination for the achievement of program goals, and can be financed through parallel financing, pooled financing, general budget support, or a combination (World Bank Independent Evaluation Group 2009b).

The World Bank generally supports SWApS in conjunction with other development partners. Unless stated otherwise, when the term “World Bank support” is used in this section to refer to a SWAp, it is meant to refer to the support of the Bank and of the partners with whom it is collaborating in its health sector work in low-income countries in Africa.

KEY FINDINGS

REVIEW OF THE LITERATURE ON HEALTH SWApS ▶

The literature on SWApS generally sheds little light on the extent to which SWApS are conducive to improving health outcomes. Most of the literature sets out the principles of how SWApS should be carried out, but does not evaluate the extent to which such approaches have been effective in improving outcomes (HLSP Institute 2005; Secretariat of the Strategic Partnership for Africa 2005; United Nations Development Programme 2005; van Reesch 2007).

A number of journal articles and publications by organizations involved in development assistance were reviewed to see if they could illuminate the extent to which SWApS were enabling improvements in health outcomes in low-income countries in sub-Saharan Africa. Generally, these materials contained much more information about the manner in which SWApS were intended to work rather than findings about the outcomes that were associated with these approaches or the lessons that could be learned about how to enhance outcomes. When the literature does comment on the achievement of outcomes, it generally suggests that planned outcomes had not been achieved. The only substantial exception to this for a single country was an evaluation of the health SWAp in Tanzania, which identified some

important health outcome goals that have been achieved under the SWAp in that country (COWI, Goss Gilroy et al. 2007). The World Bank also recently conducted a review of a number of SWApS, as will be described below.

The early literature on SWApS tended to discuss the need for mechanisms like SWApS and their promise. However, they offered few comments and little data demonstrating if or how early SWApS were associated with improved health outcomes (Cassels and Janovsky 1998). Some early literature called for SWApS to be rigorously evaluated and for the approach to be evidence-based, and some noted the lack of evidence that SWApS were associated with improved health outcomes up to that point (Garner, Flores et al. 2000; Hutton and Tanner 2004). Other literature pointed to the potential risks posed by SWApS to TB control, as well as to the achievement of other health outcomes that would need to be addressed in the design and execution of SWApS if SWApS were to fulfill their promise (Schreuder, Visschedijk et al. 2004).

Only a few country case studies have been conducted that relate to health SWApS. One such case study looked at the Zambian health sector over a 16-year period to see the extent to which the SWAp improved technical and allocative efficiency, concluding that it had not (Chansa, Sundewall et al. 2008).

A chapter of a book published in 2006 suggested that the SWAp in Uganda had led to improvements in allocative efficiency and better drug management. However, it did not identify any health outcomes that could be linked to these systemic improvements, suggesting instead that it would take a long time before health outcomes linked to these improvements could be measured (Cruz, Cooper et al. 2006). An April 2004 study of the SWAp in Uganda called it successful, but showed no evidence of any positive impact on health outcomes, only on process outcomes for the health sector (Hutton 2004).

HLSP, a private consulting firm that is actively involved in global health efforts, has conducted a number of reviews of individual health SWApS. A review of Mozambique’s SWAp outlined the constraints to the successful implementation of the SWAp process, but it offered no comments on health outcomes related to the SWAp (Martínez 2006). A review of the Uganda SWAp concluded that the SWAp had met early objectives but had then faced declining performance, due in part to the move away from SWAp principles by some donors (Örtendahl 2007). A 2006 review of the Bangladesh SWAp indicated that there were serious problems in the application of the SWAp model that were associated with its failure to achieve planned health outcomes (Martínez 2008).

In 2007, HLSP conducted a broad-based review of SWAps in Ghana, Malawi, Mozambique, Tanzania, Uganda, and Zambia. This review focused largely on the extent to which SWAp processes were working as planned. It suggested that there had been some progress in donor coordination and the use of government financial processes, but also that this progress was not consistent and that there was a loss of momentum in some countries. In addition, it concluded that the impact on health outcomes of SWAps was mixed, with some indicators showing improvement but others remaining stagnant (Walford 2007).

A comparative study in 2006 of SWAps in Uganda, Zambia, and Bangladesh suggested that the definition of a SWAp was unclear and that the country contexts might not be conducive to the achievement of desired outcomes through SWAps (Sundewall and Sahlin-Andersson 2006). Another study of the Bangladesh health SWAp suggested that its implementation was impeded by disagreement about the roles and responsibilities of government and its development partners (Sundewall, Forsberg et al. 2006).

Only one SWAp has been subjected to an independent, rigorous evaluation: the SWAp in Tanzania (COWI, Goss Gilroy et al. 2007). The evaluation of Tanzania's health SWAp, referenced above, suggested that Tanzania had made some important progress in meeting health system objectives under the SWAp, although much remained to be done to meet all of their key aims. The report noted the following:

The programmes, projects and activities implemented under the SWAp have contributed to improvements in health outcomes and to some improvements in the quality of health services at community level. These improvements can, in turn, be plausibly linked to progress toward MDG and PRSP/MKUKUTA goals, especially relating to infant and child mortality.

There has not, however, been significant progress towards achieving goals and targets relating to maternal mortality and maternal health (and to neonatal mortality) during the evaluation period. This should be a key area of emphasis for HSSP3.

REVIEW OF IHP+ DOCUMENTATION ►

The International Health Partnership and related initiatives (IHP+) was created in 2007 to further harmonize the work of development partners in the health sector and to enhance the effectiveness of their assistance. So far, there has been no rigorous evaluation of the impact of working in an IHP+ approach on the achievement of health outcomes, perhaps because it is too early to carry out such evaluations. A 2008

review of IHP+ focused largely on process matters, suggesting that in the long run better outcomes could be achieved and that in the short run process indicators should be tracked (Paris High-Level Forum on Aid Effectiveness 2005; Alexander 2007; Harmonization for Health in Africa 2007; IHP 2007a; IHP 2007b; Conway, Harmer et al. 2008; IHP 2008).

REVIEW OF THE LITERATURE ON EDUCATION SWAps ►

A number of journal articles and publications on SWAps in the education sector were reviewed to see if they could enlighten the review of health SWAps. Most of these documents focused on process issues and did not add much value to the review of SWAps in health. Nonetheless, a few articles did raise some of the same issues that were raised in the literature on health SWAps, particularly concerning the risks posed by a failure to focus on key outcomes and the losses accrued from not sufficiently involving civil society in decision-making about education-sector investments.

Several documents focused on the move toward SWAps in the education sector, but they did not comment on the extent to which SWAps were associated with the achievement of educational outcomes (Al-Samarrai and University of Sussex Institute of Development Studies 2002; Klees 2002; Institute for Health Sector Development 2003). One piece examined how community-based organizations could be involved in SWAps in education in Africa (Mundy and Haggerty 2008). This has been identified as an issue in health as well, including in the recent World Bank evaluation, discussed below (World Bank Independent Evaluation Group 2009b). One piece that did add value concerned the extent to which education SWAps were effectively promoting gender concerns. It concluded that there was considerable variance in the SWAp's approach to gender, borne partly of the SWAp's "inward-looking tendency" (Seel 2006). Studies on education SWAps in Namibia and Uganda focused largely on the process of SWAps (Eilor 2004; West 2004). A piece on the education SWAp in Nepal highlighted the potential advantages of working in a SWAp model, but also the risks that the SWAp would lack technical content and that non-governmental organizations would be excluded from deliberations on the sector after a SWAp was put in place. Another article suggested that focusing on building capacity was more important than the focus given in SWAps to ownership (Smith 2005). An article on Uganda suggested that the education SWAp in that country would lead to insufficient attention to the quality of education (Kuder 2005). As in SWAps for education, capacity and quality are certainly issues in health SWAps.

WORLD BANK INDEPENDENT EVALUATION GROUP REVIEWS ►

A portfolio evaluation that the IEG carried out in 2009, which had particular relevance to the issue of SWAps' impact on health sector outcomes, was reviewed. Titled *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition,*

and Population, the evaluation reviewed the World Bank's entire HNP portfolio from 1997 to 2007 (World Bank Independent Evaluation Group 2009a). This review assessed the extent to which SWAPs carried out with Bank support met their objectives. This part of the evaluation was based on a review of 11 SWAPs approved between 1997 and 2006, as well as detailed country case studies of the SWAPs done in Bangladesh, Ghana, the Kyrgyz Republic, Malawi, and Nepal during the same period.¹² This evaluation concluded that:

- SWAPs had helped to strengthen country capacity for sector planning, budgeting, management, and fiduciary systems.
- Only four of the 11 completed projects supporting health SWAPs had satisfactory outcomes in terms of achieving their relevant health objectives. The Tanzania SWAP had met its health objectives and the Nepal SWAP was making good progress toward doing so. However, achieving the health objectives of the SWAP had not always ensured better health outcomes.
- SWAPs can have adverse effects in the short run by disrupting attention to substance.
- SWAPs have often supported overly complex reforms and activities in countries where planned reforms exceeded government implementation capacity, sometimes resulting in the neglect of high-priority interventions and a failure to meet planned project outcomes.
- Complex projects, including multisectoral projects and SWAPs, implemented in low-capacity environments, were the least-likely project types to meet their objectives.
- There is a risk that consensus decisions among development partners in a SWAP will inhibit strategic choices and the setting of priorities.
- Weaknesses persist in the design of monitoring and evaluation (M&E) and in the use of country M&E systems that constrain a focus on results and the monitoring of results.

The report concluded that the promise of SWAPs to achieve efficiencies of process had not been demonstrated and that it was important for SWAPs to “support the right things, that [they] be properly implemented, and that the focus on results be maintained” (World Bank Independent Evaluation Group 2009a).

The report also suggested that keys to the success of SWAPs were likely to include careful prioritization of investments, a clear relation of program plans to capacity for implementation, the involvement of the private sector and civil society in the planning of investments in health, a predictable flow of funds, and a consistent focus on the quality of outcomes (World Bank Independent Evaluation Group 2009a).

The above report based its comments about SWAPs partly on a Working Paper that described the findings of case studies of health SWAPs supported by the World Bank in Bangladesh, Ghana, the Kyrgyz Republic, Malawi, Nepal, and Tanzania (World Bank Independent Evaluation Group 2009b). This Working Paper provided some comments about SWAPs that go beyond those in the broader HNP evaluation.

On the positive side, the Working Paper noted that the institutional arrangements for SWAPs were successfully established in all countries, that the countries also established a program of work (PoW), and that the countries prepared medium-term expenditure plans for implementing the PoWs. The paper also concluded that the SWAPs were “country led” and that systems for financing, procurement, and disbursement were set up effectively. In terms of the achievement of health outcomes, the paper noted that these were modest in Bangladesh; modest under the first Ghana PoW but substantial under the second PoW; and mixed in Tanzania, with substantial outcomes in child health but not in the achievement of fertility goals. The outcomes were not able to be evaluated in Malawi and, although health outcomes looked promising in Nepal and the Kyrgyz Republic, it was too early to evaluate them. The paper noted that factors outside the health sector likely contributed in important ways to the improvement in health outcomes in Ghana and that a failure to meet targets for bed nets and oral rehydration constrained the level of gains in child health. It also noted the continuing low rates of contraceptive prevalence.

On the negative side, the Working Paper concluded that:

- In some countries SWAPs incorporated “overly complex and ambitious PoWs that were not evidence-based, prioritized or phased, sufficiently assessed for risks, results-focused, and/or commensurate with national capacity to implement them.”
- SWAPs’ engagement with national partners, such as the private sector and civil society, was not very successful and could undermine the achievement of health outcomes.

12 The Bank-supported SWAPs in Ghana and Malawi are also included in this review.

- With the exception of the Kyrgyz Republic, the Bank could not document “any discernible progress in spending patterns that are supportive of poverty- and equity-related priorities of any of the PoWs.”
- Again with the exception of the Kyrgyz Republic, the results focus of the SWAs was found to be “modest at best,” while there was a “strong emphasis on process tasks... which distracted attention from health sector performance.”
- “Despite some improved capacity for planning and budgeting, there was a persistently weak link between financing and results, which ran the risk of the neglect of sector priorities.”
- “SWAs have not been effective in establishing mechanisms for and incentives to strengthen sector-wide accountability.”
- Program evaluation was exceedingly weak, with the exception of Tanzania.

The Working Paper also concluded that development partners did not sufficiently support the SWAs with appropriate expertise at the right times. Moreover, it concluded that the Bank’s “technical, financial, and economic appraisal of PoWs appears to have been inadequate in a number of countries.” The Bank also provided very weak support to monitoring and evaluation and “was weak in the candor and quality of performance reporting.” World Bank Country Directors were rarely involved in the SWAs and the technical teams from the Bank were deemed to have spent “too much time in meetings and too little time in the field.”

A 2009 IEG program review of the Stop TB Partnership commented on the extent to which SWAs have addressed TB in the Africa region, finding that they have failed to integrate TB activities within primary health care:

The lack of attention to TB in the Bank’s Africa health portfolio has not gone unnoticed, both internally and externally. ... [I]n response to the external criticism, Bank management in the Africa region has pointed to the relative small size of countries, which make single-disease projects difficult due to their high preparation and implementation costs, and the limited IDA funding available for health sector operations. Only one project is planned every few years for the smaller countries; but there is an increasingly more important focus on sector-wide approaches (SWA) in the health sector. The

health policy framework for the Africa Region — as is pointed out repeatedly in various Bank documents — has primarily emphasized the strengthening of health systems and the subsequent anticipated integration of TB activities with primary health care. **While this approach might be conceptually attractive, the intended integration of TB control with other health sector activities has simply not occurred on the ground** [emphasis added]. Furthermore, in contrast to TB control, diseases such as HIV and Malaria are treated as categorical programs in the Bank’s Africa portfolio, thus further exacerbating the imbalance (World Bank Independent Evaluation Group 2009c).

REVIEW OF WORLD BANK PROJECT DOCUMENTS

ACTION examined 15 projects in 15 countries — 14 of which were approved by the World Bank between 2001 and 2008, and five of which had supplemental credits that were approved during this same period of review. One project approved in 1997 was also reviewed, a project in Guinea-Bissau for which a supplemental credit was approved in 2004.

The two standard indicators for monitoring TB control activities are the rates of case detection and treatment success. International targets for these indicators are 70 percent and 85 percent, respectively, with each target referring exclusively to sputum-smear positive (SS+) cases. TB programs favor the achievement of high rates of treatment success and the strengthening of capacity for carrying out TB control activities before they expand case detection. This is to avoid detecting cases that TB programs may not be able to treat successfully, which could lead to the development of drug-resistant strains of the disease.

INCLUSION OF TB INDICATORS IN THE PROJECT

As noted in Table 3, of the 15 original projects that were reviewed, only three (20 percent) — Cameroon, Lesotho, and Malawi — included both case detection and treatment success as project performance indicators. The proposal for additional financing for Sierra Leone also revised the performance indicators of the original project to include both case detection and treatment success as project performance indicators.

TABLE 3. World Bank Projects Reviewed

Country	Project Name	Approval Date	Closing Date	SWAp	TB Indicators
Burkina Faso	Health Sector Support & Multisectoral AIDS Project	28-Apr-06	31-Jan-13	Yes	Treatment Success
Burkina Faso	Health Sector Support and AIDS project – Additional Financing	5-Jun-08	N/A	Yes	Treatment Success
Cameroon	Cameroon Health Sector Support Investment (SWAP)	24-Jun-08	31-Mar-14	Yes	Case Detection, Treatment Success
Congo, Democratic Republic of	DRC Health Sector Rehabilitation Support Project	1-Sept-05	31-Dec-11	No	None
Congo, Republic of	Health Sector Services Development	29-May-08	29-May-12	No	Treatment Success
Ghana	Second Health Sector Program Support Project	6-Feb-03	30-Jun-07	Yes	Treatment Success
Guinea	Health Sector Support Project	2-Jun-05	30-Sept-11	No	None
Guinea-Bissau	National Health Development Program	25-Nov-97	31-Dec-07	No	Treatment Success
Guinea-Bissau	National Health Development Program (Supplemental Credit)	16-Dec-04	N/A	No	Treatment Success
Lesotho	Lesotho: Health Sector Reform Project Phase 2	13-Oct-05	30-Sept-09	No	Case Detection, Treatment Success
Madagascar	Madagascar Sustainable Health System Development Project	22-May-07	31-Dec-09	No	Treatment Success
Malawi	Health Sector Reform Project	14-Dec-04	15-Sept-08	Yes	Case Detection, Treatment Success
Malawi	Health Sector Reform Project – Additional Financing	28-Jul-06	15-Sept-08	Yes	Case Detection, Treatment Success
Mauritania	Health and Nutrition Support Project	1-Jun-06	31-Dec-09	80% Yes	None
Niger	Instit. Strengthening & Health Sector Support Program (ISHSSP)	5-Jan-06	30-Jun-11	Yes	None
Nigeria	Second Health Systems Development	6-Jun-02	30-May-12	No	Case Detection
Nigeria	Second Health Systems Development II - Additional Financing	30-Sept-08	N/A	No	Case Detection
Sierra Leone	Health Sector Reconstruction and Development Project	25-Feb-03	31-Dec-09	No	Treatment Success
Sierra Leone	Health Sector Reconstruction and Development Project – Additional Financing	22-May-07	N/A	No	Case Detection, Treatment Success
Tanzania	Second Health Sector Development Project	16-Dec-03	31-Dec-09	Yes	Treatment Success
Tanzania	TZ-Health Sector Development II Scale-Up	5-Jul-07	N/A	Yes	Treatment Success

“The health policy framework for the Africa Region — as is pointed out repeatedly in various Bank documents — has primarily emphasized the strengthening of health systems and the subsequent anticipated integration of TB activities with primary health care. While this approach might be conceptually attractive, the intended integration of TB control with other health sector activities has simply not occurred on the ground” (World Bank Independent Evaluation Group 2009c).

Of the 15 projects that were reviewed, including the original 1997 Guinea-Bissau project, seven included only treatment success as a project performance indicator — Burkina Faso, Republic of Congo, Ghana, Guinea-Bissau, Madagascar, Sierra Leone, and Tanzania — and Nigeria included only case detection as a project performance indicator.

Four of the 15 original projects that were reviewed — the Democratic Republic of the Congo (DRC), Guinea, Mauritania, and Niger — included no TB indicator of any kind. Of these four, DRC was not a SWAp and was relatively narrowly focused on maternal and child health and malaria, Guinea was not a SWAp but did have a broad sectoral approach, Mauritania was 80 percent a SWAp, and Niger was fully a SWAp.

TRENDS IN TB CASE DETECTION AND TREATMENT SUCCESS RATES

ACTION also sought to examine trends in TB case detection and treatment success before and after the approval of World Bank support for a SWAp. Such an analysis does not show evidence of causation, as there are many other factors — both positive and negative — that could impact TB control in a country. Such factors include external support provided for TB control by the Global Fund, as took place in Ghana, Guinea-Bissau, and Sierra Leone, and later in Tanzania; the success with which a TB control program can “ring fence” or isolate itself somewhat from the SWAp; and important constraints to the achievement of desired outcomes that are not related to development assistance, such as political conflict. Despite the shortcomings of trend analysis, however, this type of analysis can shed some light on whether or not support from the World Bank might be associated with

improvements in case detection and treatment success, and the Bank itself included such an analysis in its own recent evaluation of health SWAps (World Bank Independent Evaluation Group 2009a; World Bank Independent Evaluation Group 2009b).

There were only four countries (Ghana, Guinea-Bissau, Malawi, and Tanzania) for which data were available for a sufficiently long period of time after the start of World Bank support so as to allow such an analysis to be carried out. However, the data for these four countries, three with SWAps and one SWAp-like, suggested that the impact of the SWAps on case detection and treatment success was at best mixed — even if all gains made in TB control were attributed solely to the SWAp, rather than to any other actors providing support for TB in these countries during the period in review. A SWAp might have been associated with improvements in case detection *and* treatment success in only one country, Tanzania, but even in this country case detection barely rose and was no higher in 2007 than in 2001. In the other three countries examined, the data were less positive: treatment success rose in Ghana, but case detection fell; treatment success increased in Malawi while case detection stayed the same; and both treatment success and case detection fell in Guinea-Bissau.

KEY INFORMANT INTERVIEWS

Twenty-eight people were interviewed for this report, including individuals from the World Bank, WHO, other organizations that have been involved in the design and implementation of health SWAps, and national TB programs. Each person’s views were sought on the extent to which SWAps have been associated with improvements in case detection and treatment success for TB, as well as on what steps could be taken to enhance a SWAp’s effectiveness in promoting better health outcomes (see Annex 1 for a list of key informants and their affiliations).

On the issue of TB control, key informants generally agreed that:

- TB was generally not given sufficient priority attention in SWAps.
- There was no clear association between SWAps and the achievement of TB control aims.
- When TB control aims were met in a SWAp, it was likely to be associated with “ring fencing” funds for TB control, sometimes with the assistance of funds from the Global Fund or the topping-up of SWAp funds with funds from sources outside the SWAp.

Key informants suggested that there is little evidence that SWAPs have been associated with the achievement of improved health outcomes in low-income countries in sub-Saharan Africa.

Despite the diverse backgrounds of key informants, the comments they made on the effectiveness of SWAPs were overwhelmingly consistent. None of the informants questioned the desirability of working through SWAPs and all of them believed that development agencies should not return to project approaches.

However, with only a few exceptions, the key informants suggested that:

- There is little evidence that SWAPs have been associated with the achievement of improved health outcomes in low-income countries in sub-Saharan Africa.
- There are a number of reasons for this failure to promote the achievement of better health outcomes through SWAPs, including:
 - Not all of the partners work together in a SWAP, but should.
 - Partners spend an overwhelming share of their time on process issues and insufficient time on substantive issues.
 - Many of the partners do not bring to the SWAP sufficient expertise to deal with technical, rather than process, matters.
 - There is a failure to prioritize activities within the SWAP.
 - Many SWAPs have too many indicators, which dilutes the importance of what should be the highest-priority actions.
 - Partners focus their attention on the central government, and this is not effective for countries in which health programs are implemented in a decentralized manner.
 - There is too much emphasis in SWAPs on the achievement of institutional objectives as ends in themselves, rather than as a means to achieve the ends of better health outcomes.

DISCUSSION

The evidence suggests that the World Bank and its development partners have not addressed TB adequately as part of their support to the health sector in low-income countries in sub-Saharan Africa. Only three of the 15 projects reviewed included indicators for both case detection and treatment success. Programs in three countries with high TB burdens included no indicators for TB at all, despite the fact that these programs were oriented toward broad “health sector development.” Overall, at least one TB indicator was included in the performance matrix of 11 of 15 of the original projects that were reviewed. However, this raises questions about why, if TB was to be addressed as part of the projects, so few of them would include performance indicators for both case detection and treatment success, the standard indicators for TB control. This is especially perplexing given the low rates of case detection and treatment success being achieved in many of these countries. One would generally expect low-income countries in sub-Saharan Africa to include TB as an important focus of any broad-based approach to health sector support, and it is difficult to understand why no TB indicators would be included in projects that adopted a broad sectoral approach, such as in Guinea, Mauritania, and Niger.

There is little other evidence from project documents or from the 28 key informant interviews to suggest that the World Bank and its development partners gave TB the rigorous and priority attention that it should have in countries with a high TB burden.

ACTION also sought to examine the extent to which support through SWAPs has been associated with improved TB case detection and treatment success. But as noted earlier, it is difficult to determine the impact of such support on TB control. In the absence of rigorous evaluations of the outcomes associated with health SWAPs, this report’s conclusions must instead take into account the sum total of findings reported in the literature, evaluations of such support of varying degrees of complexity and validity, the limited inferences that could be drawn from the analysis of trends in TB case detection and treatment success, and qualitative information gathered from interviews.

The information gleaned from each of these sources suggests that World Bank health-sector projects, including SWAPs, inconsistently and generally inadequately focus on improving both TB case detection and treatment success. Moreover, the available evidence suggests that support through SWAPs, as currently being implemented, does not effectively or efficiently enable the achievement of desired TB outcomes or of health outcomes more broadly.

Where progress in achieving desired outcomes has taken place, progress might be associated with a number of country-specific factors that both our research and the World Bank's recent evaluation identified. Specifically, progress in TB control was found in countries where:

- Priority attention is given to TB control
- There is a national strategic plan for TB that fits within a national strategic plan for health
- The SWAp helps to finance support for core health-system functions at the local levels — which might sometimes be a necessary condition for achieving better outcomes
- Assistance from donors like the Global Fund and technical assistance from WHO build on the health-system foundation and provide some of the sufficient conditions needed for success

There is little other evidence from project documents or from the 28 key informant interviews to suggest that the World Bank and its development partners gave TB the rigorous and priority attention that it should have in countries with a high TB burden.

These findings are important given that (1) the SWAp is a preferred mode of development assistance in low-income countries in Africa for the World Bank and many other development agencies, and that (2) a number of development partners appear to be expanding their assistance through SWAps without sufficient concern for the fact that, over the last ten years, SWAps have in too few cases been associated with the achievement of better health outcomes, in TB or in other critical health areas.

There are a number of measures that could be taken to enhance the likely effectiveness of SWAps in the health sector. These measures mirror those recommended in the recent World Bank IEG evaluation, as well as some important recommendations about focusing on results made in recent months by the Center for Global Development (CGD) and the Global Health Policy Center at the Center for Strategic and International Studies (Morrison and CSIS Commission on Smart Global Health Policy 2009; Birdsall and Savedoff 2010). These are based on the presumption that SWAps will continue to be a preferred mode of operation for most partners in health in low-income countries in sub-Saharan Africa and that, unless there is a substantial change in the manner in which these SWAps are made to focus on results, SWAps will not meet their intended health outcomes effectively, efficiently, or consistently in the future.

These recommendations are elaborated upon in the final section of the report, which follows.

FINDINGS AND RECOMMENDATIONS

As elaborated below, the evidence suggests that SWAPs are not associated sufficiently with improvements in TB control or with the achievement of health outcomes more broadly. Mirroring the findings of the World Bank's Independent Evaluation Group, there is growing evidence that SWAPs will not be effective or efficient ways of improving the health of the poor in low-income countries in sub-Saharan Africa unless the development partners involved in SWAPs substantially change the way they carry out their work. An important question now facing the development community is whether it wishes to continue providing assistance without sufficient evidence of the effectiveness of the SWAP approach, or whether it wishes to improve the approach to SWAPs so that its assistance can have a greater impact on health outcomes.

FINDINGS

There is an unacceptable dearth of scientific assessment that demonstrates the impact of SWAPs on health outcomes, despite the billions of dollars that have been invested in this approach since the mid-1990s.

Information collected through 28 key informant interviews, an analysis of program documents, and a review of the available literature suggests that the World Bank and its development partners urgently need to adjust their approach to SWAPs if SWAPs are to effectively and efficiently produce better health outcomes.

ACTION interviewed 28 people for this review, asking them about the extent to which SWAPs in health were associated with improvements in TB control or with the achievement of other health outcomes. With very few exceptions, the key informants to this review suggested that for SWAPs in low-income countries in sub-Saharan Africa there is:

- An overemphasis on process to the detriment of substance
- A widespread failure to focus on priority issues
- A broad failure to pay attention to the capacity for implementation in decentralized systems

- A lack of engagement during implementation on key technical matters, partly because the development partners lack the technical staff to engage in such efforts

Moreover, almost all of them noted that in most countries SWAPs are not yet being implemented in a way that has led to improvements in health outcomes in effective, efficient, measurable, and sustainable ways. Key informants also noted that most SWAPs have not generally led to better health outcomes and that SWAPs may not yet have reduced transaction costs, either for countries or their development partners. The available scientific literature and other reports on SWAPs show little evidence that SWAPs have led to better health outcomes — most published evidence suggests that they have not.

These findings are consistent with the findings of a major evaluation conducted by the World Bank Independent Evaluation Group, which found that “only 4 of the 11 completed projects supported by SWAPs had satisfactory outcomes in achieving their relevant program objectives” (World Bank Independent Evaluation Group 2009a). The review found that SWAPs are associated with mixed results at best, while it identified major flaws in the approach the Bank and its development partners are taking to SWAPs. These include, among others:

- A general lack of attention to results
- Insufficient attention to ensuring that SWAPs are technically sound
- A general failure to monitor country expenditures to be sure they focus on the highest-priority investments
- Very weak monitoring and evaluation of the health programs that SWAPs are supporting

The above findings notwithstanding, there was widespread support among the key informants for SWAPs in health that:

- SWAPs are essential to ensuring that development assistance is harmonized and efficient.

- SWApS have been successful in leading to greater harmonization of approaches among donors.
- Countries and their partners cannot and should not go back to project approaches.

An important question now facing the development community is whether it wishes to continue providing assistance without sufficient evidence of the effectiveness of the SWAp approach, or whether it wishes to improve the approach to SWApS so that its assistance can have a greater impact on health outcomes.

Thus, there is a major disconnect between the level of support for SWApS and the extent to which this approach is associated with the achievement of health outcomes. This discrepancy strongly suggests that there is a need to “make SWApS work” by increasing their focus on the achievement of key health outcomes.

The World Bank and its development partners are not addressing TB adequately or appropriately through SWApS in sub-Saharan Africa.

This review examined the extent to which health sector development projects in low-income countries in sub-Saharan Africa, supported by the World Bank and its development partners, included appropriate attention to TB control. The evidence suggests that the World Bank and its development partners did not pay sufficient attention to improving the control of TB from 2001 to 2008 in these projects. Only three of the 15 original projects examined (20 percent) included indicators to improve both TB case detection and treatment success rates — the two key indicators for TB control. Programs in four countries with high TB burdens included no TB indicators at all, despite the fact that three of these programs were oriented toward “health sector development.” There was little evidence from either project documents or 28 key informant interviews to suggest that the World Bank and its development partners gave TB the rigorous and priority attention that it should be given in countries with a high TB burden.

Key informants overwhelmingly suggested that TB was not given priority attention, largely due to the focus on process rather than substance and to the failure of the development partners to prioritize TB within SWApS. Key informant interviews also did not identify any successful impacts on TB that might have been driven by SWApS. Rather, the most pertinent comments suggested that improving TB control in the presence of a SWAp occurs most in those countries that “ring fence” their TB program from the SWAp and continue, often with financing separate from the SWAp, to pay focused attention to improving both case detection and treatment success.

RECOMMENDATIONS

The World Bank and other development agencies need to see the failure of SWApS to more consistently promote better health outcomes in low-income countries in sub-Saharan Africa as a potentially lethal breakdown in their development-assistance programs for health in sub-Saharan Africa. They urgently need to reduce the emphasis in SWApS on *process* and increase the emphasis on *outcomes*. They also need to start viewing SWApS as a means to achieving better health outcomes rather than as an end in themselves. While efforts to strengthen health systems are important and they might be *necessary* conditions for the achievement of health outcomes in some settings, they will rarely be *sufficient* conditions for such achievement. Rather, reducing morbidity and mortality will almost always require well-focused and continuous technical engagements with countries in high-priority areas around specific burdens of disease, regardless of the approach to development assistance taken by the development partners active in that country. Tanzania may be one country which has lessons to suggest about achieving health outcomes through SWApS.

There is a major disconnect between the level of support for SWApS and the extent to which this approach is associated with the achievement of health outcomes.

For SWAps to promote improvements in health outcomes, the following measures should be taken with urgency:

The World Bank and other development partners must look beyond the process of coordinating aid and toward measuring and improving health outcomes.

After many years of paying insufficient attention to results, management within these institutions must provide stronger incentives for staff to focus on achieving results. In many cases, both countries *and* their development partners are failing to pay sufficient attention to results. If the achievement of key indicators for TB control were a trigger for the disbursement of financing, then it is likely that both countries and their development partners would pay more attention to realizing these results than they do now. This would also cause implementers and their development partners to be held more accountable for helping to achieve results. Of course, any effort to use “results-based financing” in this way would have to take into account the constraints of such a financing model, including the problems it might pose for predictable levels of financing. Normally, one thinks of results-based financing as a way to encourage those implementing investments to focus on results. The concern here, however, is the need to motivate both development partners *and* implementers to have such a focus. Moreover, evaluation must be adequately funded and integral to all development-assistance efforts in health. These are findings that the World Bank and others have repeatedly come to themselves, but have failed to sufficiently act on. Absent such changes, established initiatives will fail to improve health outcomes. Moreover, the International Health Partnership and related initiatives (IHP+) will risk becoming another process-oriented effort that fails to improve health outcomes.

The World Bank and other development agencies need to see the failure of SWAps to more consistently promote better health outcomes in low-income countries in sub-Saharan Africa as a potentially lethal breakdown in their development-assistance programs for health in sub-Saharan Africa.

To better ensure accountability for improving health outcomes within SWAps:

- Health programs should be reviewed at least once every two years by a truly independent technical team that assesses the impact of program implementation compared to stated objectives, publicly reports on findings, and makes recommendations for improving performance. Despite the best efforts of stakeholders, the current arrangements for project oversight generally do not produce uncompromised, publicly available information on the status of development investments, as the World Bank itself has noted (World Bank Independent Evaluation Group 2009a). The normal mechanism for monitoring the progress of investments in health is for them to be “supervised” by agents of those development agencies that collaborated with countries in the program’s design. Despite the talents, rigor, and honesty of these individuals, there is a natural tendency for them to be less than candid in identifying and acting on problems in program implementation, as the World Bank Working Paper on SWAps also indicates (World Bank Independent Evaluation Group 2009b). This is exacerbated by the tendency of countries not to want to be criticized for implementation problems. Some aspects of project monitoring can be done best by staff of development organizations in conjunction with their country collaborators. However, a truly independent and candid assessment of program implementation can best be done periodically only by an independent group of highly knowledgeable people whose mandate is to report publicly and candidly on their findings. Such reviews must be included in program financing or they will not be carried out.
- The World Bank and other development agencies should make public, at a minimum, the Annual Joint Program Reviews that cover the health projects they support. Public oversight of key development investments in low-income settings is critical to the success of these investments. The lack of transparency currently surrounding the progress of these investments constrains civil society from providing useful oversight of them and contributing to the identification and addressing of implementation problems. The new World Bank policy on transparency may be a valuable step toward addressing this matter.

- SWAps must be more rigorously monitored and evaluated to determine what is working and what is not. The World Bank and its development partners should invest more resources in monitoring and evaluation to better determine what is working and what is not within the implementation of SWAps. They should disseminate this information widely among all stakeholders, and the results of such research should be used to improve the implementation of SWAps over time.

The World Bank and other development institutions must ensure that the development assistance they provide is appropriate to country capacity.

SWAps were conceived for application in countries that exhibit strong financial accountability, a coherent policy framework, and substantial country capacity for effective program implementation. In practice, however, SWAps have generally been implemented in contexts that do not fit this model. In part for this reason, the aims of SWAps have often exceeded available country capacity and have failed to pay sufficient attention to priority health interventions (World Bank Independent Evaluation Group 2009a). Development partners must better assess risk before developing SWAps. In addition, funds should flow on a large scale only to those SWAps which evidence shows are helping to achieve improvements in health outcomes, particularly for the poor, women and girls, and other marginalized groups. This will encourage greater attention to the appropriate design of SWAps.

The assistance that the World Bank and other development partners provide for TB through SWAps must lead to improvements in TB case finding and treatment success.

There remain enormous gaps in TB case detection and treatment success, the effective management of TB-HIV and drug-resistant TB, the development of sufficient human resources and laboratory capacity, and the implementation of effective infection control measures to reduce the spread of TB in settings where people congregate. SWAps in countries where TB is a disease of public-health consequence should include indicators for tracking the progress being made to improve TB case detection and treatment success. Targets for improvements in these indicators should be established, performance of the SWAps should be consistently measured against these benchmarks, and staff should be held accountable for meeting these targeted health outcomes.

Acronyms

ACTION	Advocacy To Control TB Internationally
AIDS	Acquired Immune Deficiency Syndrome
CGD	Center for Global Development
DFID	[UK] Department for International Development
DOTS	Directly Observed Therapy, Shortcourse
DRC	Democratic Republic of the Congo
HIV	Human Immunodeficiency Virus TB – Tuberculosis
HNP	Health, Nutrition, Population
IEG	[World Bank] Independent Evaluation Group
IHP+	International Health Partnership and related initiatives
MAP	[World Bank] Multicountry AIDS Program
MDR-TB	Multidrug-resistant Tuberculosis
PEPFAR	President’s Emergency Plan for AIDS Relief
PoW	Program of Work
REF	RESULTS Educational Fund
SS+	Sputum-smear Positive
SWAp	Sector-wide Approach
WHO	World Health Organization
XDR-TB	Extensively Drug-Resistant Tuberculosis

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ANNEX 1. Persons Interviewed

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ANNEX 2. World Bank Projects Reviewed (Alphabetically by country, by year)

Project ID	Country	Project Name	Approval Date	Closing Date	Lending Instrument	SWAp	TB Indicators
P093987	Burkina Faso	Health Sector Support & Multisectoral AIDS Project	28-Apr-06	31-Jan-13	Sector Investment & Maintenance Loan	Yes	Treatment Success
P110815	Burkina Faso	Health Sector Support and AIDS project — Additional Financing	5-Jun-08	N/A	Sector Investment & Maintenance Loan	Yes	Treatment Success
P104525	Cameroon	Cameroon Health Sector Support Investment (SWAp)	24-Jun-08	31-Mar-14	Specific Investment Loan	Yes	Case Detection, Treatment Success
P088751	Congo, Democratic Republic of	DRC Health Sector Rehabilitation Support Project	1-Sept-05	31-Dec-11	Specific Investment Loan	No	None
P106851	Congo, Republic of	Health Sector Services Development	29-May-08	29-May-12	Specific Investment Loan	No	Treatment Success
P073649	Ghana	Second Health Sector Program Support Project	6-Feb-03	30-Jun-07	Specific Investment Loan	Yes	Treatment Success
P065126	Guinea	Health Sector Support Project	2-Jun-05	30-Sept-11	Specific Investment Loan	No	None
P035688	Guinea-Bissau	National Health Development Program	25-Nov-97	31-Dec-07	Specific Investment Loan	No	Treatment Success
P088282	Guinea-Bissau	National Health Dev. Program (Supplemental Credit)	16-Dec-04	N/A	Specific Investment Loan	No	Treatment Success
P076658	Lesotho	Lesotho: Health Sector Reform Project Phase 2	13-Oct-05	30-Sept-09	Adaptable Program Loan	No	Case Detection, Treatment Success
P103606	Madagascar	Madagascar Sustainable Health System Development Project	22-May-07	31-Dec-09	Specific Investment Loan	No	Treatment Success
P083401	Malawi	Health Sector Reform Project	14-Dec-04	15-Sept-08	Sector Investment & Maintenance Loan	Yes	Case Detection, Treatment Success
P098792	Malawi	Health Sector Reform Project — Additional Financing	28-Jul-06	15-Sept-08	Sector Investment & Maintenance Loan	Yes	Case Detection, Treatment Success
P094288	Mauritania	Health and Nutrition Support Project	1-Jun-06	31-Dec-09	Specific Investment Loan	80% Yes	None
P083350	Niger	Instit. Strengthening & Health Sector Support Program (ISHSSP)	5-Jan-06	30-Jun-11	Sector Investment & Maintenance Loan	Yes	None
P070290	Nigeria	Second Health Systems Development	6-Jun-02	30-May-12	Specific Investment Loan	No	Case Detection
P110697	Nigeria	Second Health Systems Development II — Additional Financing	30-Sept-08	N/A	Specific Investment Loan	No	Case Detection
P074128	Sierra Leone	Health Sector Reconstruction and Development Project	25-Feb-03	31-Dec-09	Specific Investment Loan	No	Treatment Success
P103740	Sierra Leone	Health Sector Reconstruction and Development Project — Additional Financing	22-May-07	N/A	Specific Investment Loan	No	Case Detection, Treatment Success
P082335	Tanzania	Second Health Sector Development Project	16-Dec-03	31-Dec-09	Adaptable Program Loan	Yes	Treatment Success
P105093	Tanzania	TZ-Health Sector Development II Scale-Up	5-Jul-07	N/A	Adaptable Program Loan	Yes	Treatment Success

Source: World Bank project database; Projects in Burundi (P078111) and Madagascar (P088729) met the criteria for selection but sufficient documentation to complete the analysis was not available on the online database.

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THE “WHO” OF ACTION

ACTION (Advocacy to Control Tuberculosis Internationally) is an international partnership of civil society advocates working to mobilize resources to treat and prevent the spread of tuberculosis (TB), a global disease that kills one person every 20 seconds.

ACTION’s mission is to build support for increased resources for effective TB control, especially among key policymakers and other opinion leaders in both high TB burden countries and donor countries. With effective policy advocacy and greater political will, rapid progress can be made against the global TB epidemic.

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