

April 2006

GLOBAL HEALTH

Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief



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Highlights of [GAO-06-395](#), a report to congressional committees

Why GAO Did This Study

The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 authorizes the President's Emergency Plan for AIDS Relief (PEPFAR) and promotes the ABC model (Abstain, Be faithful, or use Condoms). It recommends that 20 percent of funds appropriated pursuant to the act be spent on prevention and requires that, starting in fiscal year 2006, 33 percent of prevention funds appropriated pursuant to the act be spent on abstinence-until-marriage. The Office of the U.S. Global AIDS Coordinator (OGAC) is responsible for administering PEPFAR. GAO reviewed PEPFAR prevention funds, described PEPFAR's strategy to prevent sexual HIV transmission, and examined related challenges.

What GAO Recommends

GAO recommends that the Secretary of State direct the Global AIDS Coordinator to collect and report information on the abstinence-until-marriage spending requirement's effects and use it to assess whether the requirement should apply only to the Global HIV/AIDS Initiative account. GAO also suggests that Congress use the information to assess how well the requirement supports the Leadership Act's endorsement of both the ABC model and strong abstinence programs. OGAC agreed regarding collecting information but disagreed with applying the requirement only to certain funds. We modified our recommendation in light of this concern.

www.gao.gov/cgi-bin/getrpt?GAO-06-395.

To view the full product, including the scope and methodology, click on the link above. For more information, contact David Gootnick at (202) 512-3149 or gootnickd@gao.gov.

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What GAO Found

In fiscal years 2004-2006, the PEPFAR prevention budget increased by almost 55 percent, from \$207 million to \$322 million. During this time, the prevention share of the total PEPFAR budget fell from 33 to 20 percent, consistent with the Leadership Act's recommendation that 20 percent of funds appropriated pursuant to the act should support prevention.

The PEPFAR strategy for preventing sexual transmission of HIV is largely shaped by the ABC model and the abstinence-until-marriage spending requirement. In addition to adopting the ABC model, OGAC developed guidance for applying it—stating, for instance, that prevention interventions should be integrated and respond to local epidemiology and cultural norms. OGAC also established policies for applying the spending requirement for fiscal year 2006. To meet the 33 percent spending requirement, it mandated that country teams—PEPFAR officials in the field—spend half of prevention funds on sexual transmission prevention and two-thirds of those funds on abstinence/faithfulness (AB) activities. At the same time, OGAC permitted certain teams, especially those with relatively small budgets, to seek waivers from this policy to help them respond to local prevention needs. OGAC also applied the spending requirement to all PEPFAR prevention funding as a matter of policy, although it determined that, as a matter of law, it applies only to funds appropriated to the Global HIV/AIDS Initiative account.

OGAC's ABC guidance and the abstinence-until-marriage spending requirement, including OGAC's policies for implementing it, have presented challenges for country teams. First, although most teams found the ABC guidance generally clear, two-thirds reported that ambiguities in some parts of the guidance led to uncertainty about implementing the model. OGAC officials told GAO that they plan to clarify the guidance. Second, although several teams told GAO that they value the ABC model and emphasize AB messages for certain populations, teams also reported that the spending requirement can limit their efforts to design prevention programs that are integrated and responsive to local prevention needs. Seventeen of 20 country teams reported that fulfilling the spending requirement, including OGAC's policies implementing it, presents challenges to their ability to respond to local prevention needs. Ten of these teams (primarily those with smaller PEPFAR budgets) received exemptions from the requirement, allowing them to dedicate less than 33 percent of prevention funds to AB activities. In general, the nonexempted teams were effectively required to spend more than 33 percent of prevention funds on AB activities; as a result, OGAC should just meet the overall 33 percent spending requirement for fiscal year 2006. However, to meet the requirement, nonexempted country teams have, in some cases, reduced or cut funding for certain prevention programs, such as programs to deliver comprehensive ABC messages to populations at risk of contracting HIV. Finally, OGAC's decision to apply the spending requirement to all PEPFAR prevention funds may further challenge teams' ability to address local prevention needs.

Contents

Letter

Results in Brief	1
Background	3
PEPFAR Prevention Funding in the 15 Focus Countries Grew Significantly during First 3 Years	8
PEPFAR Sexual Transmission Prevention Strategy Is Driven by ABC Approach, Abstinence-Until-Marriage Spending Requirement, and Local Prevention Needs	19
ABC Guidance and Abstinence-Until-Marriage Spending Requirement Present Challenges for Country Teams	26
Conclusions	31
Recommendation for Executive Action	44
Matters for Congressional Consideration	45
Agency Comments and Our Evaluation	46

Appendixes

Appendix I: Scope and Methodology	50
Appendix II: AB and “Other Prevention” Programs in Four Focus Countries	54
Appendix III: Prevention Program Indicators and Methods of Measuring PEPFAR Prevention Program Results	62
Appendix IV: PEPFAR Planning and Reporting Process	67
Appendix V: Methods for Reporting Allocations among PEPFAR Prevention Program Areas	69
Appendix VI: Joint Comments from State, USAID, and HHS	73
GAO Comments	84
Appendix VII: GAO Contact and Staff Acknowledgments	87

Figures

Figure 1: Stage of the AIDS Epidemic in PEPFAR Focus Countries	10
Figure 2: Selected Spending Recommendations and Requirements for Fiscal Years 2006-2008 Contained in the 2003 Leadership Act	12
Figure 3: PEPFAR Prevention Program Areas	15
Figure 4: Total PEPFAR Prevention Funding in the 15 Focus Countries, Fiscal Years 2004-2006	20

Figure 5: PEPFAR Prevention Funding, by Focus Country, Fiscal Years 2004-2006	21
Figure 6: Proportion of PEPFAR Funding Dedicated to Prevention in the 15 Focus Countries, Fiscal Years 2004-2006	22
Figure 7: Proportion of PEPFAR Funding Dedicated to Prevention, by Focus Country, Fiscal Years 2004-2006	23
Figure 8: Reported Allocation of Focus Countries' Total PEPFAR Prevention Funding by Each Prevention Program Area, Fiscal Years 2004-2006	24
Figure 9: Percentage of Reported Fiscal Year 2005 PEPFAR Sexual Transmission Prevention Funding Allocated to Abstinence/Faithfulness and "Other Prevention" by Each Focus Country Team	25
Figure 10: Illustration of a Country Team's Prevention Funding Allocated According to OGAC's Policies Implementing the Abstinence-Until-Marriage Spending Requirement	29
Figure 11: Prevention Allocations for Nonexempted and Exempted Focus Country Teams, Fiscal Years 2005 and 2006	43
Figure 12: OGAC Planning and Reporting Requirements for Fiscal Years 2005 and 2006	68

Abbreviations

AB	abstinence/faithfulness
ABC	Abstain, Be faithful, or use Condoms
COPRS	Country Operational Plan and Reporting System
GHAJ	Global HIV/AIDS Initiative
HHS/CDC	Department of Health and Human Services—Centers for Disease Control and Prevention
NGO	nongovernmental organization
OGAC	Office of the U.S. Global AIDS Coordinator
PEPFAR	President’s Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
UNAIDS	Joint United Nations Programme for HIV/AIDS
USAID	U.S. Agency for International Development

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April 4, 2006

Congressional Committees

In January 2003, citing the need “to meet a severe and urgent crisis abroad,” President Bush announced his Emergency Plan for AIDS Relief (PEPFAR), a \$15 billion, 5-year initiative to combat the global HIV/AIDS epidemic through prevention, treatment, and care interventions. This initiative represented a significant increase in U.S. funding for HIV/AIDS. Prior to PEPFAR, the United States had committed to provide \$5 billion to bilateral HIV/AIDS initiatives; under PEPFAR, the total financial U.S. commitment increased by nearly \$10 billion, with \$9 billion¹ targeted to HIV/AIDS initiatives in 15 focus countries.² PEPFAR’s primary prevention goal is to avert 7 million HIV infections in these countries—where heterosexual intercourse is generally the primary mode of transmission—by the year 2010. The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003³ (Leadership Act), which authorizes PEPFAR, endorses using the “ABC model” (Abstain, Be faithful, or use Condoms) to prevent the sexual transmission of HIV and establishes the Global HIV/AIDS Initiative (GHAI) account. The act also recommends that 20 percent of funds appropriated pursuant to the act be dedicated to HIV/AIDS prevention and requires that, beginning in fiscal year 2006, at least 33 percent of prevention funds appropriated pursuant to the act be spent on abstinence-until-marriage programs. Finally, the act provides for the establishment of an HIV/AIDS Coordinator within the Department of State (State) to lead the U.S. response to the HIV/AIDS epidemic and oversee all U.S. efforts to

¹The remaining \$1 billion was intended for the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (the Global Fund).

²The President named the following 14 focus countries in 2003: Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia. Vietnam was added as the fifteenth focus country in June 2004.

³Pub. L. No. 108-25.

combat HIV/AIDS abroad.⁴ Since its establishment in January 2004, State's Office of the U.S. Global AIDS Coordinator (OGAC) has defined five HIV/AIDS prevention program areas—abstinence/faithfulness (AB), “other prevention,” prevention of mother-to-child transmission (PMTCT), safe medical injections, and blood safety⁵—and defined abstinence-until-marriage programs as AB activities.

Responding to broad-based congressional interest in HIV/AIDS prevention efforts under PEPFAR, in this report we (1) review trends and allocation of PEPFAR prevention funding, (2) describe the PEPFAR strategy for preventing the sexual transmission of HIV, and (3) examine key challenges associated with applying the PEPFAR sexual transmission prevention strategy. We conducted this review under the Comptroller General's authority.

To address these objectives, we reviewed documents such as the PEPFAR 5-year strategy,⁶ first annual report to Congress, and fiscal year 2004 operational plan; operational plans and annual and midyear progress reports provided by U.S. agency officials responsible for managing PEPFAR in the focus countries (focus country teams); PEPFAR guidance to the field; and budget documents provided by OGAC. In addition, we interviewed U.S.-based officials from OGAC, USAID, and the Department of Health and Human Services—Centers for Disease Control and Prevention (HHS/CDC), as well as several Washington, D.C.-based nongovernmental organizations (NGOs). We also conducted structured interviews between June 2005 and January 2006 with key State, USAID, HHS/CDC, and other

⁴The U.S. agencies primarily responsible for implementing PEPFAR are the Department of State; the U.S. Agency for International Development (USAID); and the Department of Health and Human Services (HHS). Other agencies involved in PEPFAR are the Department of Defense, the Peace Corps, and the Departments of Labor and Commerce.

⁵Abstinence/faithfulness and “other prevention” funds generally are aimed at preventing the sexual transmission of HIV, while funds in the other three categories are aimed at preventing nonsexual transmission. “Other prevention” includes activities such as programs for high-risk groups to increase their awareness of HIV/AIDS prevention behaviors and their access to HIV prevention services, such as condom promotion and distribution; condom social marketing; substance abuse prevention programs; management and treatment of sexually transmitted infections; and messages or programs to reduce injection drug use and related risks. In its Second Annual Report to Congress, released February 2006, OGAC began referring to these activities as “condoms and related prevention activities.”

⁶“The President's Emergency Plan for AIDS Relief U.S. Five-Year Global HIV/AIDS Strategy,” Feb. 23, 2004.

U.S. agency staff in the 15 focus countries.⁷ We conducted 11 of these structured interviews over the telephone and 4 during site visits. We visited Botswana, Ethiopia, South Africa, and Zambia in July 2005, selecting this targeted sample of focus countries based on criteria such as level of PEPFAR funding, HIV prevalence rate,⁸ and prevention focus. In the countries that we visited, we interviewed key U.S. government officials, host country government officials, NGOs, faith-based organizations, local community-based organizations, and program beneficiaries. We also requested information from five additional PEPFAR country teams⁹ regarding their PEPFAR funding, the process of developing country operational plans, and the effects, if any, of the abstinence-until-marriage spending requirement on their prevention programming; we received responses from two of the five country teams. (See app. I for a detailed description of our scope and methodology.) In general, we found the data on PEPFAR prevention funding, with the exception of data on spending allocations among certain prevention program areas, sufficiently reliable for the purposes of our engagement. We conducted our work from February 2005 to February 2006 in accordance with generally accepted government auditing standards.

Results in Brief

PEPFAR prevention funding¹⁰ in the 15 focus countries grew by more than 40 percent between fiscal years 2004 and 2005 and by an additional 10 percent between 2005 and 2006, rising from \$207 million in fiscal year 2004

⁷These officials spoke with us with the understanding that individual respondents and the countries where they serve would not be named in our discussion of the structured interviews.

⁸HIV prevalence represents the percentage of the population that is estimated to be HIV positive. Estimates of HIV prevalence are often based on surveillance of pregnant women in prenatal clinics or population-based surveys. In contrast, HIV incidence refers to the number of new infections over a period of time (usually 1 year).

⁹These countries are Cambodia, India, Malawi, Russia, and Zimbabwe. Each of these country teams receives at least \$10 million in U.S. government funding for HIV/AIDS and is therefore required to submit an operational plan to OGAC each fiscal year, starting in fiscal year 2006.

¹⁰As discussed on page 11, PEPFAR prevention funding is defined for the purposes of this report as funding appropriated to four accounts in the 15 PEPFAR focus countries, as well as bilateral HIV/AIDS funding in the five additional PEPFAR countries. Funding data for fiscal years 2004 and 2005 are actual, while funding data for fiscal year 2006 are planned funding for activities that have not yet been approved by OGAC.

to \$322 million in fiscal year 2006. At the same time, consistent with the Leadership Act's recommendation that 20 percent of funds appropriated pursuant to the act be spent on prevention, the prevention portion of total PEPFAR funding in the 15 focus countries declined from 33 to 20 percent. The proportion of focus countries' total PEPFAR prevention funding allocated to each of the five nonsexual and sexual transmission prevention program areas varied during fiscal years 2004-2006, and focus country teams reported allocating varying amounts for sexual transmission prevention programs in fiscal year 2005. However, there are limitations in the reliability of these reported allocations because of challenges and inconsistencies in country teams' categorization of funding for certain ABC programs and some broad sexual transmission prevention activities.

The PEPFAR strategy for preventing sexual transmission of HIV is largely shaped by three elements: the ABC model, the Leadership Act's abstinence-until-marriage spending requirement, and local prevention needs in the PEPFAR countries.

- In developing the PEPFAR sexual transmission prevention strategy, OGAC adopted the ABC model, endorsed by the Leadership Act, as an effective method for preventing HIV/AIDS. In addition, to guide country teams' application of the ABC model, OGAC identified general principles for the teams to consider in developing and implementing PEPFAR ABC programs—stating, for example, that prevention interventions should be responsive to characteristics of the epidemic in their country and integrated, so that prevention messages are harmonized at the community level. OGAC's guidance regarding the ABC model (ABC guidance) also outlined the types of activities that can be funded through PEPFAR and directed country teams to emphasize different components of the ABC model for various target populations.
- The PEPFAR sexual transmission prevention strategy reflects the Leadership Act's requirement that, beginning in fiscal year 2006, at least 33 percent of prevention funds appropriated pursuant to the act support abstinence-until-marriage programs.¹¹ To ensure compliance with the spending requirement, OGAC established policies in August 2005 implementing the requirement. These policies directed 20 country

¹¹Although the spending requirement did not take effect until fiscal year 2006, OGAC encouraged country teams to dedicate 33 percent of total prevention funds to AB activities in fiscal years 2004 and 2005, consistent with the Leadership Act's recommendation to do so.

teams¹² to dedicate at least 50 percent of prevention funding to sexual transmission prevention activities (50 percent policy) and 66 percent of that amount to AB activities (66 percent policy) starting in fiscal year 2006. OGAC also instructed the teams to isolate AB spending in their annual reports to demonstrate adherence to the spending requirement. In addition, OGAC allowed certain country teams to submit justifications requesting exemption from its policies implementing the spending requirement. Finally, OGAC applied the spending requirement to all PEPFAR prevention funding¹³ (about \$357 million in fiscal year 2006) as a matter of policy, although it determined that, as a matter of law, the requirement applies only to funds appropriated to the GHAI account (about \$322 million for prevention in fiscal year 2006).

- Working within the parameters of the ABC model and the abstinence-until-marriage spending requirement, country teams design prevention programs that respond to the countries' prevention needs. For example, country teams reserve funding for AB activities to comply with the spending requirement and take steps to allocate their prevention funds according to factors such as the average age when sexual activity begins in their respective countries.

OGAC's ABC guidance and the Leadership Act's abstinence-until-marriage spending requirement have presented several challenges to country teams.

- Lack of clarity in the ABC guidance has created challenges for a majority of focus country teams. Although a number of the teams told us that they found the guidance clear or easy to implement, 10 of the 15 focus country teams cited instances where elements of the guidance were ambiguous and confusing, leading to difficulties in its interpretation and implementation. For example, although the guidance restricts activities promoting condom use, it does not clearly delineate the difference between condom education and condom promotion, causing uncertainty over whether certain condom-related activities are permissible. OGAC officials acknowledged that certain components of the guidance can be confusing and told us that they are working to

¹²These 20 country teams are the 15 focus country teams and the 5 additional teams that receive at least \$10 million in PEPFAR funding.

¹³As shown on page 11, PEPFAR prevention funding is defined for the purposes of this report as funding appropriated to four accounts in the 15 PEPFAR focus countries, as well as bilateral HIV/AIDS funding in the five additional PEPFAR countries.

clarify them. They also provided a document—distributed to country teams in August 2005—that aims to address some of the concerns that country teams identified. OGAC plans to update this document each fiscal year, based on country teams’ feedback about implementing the ABC guidance.

- Satisfying the Leadership Act’s abstinence-until-marriage spending requirement presents challenges to most country teams. Several focus country teams indicated that they value the ABC model as an HIV/AIDS prevention tool and noted the importance of AB messages, particularly for certain populations. However, about half of the focus country teams told us that meeting the spending requirement can undermine the integration of prevention programs by forcing them to isolate funding for AB activities. Further, 17 of the 20 PEPFAR teams required to meet the spending requirement unless they obtain exemptions from it reported that the spending requirement presents challenges to their ability to respond to local epidemiology and cultural and social norms. As permitted under OGAC’s policies, 10 of these 17 teams requested exemption from the spending requirement, citing a variety of constraints related to meeting it, such as reduced spending for PMTCT and limited funding for prevention messages to high-risk groups. Although the remaining 7 country teams did not request exemptions (they did not meet OGAC’s proposed criteria for submitting requests), they also identified specific program constraints related to meeting the spending requirement, such as cuts in PMTCT services or reduced funding for prevention programs aimed at HIV-positive individuals.¹⁴ Despite approving the 10 exemption requests, OGAC should just meet the overall spending requirement specified by the Leadership Act for fiscal year 2006 by effectively requiring teams that do not request exemptions to, in most cases, spend more than the 33 percent of prevention funds on AB activities. Although exempted country teams avoid, to some degree, the challenges they identified related to meeting the spending requirement, teams that are not exempted from the requirement must sometimes reduce or cut funding for certain prevention programs. For example, one country team told us that, to meet the spending requirement, it had to limit funding for comprehensive ABC messages to populations at risk of contracting HIV. Our analysis shows that for exempted country teams, total planned prevention funds dedicated to

¹⁴These programs aim to prevent transmission of HIV from infected individuals to uninfected individuals.

“other prevention” increased by approximately \$700,000 between fiscal years 2005 and 2006, remaining at about 21 percent of their total prevention funding in each fiscal year. For nonexempted country teams, total planned prevention funds dedicated to “other prevention” declined by approximately \$5 million—from about 23 percent of overall planned prevention funds in fiscal year 2005 to about 18 percent in fiscal year 2006. Finally, OGAC’s decision to apply the spending requirement to all PEPFAR prevention funding may further constrain some country teams’ ability to respond to local prevention needs. For example, this policy prevents one country team from funding certain condom social marketing programs with \$1.5 million in non-GHAI funding, despite its having reduced funding for those programs to comply with the abstinence-until-marriage spending requirement.

In light of reported challenges presented by the abstinence-until-marriage spending requirement, we are recommending that the Secretary of State direct the U.S. Global AIDS Coordinator to collect and report to Congress information from the country teams about the spending requirement’s effect on their prevention programming and use that information to, among other things, consider whether the Leadership Act’s abstinence-until-marriage spending requirement should be applied only to funds appropriated to the Global HIV/AIDS Initiative account. We are also suggesting that, in light of this information, Congress should assess the extent to which the spending requirement supports the Leadership Act’s endorsement of both the ABC model and strong abstinence-until-marriage programs.

We provided a draft of this report to the Department of State/OGAC, HHS, and USAID. In commenting jointly on our report, the agencies reiterated their strong commitment to fight HIV/AIDS, stating that “only a vigorous and comprehensive prevention approach will turn the tide against the global HIV/AIDS pandemic.” Consistent with our report’s discussion, they also noted the importance of the ABC model in preventing sexual transmission of HIV. Regarding our finding that interpreting and implementing the ABC guidance has created challenges for most of the focus country teams, the agencies commented that they are committed to continually improving efforts to communicate policy to the field. The agencies expressed appreciation for our report’s findings regarding difficult trade-offs that country teams have had to make with respect to funding for prevention activities and agreed with our recommendation to collect information regarding the effects of the Leadership Act’s abstinence-until-marriage spending requirement. They disagreed with our recommendation

regarding applying the abstinence-until-marriage spending requirement only to funds appropriated to the GHAI account, stating that doing so would limit their ability to use a unified budget approach and would have little impact, given the small amount of non-GHAI funding that the focus country teams receive. We recognize that allowing country teams to apply the spending requirement solely to GHAI funds entails some trade-offs. Given the agencies' concerns about maintaining a unified budget approach, we have modified our recommendation to recommend that they consider this policy change after collecting information on the effect of the spending requirement. With respect to the non-GHAI funding amounts, we would note that the five additional countries required, absent exemptions, to meet the spending requirement receive more than 80 percent of their funds through non-GHAI accounts. Thus, we believe that our modified recommendation is warranted. Finally, OGAC and USAID also provided technical comments on the draft, which we have incorporated as appropriate.

Background

Each day, an estimated 13,400 people worldwide are newly infected with HIV; more than 20 million have died from AIDS since 1981. HIV is transmitted both sexually (through sexual intercourse with an infected person) and nonsexually (through the sharing of needles or syringes with an infected person; unsafe blood transfusions; or the passing of the virus from mother to child during pregnancy, childbirth, or breastfeeding). However, the majority of HIV infections worldwide are transmitted sexually.¹⁵ About two-thirds of the estimated 40 million people currently living with HIV/AIDS are in sub-Saharan Africa where, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), adult HIV prevalence averaged 7.4 percent in 2004.

¹⁵According to the World Bank, more than three-quarters of HIV infections in developing countries are transmitted through sexual intercourse. Heterosexual intercourse is the primary mode of transmission in 14 of the 15 PEPFAR focus countries. Intravenous drug-use is the primary mode of transmission in Vietnam. World Bank estimates show that about 15 to 20 percent of all HIV infections in Africa occur through mother-to-child transmission. In developing countries, on average, blood transfusions account for less than 10 percent of HIV infections, and medical injections with dirty needles are thought to account for about 5 percent of all HIV infections.

Nature of AIDS Epidemic in PEPFAR Countries

HIV/AIDS is an urgent and growing health problem, driven by complex factors that present challenges to HIV prevention. The nature of the AIDS epidemic varies among the 15 PEPFAR focus countries, 12 of which are in sub-Saharan Africa (see fig. 1). In addition, the groups most vulnerable to HIV infection vary among the focus countries. For example, while girls and young women are most vulnerable in some countries, populations typically considered high-risk groups, such as intravenous drug-users or commercial sex workers, are most vulnerable in others.¹⁶ Figure 1 shows that although the epidemic in some focus countries is concentrated in certain populations, in other focus countries it has spread among the general population.

¹⁶According to the World Health Organization, girls and young women in Kenya are particularly vulnerable to HIV infection. In that country, women aged 15-24 are more than twice as likely to be infected as men in this age group. In Rwanda, however, the groups with evidence of the highest infection rates include sex workers, as well as men attending clinics that offer treatment for sexually transmitted infections.

Figure 1: Stage of the AIDS Epidemic in PEPFAR Focus Countries



Sources: World Bank (data), supplemented by information provided by OGAC and USAID; MapArt (image).

Note: According to UNAIDS and the World Health Organization, a concentrated epidemic is defined as one in which HIV has infected at least 5 percent of individuals in defined subpopulations but is not well-established in the general population. In a generalized epidemic, HIV has spread among the general population, infecting at least 1 percent.

PEPFAR Funding and Requirements

In fiscal year 2004, the U.S. Congress appropriated \$2.4 billion for global HIV/AIDS efforts, directing \$865 million of this amount to four accounts: (1) the GHAI account, which received most of the funding; (2) the Child Survival and Health account; (3) the Prevention of Mother to Child Transmission account; and (4) CDC's Global AIDS Program.¹⁷ In this report, the term *PEPFAR funding* describes funds appropriated to these four accounts¹⁸ in the 15 focus countries, as well as bilateral HIV/AIDS funding in five additional countries.¹⁹ For fiscal years 2004 and 2005, total PEPFAR funding consists of central and country-level actual appropriations allocated by OGAC for prevention, care, and treatment activities. Similarly, PEPFAR prevention funding for these fiscal years consists of central and country-level actual appropriations allocated by OGAC for prevention activities (AB, blood safety, PMTCT, safe medical injections, and "other prevention"). For fiscal year 2006, total PEPFAR funding consists of planned central and country-level PEPFAR funding for prevention, care, and treatment activities that have not yet been approved by OGAC.²⁰ PEPFAR prevention funding for fiscal year 2006 consists of planned central and country-level PEPFAR funding for prevention activities that have not yet been approved by OGAC.

¹⁷The remaining \$1.5 billion was appropriated for, among other initiatives, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (the Global Fund) and international HIV/AIDS research through the National Institutes of Health. The Global Fund is a multilateral, nonprofit, public-private mechanism to rapidly disburse grants to augment existing spending on the prevention and treatment of HIV/AIDS, tuberculosis, and malaria while maintaining sufficient oversight of financial transactions and program effectiveness. (See GAO, *Global Health: Global Fund to Fight AIDS, TB and Malaria Has Advanced in Key Areas, but Difficult Challenges Remain*, [GAO-03-601](#) [Washington, D.C.: May 7, 2003]).

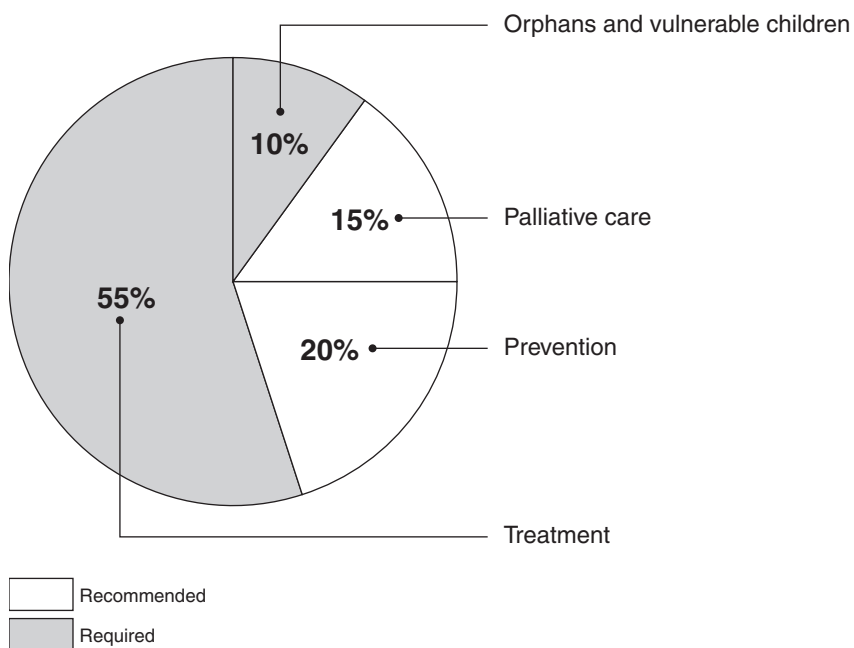
¹⁸The PMTCT account expired at the end of fiscal year 2004, but some country teams carried over PMTCT funds from fiscal year 2004 to fiscal year 2005. Therefore, for fiscal year 2006, this report defines PEPFAR funding as funds appropriated to the remaining three accounts. Although the PMTCT account expired, OGAC continues to fund PMTCT activities through the other funding accounts.

¹⁹Others have used *PEPFAR funding* to describe all U.S. government funds dedicated to combating HIV/AIDS worldwide, including funds such as U.S. contributions to the Global Fund.

²⁰According to OGAC officials, focus country teams received an additional \$150 million in fiscal year 2006 "plus-up" funding for prevention, treatment, and care activities in January 2006. Fiscal year 2006 funding figures are likely to change slightly throughout the fiscal year, as country teams make adjustments to their funding allocations. Data on fiscal year 2006 planned PEPFAR prevention funding are current as of March 15, 2006.

The Leadership Act specifies the percentages of PEPFAR funds to be allocated for HIV/AIDS prevention, treatment, and care for fiscal years 2006-2008. For example, the act recommends that 20 percent of funds appropriated pursuant to the act be spent on prevention and 15 percent on palliative care for those living with the disease.²¹ The act also requires that, beginning in fiscal year 2006, at least 55 percent of funds appropriated pursuant to the act be spent on treatment and at least 10 percent on orphans and vulnerable children. (See fig. 2.) See page 14 for information on additional spending recommendations and requirements specifically related to prevention funds.

Figure 2: Selected Spending Recommendations and Requirements for Fiscal Years 2006-2008 Contained in the 2003 Leadership Act



Source: GAO analysis of 2003 Leadership Act.

²¹According to the PEPFAR 5-year HIV/AIDS strategy, palliative care includes routine clinical care to evaluate the need for symptom relief (e.g., from diarrhea or headache); treatment for HIV/AIDS related diseases such as tuberculosis and opportunistic infections; preparing people for antiretroviral therapy, where possible; and, when treatment is not available or has failed, compassionate end-of-life care.

ABC Model and Abstinence-Until-Marriage Spending Requirement

The Leadership Act finds that “behavior change, through the use of the ABC model, is a very successful way to prevent the spread of HIV” and requires that prevention funding be set aside for abstinence-until-marriage programs. It defines the model as “Abstain, Be faithful, use Condoms, in order of priority.” The ABC model is based, in part, on the experience of Uganda, which implemented an ABC campaign in the 1980s and observed a decline in HIV/AIDS prevalence by 2001.²² Although substantial debate exists about the extent to which each component of the model is responsible for reducing HIV prevalence in individual countries, there is general consensus that using the ABC model can have a positive impact in combating HIV/AIDS. In November 2004, a key consensus statement authored by eight leading public health experts²³ observed that “all three elements of [the ABC model] are essential to reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population.” For example, it noted that “for those who have not started sexual activity the first priority should be to encourage abstinence or delay of sexual onset” and, “when targeting sexually active adults, the first priority should be to promote mutual fidelity with an uninfected partner as the best way to assure avoidance of HIV infection.” Finally, according to the document, “all people should have accurate and complete information about different prevention options, including all three elements of the ABC approach.” The statement was signed by more than 125 prominent figures, including the President of Uganda; the Archbishop of the Anglican Church of South Africa; officials from UNAIDS, the World Health Organization, and the World Bank; and dozens of other academics, representatives of faith-based groups, and public health advocates. In promoting the ABC model, the Leadership Act authorizes prevention activities that provide information on delaying sexual debut; abstinence; fidelity and monogamy; reduction of casual sexual partnering; reducing sexual violence and coercion, including child

²²In 1986, the Ugandan government launched a nationwide information, education, and communication tour to encourage Ugandans to abstain from sex until marriage, remain faithful to one partner (termed “zero-grazing”), and use condoms when necessary. According to the U.S. Census Bureau and UNAIDS, national HIV/AIDS prevalence in Uganda fell from about 15 percent in the early 1990s to 5 percent in 2001.

²³Cates, Willard; Cassell, Michael M.; Gayle, Helene D.; Green, Edward C.; Halperin, Daniel T.; Hearst, Norman; Kirby, Douglas; and Steiner, Markus J. “The Time Has Come for Common Ground on Preventing Sexual Transmission of HIV,” *Lancet*: Vol. 364, Nov. 27, 2004.

marriage, widow inheritance, and polygamy; and where appropriate, use of condoms.

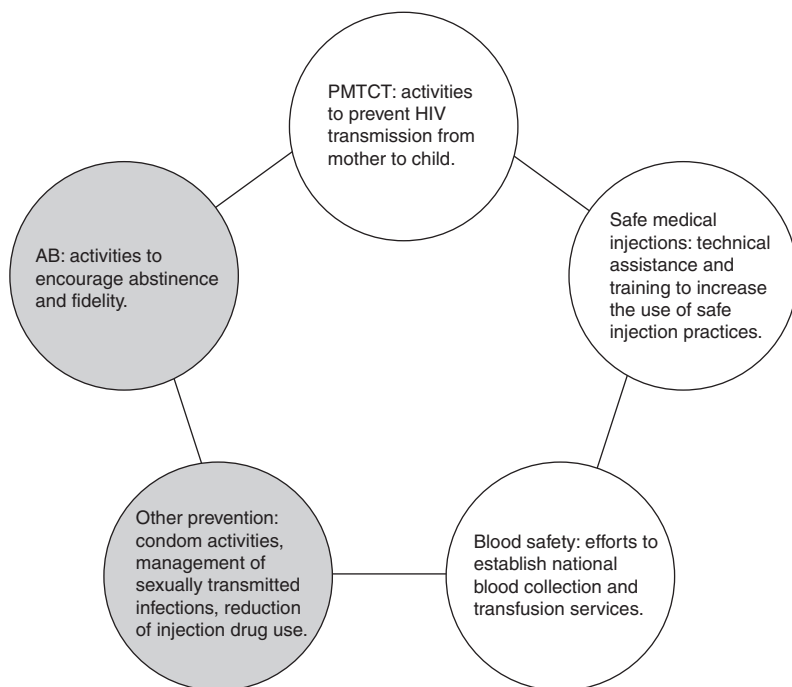
The act also requires that at least one-third of prevention funding appropriated pursuant to the act be spent on abstinence-until-marriage programs. The act recommended this spending distribution for fiscal years 2004-2005 and made it mandatory for fiscal years 2006-2008. In June 2004, OGAC notified Congress that it defines abstinence-until-marriage activities as programs that address both abstinence and faithfulness. Specifically, OGAC stated that abstinence-until-marriage programs would focus on achieving two goals: (1) encouraging individuals to be abstinent from sexual activity outside of marriage to protect themselves from exposure to HIV and other sexually transmitted infections and (2) encouraging individuals to practice fidelity in sexual relationships, including marriage, to reduce their risk of exposure to HIV.²⁴


PEPFAR Prevention Program Areas


The five PEPFAR prevention program areas—abstinence/faithfulness (AB), blood safety, prevention of mother-to-child transmission (PMTCT), safe medical injections, and other prevention—are divided into two groups: those aimed at preventing sexual transmission and those aimed at preventing nonsexual transmission of the disease. (See fig. 3.)

²⁴Office of the U.S. Global AIDS Coordinator, *Appendix 2: The Emergency Plan for AIDS Relief: Fiscal Year 2004 Prevention Expenditures and Program Classification Criteria* (Washington, D.C.: U.S. Department of State, 2004).

Figure 3: PEPFAR Prevention Program Areas



 Nonsexual transmission prevention programs

 Sexual transmission prevention programs

Source: GAO analysis of OGAC's fiscal year 2006 Country Operational Plan Guidance.

The sexual transmission prevention program areas are focused as follows.

- AB activities encourage
 - abstinence until marriage,
 - delay of first sexual activity,
 - secondary abstinence,²⁵

²⁵According to OGAC, secondary abstinence is for unmarried youths who have already engaged in sexual intercourse.

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- faithfulness in marriage and monogamous relationships,
 - reduction of sexual partners among sexually active unmarried persons, and
 - social and community norms related to the above practices.

“Other prevention” activities include the

- purchase and promotion of condoms,
- management of sexually transmitted infections (if not in a palliative care setting), and
- messages or programs to reduce injection drug use and related risks.²⁶

(See app. II for examples of AB and “other prevention” programs that are being implemented under PEPFAR. For information on the organizations that have implemented sexual transmission prevention programs under PEPFAR, see <http://www.state.gov/s/gac/>.)

Office of the Global AIDS Coordinator

The Leadership Act provided for the establishment of an HIV/AIDS Coordinator, within the Department of State, to lead the U.S. response to HIV/AIDS abroad. The Coordinator’s authorities and duties include carrying out international prevention, care, treatment, and other HIV/AIDS-related activities through NGOs and U.S. executive branch agencies and coordinating their efforts. The agencies primarily responsible for implementing PEPFAR are the Department of State, USAID, and HHS. OGAC, established within the Department of State in January 2004, has been responsible for developing a global HIV/AIDS strategy and administering PEPFAR.

²⁶According to OGAC, “[intravenous drug use] prevention was included under sexual prevention because it falls within [PEPFAR’s] category of “other prevention,” i.e. other prevention that is not abstinence and be faithful (e.g., women in prostitution, truckers, men who have sex with men, etc).”

OGAC's Key Strategic Principles

OGAC's overall strategic cornerstones and principles, laid out in its 5-year global HIV/AIDS strategy for PEPFAR, include commitments to

- respond with urgency to the crisis;
- make policy decisions that are evidence based;
- demand accountability for results;
- implement programs that are suited to local needs and host government policies;
- develop and strengthen integrated HIV/AIDS prevention, treatment, and care services; and
- focus on rapid service delivery.²⁷

OGAC's Prevention Target for PEPFAR

OGAC's 5-year strategy states the PEPFAR prevention goal—announced by the President and repeated in the Leadership Act—of averting 7 million infections in the 15 focus countries.²⁸ Although PEPFAR is authorized through fiscal year 2008, OGAC plans to reach its prevention goal by the year 2010.²⁹ This prevention goal is cumulative; that is, infections averted in 2004 through 2009 will count toward the final total of infections averted by 2010. In addition, this goal is to be reached both through PEPFAR activities and through interventions by other donors and the host nations. (See app. III for a discussion of OGAC's indicators, models, and method for measuring infections averted, including the challenges that OGAC faces in measuring infections averted and, thus, in assessing the success of its prevention activities.)

²⁷The field of HIV/AIDS prevention also involves longer-term, research-oriented initiatives, such as research for vaccines and microbicides.

²⁸President Bush also established goals of treating at least 2 million people with life-extending drugs and providing humane care for millions of people suffering from AIDS and for children orphaned by AIDS. OGAC has stated that its goal is to provide care for 10 million people in the 15 focus countries.

²⁹In contrast, OGAC aims to reach the PEPFAR care and treatment goals by 2008.

PEPFAR Awards Process

PEPFAR funding for the 15 focus countries is allocated both centrally and at the country level.³⁰ Central awards are multicountry awards that are managed by U.S. agency headquarters in Washington, D.C. These one-time, 5-year awards are intended to increase funding for program activities with high levels of congressional interest and minimal existing activities in the field.³¹ Country-level awards are managed by the focus country teams.

Each year, to receive country-level funding for the coming fiscal year, country teams submit budgets, or “operational plans,” to OGAC outlining planned activities and the organizations that will implement them (implementing partners). The plans are subject to OGAC’s review and approval. (See app. IV for a description of OGAC’s review process and a time line of the PEPFAR awards process.) Country teams consider a variety of criteria when selecting implementing partners, such as the applicant organizations’ ability to scale up rapidly, sustain programs, and function in-country; the strength of their administrative and financial controls; and the extent to which their priorities mirror those of the host government and the U.S. government. Teams also often place a priority on working with local, indigenous organizations rather than large, international organizations. In addition, many country teams take steps to encourage faith-based organizations to apply for funding, although none of the teams reserves a specific percentage or amount of funding for faith-based organizations. For example, they may write grants specifically designed for organizations that use a faith-based approach or instruct prime implementing partners to work with small faith-based organizations that lack the capacity or experience to handle large amounts of funding.³²

³⁰Until recently, OGAC referred to central awards as “track 1” and to country-level awards as “track 1.5” and “track 2.” According to OGAC, the first round of funding managed by the focus country teams was awarded as track 1.5 funding, whereas subsequent rounds were awarded as track 2 funding.

³¹OGAC’s target areas for central awards for prevention include AB, blood safety, PMTCT, and safe medical injection activities. According to OGAC, it has chosen organizations with the capacity to rapidly expand activities, a proven track record, and existing operations in the focus countries for central awards. Central awards were made in two rounds: the first for blood safety, safe medical injections, and antiretroviral treatment; the second for orphans and vulnerable children and AB activities. Central awards were made for every focus country except Vietnam.

³²In December 2005, President Bush announced the New Partners Initiative, under which \$200 million in grants will be awarded to nongovernmental organizations with little or no experience working with the U.S. government to provide HIV/AIDS prevention and care services in the 15 focus countries.

PEPFAR Prevention Funding in the 15 Focus Countries Grew Significantly during First 3 Years

PEPFAR prevention funding in the 15 focus countries increased by more than 40 percent between fiscal years 2004-2005 and by an additional 10 percent between fiscal years 2005 and 2006.³³ At the same time, the proportion of total PEPFAR funding in the 15 focus countries dedicated to prevention declined from 33 to 20 percent. The proportion of total focus country PEPFAR prevention funding that was allocated to each of the five prevention program areas varied from fiscal year 2004 to fiscal year 2006, and individual country teams reported varying allocations among AB and “other prevention.” However, there are limitations in the reliability of the reported figures.

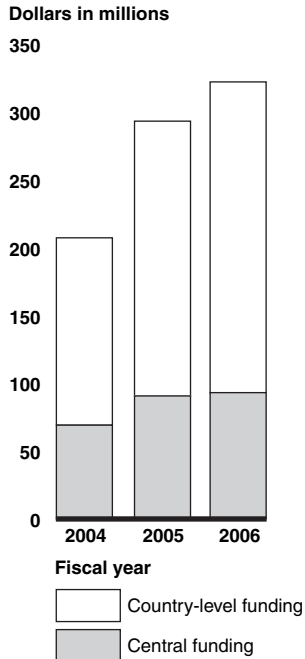
PEPFAR Prevention Funding in the 15 Focus Countries Increased in Fiscal Years 2004-2006

PEPFAR prevention funding in the 15 focus countries increased from \$207 million in fiscal year 2004³⁴ to \$294 million in fiscal year 2005, or by more than 40 percent. It further increased to \$322 million—about 10 percent—in fiscal year 2006. (See fig. 4.)

³³OGAC officials were unable to provide data on PMTCT central funding for prevention. While they estimated that \$6.5 million in central PMTCT funding went to prevention in fiscal years 2004 and 2005, we have not included these rough estimates in our funding figures.

³⁴In fiscal year 2004, the focus countries obligated about \$200 million in country-level and centrally awarded funds for prevention activities. Obligations represent a binding financial commitment (such as an order placed, contract awarded, or service received) that will result in immediate or future outlays.

Figure 4: Total PEPFAR Prevention Funding in the 15 Focus Countries, Fiscal Years 2004-2006



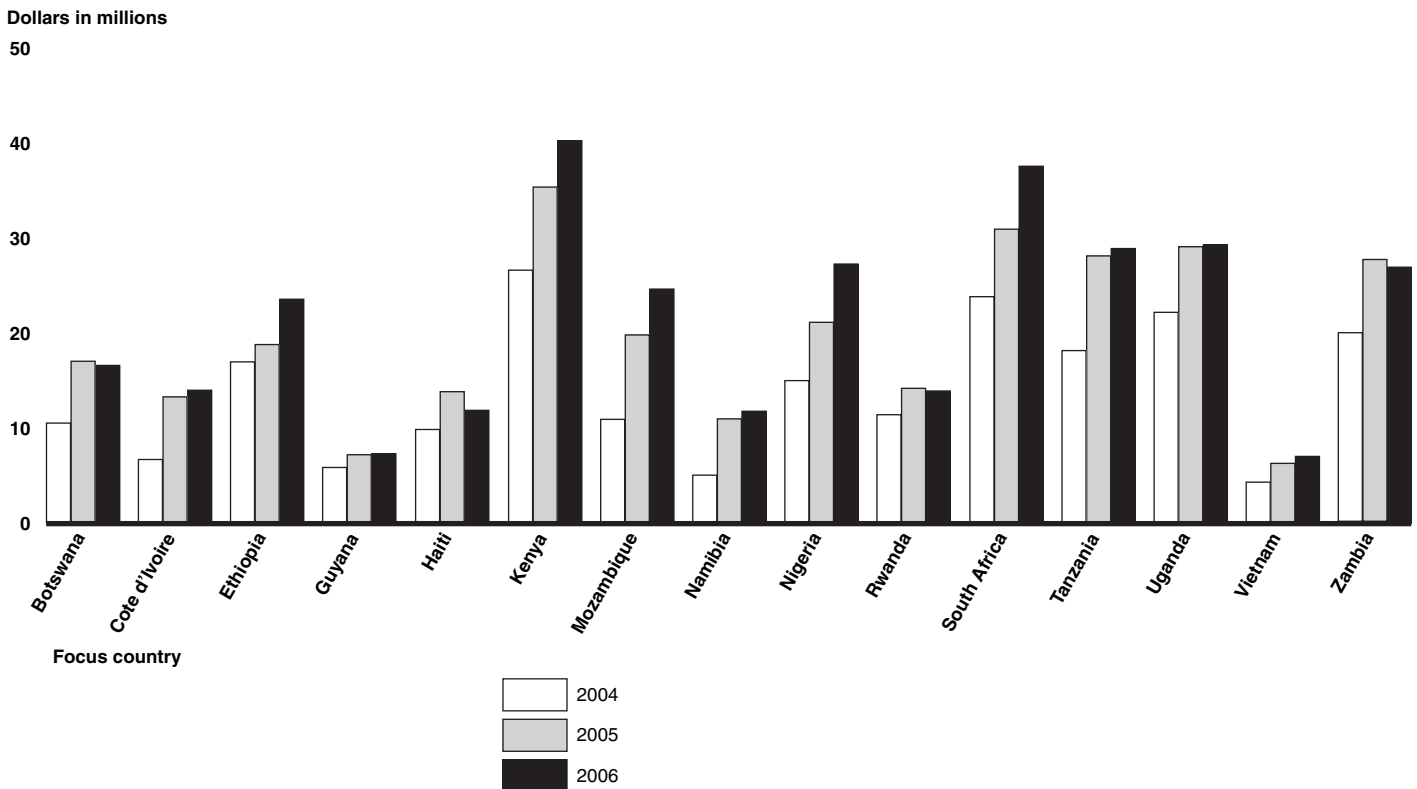
Sources: GAO analysis of fiscal year 2004 budget data provided by OGAC; OGAC's Country Operational Plan and Reporting System database; and OGAC Central Awards database.

Note: Fiscal year 2006 funding is planned.

For each of fiscal years 2004 through 2006, about 30 percent of the 15 focus countries' total PEPFAR prevention funding was awarded centrally. Although the majority of funding for blood safety (91 percent) and safe medical injection (91 percent) activities was awarded centrally, only 21 percent of AB funding was awarded centrally. None of the "other prevention" funding was awarded centrally.

In addition, PEPFAR prevention funding for the individual focus country teams generally increased between fiscal years 2004 and 2005 and, for most of the countries, increased again slightly in 2006. The amount of PEPFAR prevention funding for each focus country team varies. (See fig. 5.)

Figure 5: PEPFAR Prevention Funding, by Focus Country, Fiscal Years 2004-2006



Sources: GAO analysis of fiscal year 2004 budget data provided by OGAC; OGAC's Country Operational Plan and Reporting System database; and OGAC Central Awards database.

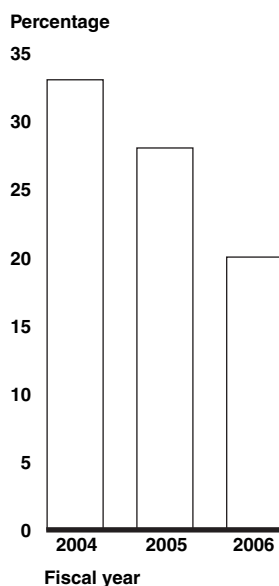
Note: Fiscal year 2006 funding is planned.

Proportion of Focus Countries' PEPFAR Funding Dedicated to Prevention Has Declined

The proportion of PEPFAR funding in the 15 focus countries dedicated to prevention declined from 33 percent in fiscal year 2004 to 20 percent in fiscal year 2006, consistent with the Leadership Act's recommendation that one-fifth of funds appropriated pursuant to the act be spent on prevention. (See fig. 6.) OGAC's fiscal year 2004 operational plan predicted this decline, noting that the proportion of total PEPFAR funding allocated to prevention would likely begin to decrease relative to the proportion allocated to care and treatment. OGAC expected the proportion allocated to care and treatment to increase over time because (1) previous U.S. global HIV/AIDS efforts had focused on prevention and (2) factors such as limited infrastructure and a lack of adequately trained staff in the focus

countries lengthen the time required to develop and expand treatment and care programs.

Figure 6: Proportion of PEPFAR Funding Dedicated to Prevention in the 15 Focus Countries, Fiscal Years 2004-2006

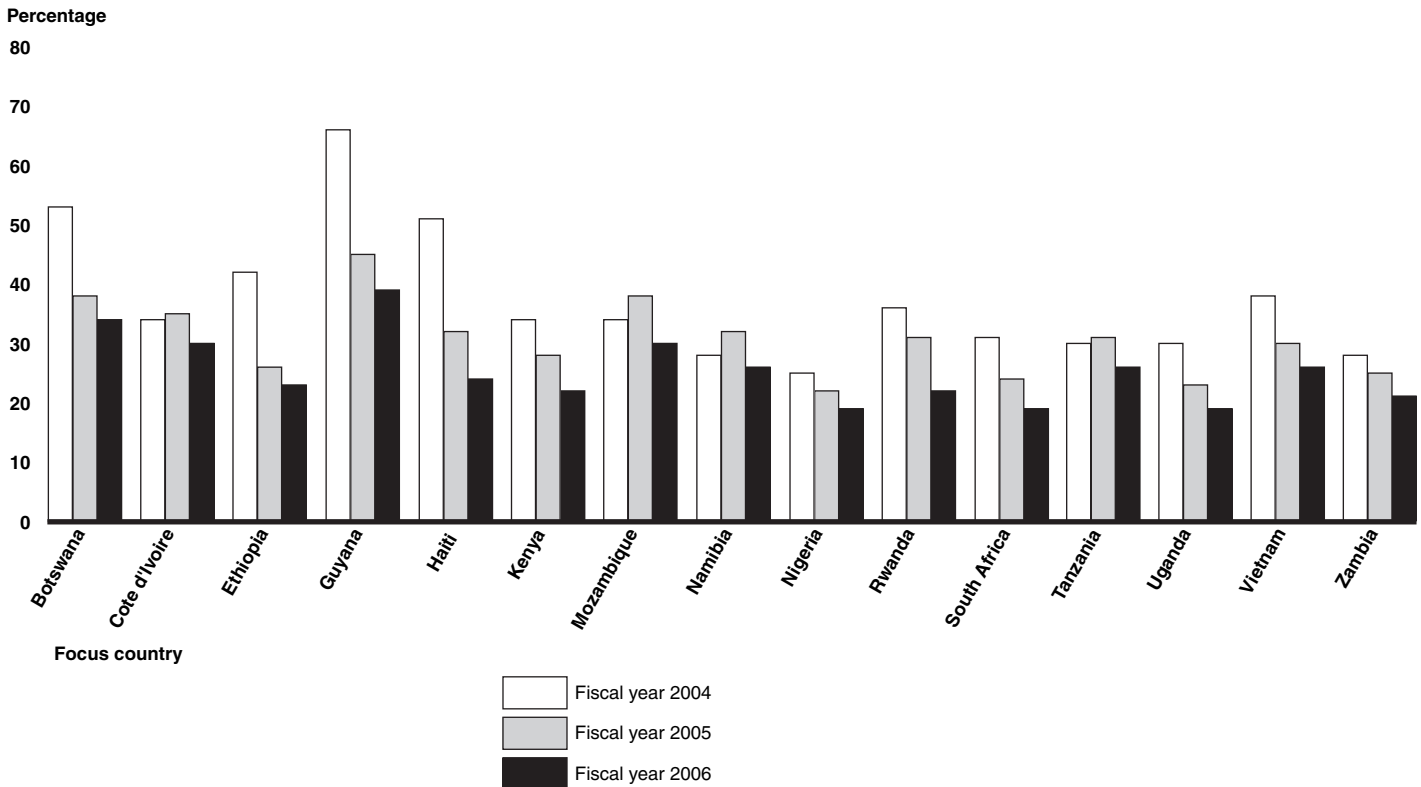


Sources: GAO analysis of fiscal year 2004 budget data provided by OGAC; OGAC's Country Operational Plan and Reporting System database; and OGAC Central Awards database.

Note: Fiscal year 2006 funding is planned.

For most of the focus country teams, the proportion of PEPFAR funding dedicated to prevention also declined in fiscal years 2004-2006. (See fig. 7.)

Figure 7: Proportion of PEPFAR Funding Dedicated to Prevention, by Focus Country, Fiscal Years 2004-2006



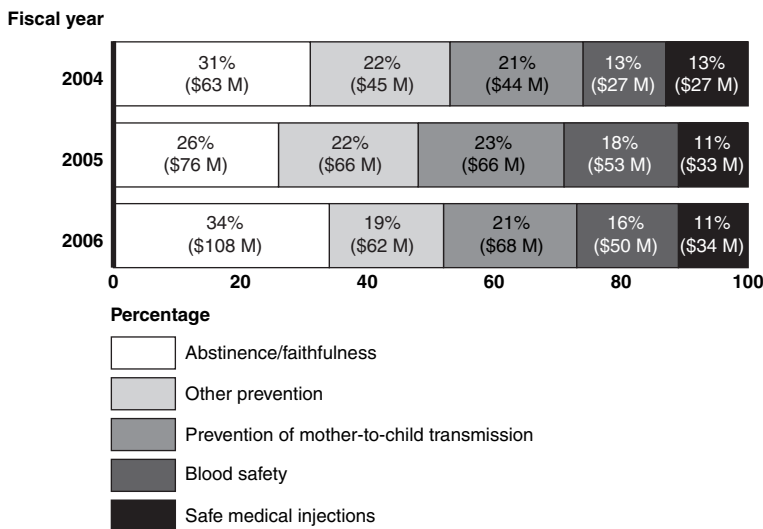
Sources: GAO analysis of fiscal year 2004 budget data provided by OGAC; OGAC's Country Operational Plan and Reporting System database; and OGAC Central Awards database.

Note: Fiscal year 2006 funding is planned.

Proportion of Focus Countries' PEPFAR Prevention Funding Allocated to Each Prevention Program Area Varied in Fiscal Years 2004-2006, but Data Reliability Has Limitations

The proportion of total PEPFAR prevention funding that the 15 focus country teams reported allocating to each of the five prevention program areas varied to some extent during fiscal years 2004-2006. (See fig. 8.)³⁵ However, there are limitations in the reliability of these data because of challenges and inconsistencies in country teams' categorization of funding for certain integrated ABC programs and some broad sexual transmission prevention activities. The lack of a standardized method for categorizing these programs means that, to some extent, the varied numbers of funding reported across fiscal years may reflect the variations in categorization methods rather than actual differences. (See app. V for a description of country teams' varying methods for categorizing sexual transmission prevention funding and the effect of this variation on the reported allocations' reliability.)

Figure 8: Reported Allocation of Focus Countries' Total PEPFAR Prevention Funding by Each Prevention Program Area, Fiscal Years 2004-2006



Sources: GAO analysis of fiscal year 2004 budget data provided by OGAC; OGAC's Country Operational Plan and Reporting System database; and OGAC Central Awards database.

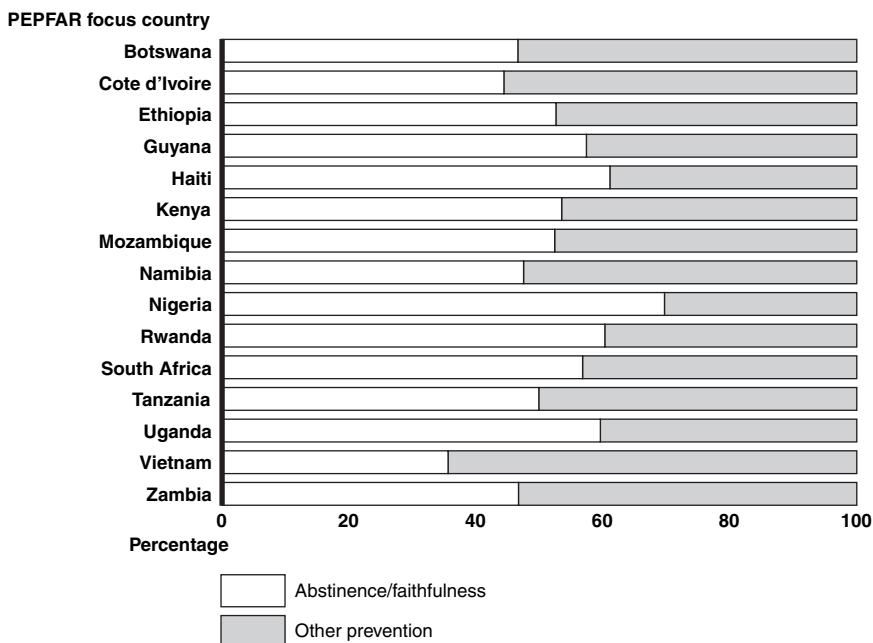
Note: Fiscal year 2006 funding is planned. Because of data reliability issues discussed in appendix V, these figures should be used only to understand general trends in data, rather than precise percentage

³⁵These figures also include central funding.

differences between program areas and fiscal years. Due to rounding, the percentages may not add up to 100.

We analyzed country teams' reported allocations for AB and "other prevention" for fiscal year 2005 and found that these allocations also varied. For example, 11 country teams reported allocating between 40 and 60 percent of their sexual transmission prevention funding to AB, 3 teams reported allocating somewhat over 60 percent, and 1 reported allocating slightly less than 40 percent to AB. (See fig. 9.)³⁶

Figure 9: Percentage of Reported Fiscal Year 2005 PEPFAR Sexual Transmission Prevention Funding Allocated to Abstinence/Faithfulness and "Other Prevention" by Each Focus Country Team



Source: GAO analysis of OGAC's Country Operational Plan and Reporting System database.

Note: Individual country teams use different methods for categorizing funding in the AB and "other prevention" program areas (see app. V). These data should not be used to make direct comparisons between individual country teams but rather to understand the overall pattern of funding across country teams.

³⁶The reported allocations shown in figure 9 include both central and country-level funding.

PEPFAR Sexual Transmission Prevention Strategy Is Driven by ABC Approach, Abstinence-Until-Marriage Spending Requirement, and Local Prevention Needs

The PEPFAR strategy for preventing sexual transmission of HIV has three primary components: (1) the ABC model and OGAC guidance for implementing it, (2) the abstinence-until-marriage spending requirement and OGAC's interpretation of it, and (3) country teams' strategies for responding to local prevention needs. OGAC adopted the ABC model as its primary sexual transmission prevention strategy and, in August 2005, provided guidance for country teams to use in applying the model. To guide the teams' application of the requirement that at least 33 percent of prevention funding appropriated pursuant to the Leadership Act fund abstinence-until-marriage programs, OGAC directed the teams to spend at least 50 percent of their prevention funds on sexual transmission prevention and 66 percent of those funds on AB activities. Finally, in designing their sexual transmission prevention strategies, country teams respond to local factors, such as the host government's capacity to expand activities in sexual transmission prevention program areas, as well as to the ABC model and the spending requirement.

PEPFAR Sexual Transmission Prevention Strategy Is Based Primarily on ABC Model and OGAC's ABC Guidance

OGAC adopted the ABC model, endorsed by the Leadership Act, as the primary PEPFAR strategy for preventing sexual transmission of HIV. The PEPFAR 5-year strategy states that evidence from Uganda and other countries "demonstrates the effectiveness of a balanced approach to behavior change that encourages the adoption of 'ABC' behaviors."

In January 2005, OGAC released guidance to country teams to shape their incorporation of the ABC model into their sexual transmission prevention strategies.³⁷ The guidance identifies key principles that country teams should consider in developing and implementing ABC programs.

- *The model should be applied in accordance with local prevention needs.* The guidance states that one of PEPFAR's commitments is to ensure "that interventions be informed by, and responsive to, local needs, local epidemiology, and distinctive social and cultural patterns."

³⁷Office of the U.S. Global AIDS Coordinator, *Guidance to In-Country Staff and Implementing Partners Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections within the President's Emergency Plan for AIDS Relief* (Washington, D.C.: U.S. Department of State, March 2005). This guidance was released in its final form in March 2005. According to OGAC, the only difference between the draft guidance provided to country teams in January and the final guidance was the language regarding human papilloma virus.

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- *Prevention activities should be integrated.* The guidance notes that “all implementing partners must harmonize [prevention messages] at the community level.”
 - *Prevention activities should be coordinated with the HIV/AIDS strategies of host governments.*
 - *Prevention interventions should be driven by best practices.*

Taking these principles into account, the guidance states that “the optimal balance of ABC activities will vary across countries according to the patterns of disease transmission, the identification of core transmitters (i.e., those at highest risk of transmitting HIV), cultural and social norms, and other contextual factors.”

In addition, OGAC’s ABC guidance contains rules for country teams to follow in developing and implementing their sexual transmission prevention strategies. First, the guidance specifies the components of the ABC model that should be targeted to certain populations. For example, messages about abstinence-until-marriage and delay of first sexual activity should be targeted to youths; fidelity should be emphasized for married couples and those in monogamous relationships; and condom use should be promoted to those who practice risky sexual behaviors, such as commercial sex workers and individuals who have sex with someone of unknown HIV status. Second, the guidance sets parameters on the prevention messages that may be delivered to youths. Specifically, although PEPFAR funds may be used to deliver age-appropriate AB information to in-school youths aged 10 to 14 years, the funds may not be used to provide information on condoms to these youths. When students are identified as being at risk, they may be referred to out-of-school programs that provide integrated ABC information and that provide condoms. Under these rules, PEPFAR funds may be used to provide integrated ABC information to youths older than 14.

OGAC also released the following guidance regarding the use of PEPFAR funds for ABC programs:

- Any PEPFAR-funded program that provides information about condoms must also provide information about abstinence and faithfulness.
- PEPFAR funds may not be used to physically distribute or provide condoms in school settings.

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- PEPFAR funds may not be used in schools for marketing efforts to promote condoms to youths.
 - PEPFAR funds may not be used in any setting for marketing campaigns that target youths and encourage condom use as the primary intervention for HIV prevention.
 - PEPFAR funds may be used to target at-risk populations with specific outreach, services, comprehensive prevention messages, and condom information and provision. The guidance defines at-risk groups as
 - commercial sex workers and their clients,
 - sexually active discordant couples or couples with unknown HIV status,
 - substance abusers,
 - mobile male populations,
 - men who have sex with men,
 - people living with HIV/AIDS, and
 - those who have sex with an HIV-positive partner or one whose status is unknown.

PEPFAR Strategy Is Shaped by Abstinence-Until-Marriage Spending Requirement and OGAC's Implementation of the Requirement

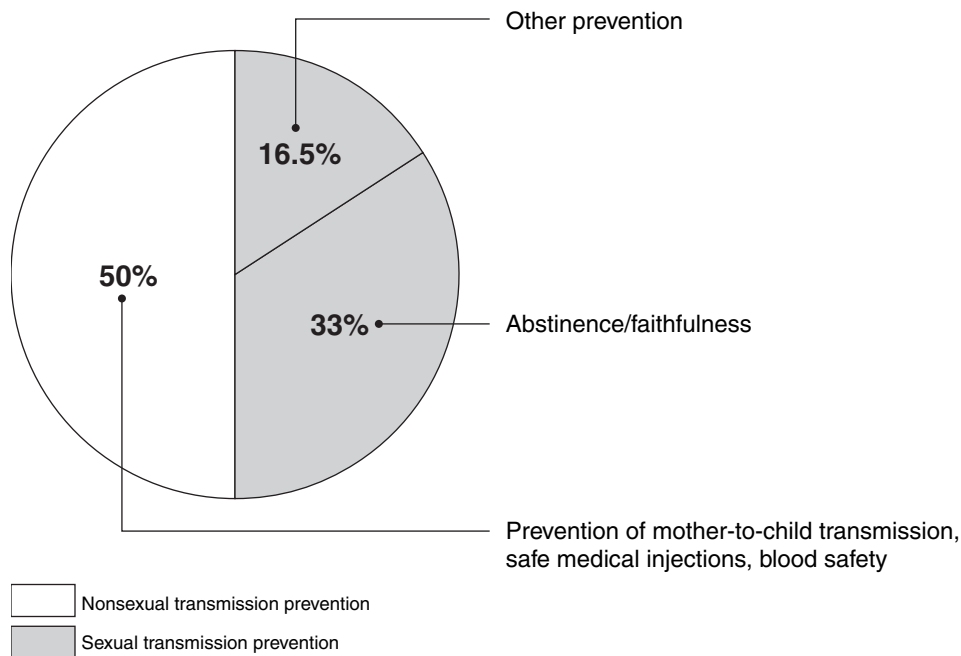
The PEPFAR strategy reflects the Leadership Act's abstinence-until-marriage spending requirement, as well as OGAC's recent policies implementing this requirement. Having defined abstinence-until-marriage activities as AB programs, in late August 2005, OGAC issued policies to help ensure that the 33 percent spending requirement is met. These policies directed each of the 15 focus country teams and 5 additional country teams³⁸ to spend at least 50 percent of their prevention funding³⁹ on sexual

³⁸These countries are Cambodia, India, Malawi, Russia, and Zimbabwe. OGAC officials said they chose to apply the 66 percent requirement to these countries because each country receives more than \$10 million in U.S. government funding for HIV/AIDS activities.

³⁹The sum of funding for all five prevention program areas.

transmission prevention and at least 66 percent of that amount on AB activities. In other words, OGAC requires country teams to spend \$2.00 on AB activities for every \$1.00 they spend on “other prevention” activities—a 2-to-1 ratio. To show compliance with the spending requirement, country teams’ operational plans must isolate the amount of funding spent on AB activities. OGAC’s policies relate to the Leadership Act’s requirement in the sense that, if a country spends exactly half of its prevention funding on sexual transmission prevention and two-thirds of that funding on AB activities, it will then spend one-third of its total prevention funding on AB. Figure 10 provides an illustrative example of a country team’s prevention funding strictly allocated according to OGAC’s policies.

Figure 10: Illustration of a Country Team’s Prevention Funding Allocated According to OGAC’s Policies Implementing the Abstinence-Until-Marriage Spending Requirement



Source: GAO.

Note: Percentages do not add up to 100, due to rounding.

In certain cases, OGAC allows country teams to submit justifications requesting exemptions to the spending requirement, as defined by the 50 percent and 66 percent policies. For example, OGAC guidance to the country teams states that if 80 percent of a country's epidemic is among prostitutes, a team can submit a justification for spending a higher proportion of sexual transmission prevention funds on correct and consistent condom use. However, the guidance also cautions that, in a generalized epidemic, a very strong justification is required for not meeting the 66 percent policy. The guidance adds that OGAC expects all focus country teams, in particular those with total PEPFAR funding exceeding \$75 million, to adhere to the policies implementing the spending requirement.⁴⁰

OGAC also directed country teams to apply the spending requirement to all PEPFAR prevention funding (about \$357 million in fiscal year 2006).⁴¹ OGAC adopted this policy although it determined that, as a matter of law, the requirement applies only to funds appropriated to the GHAI account (about \$322 million for prevention in fiscal year 2006). Under OGAC's policy, the abstinence-until-marriage spending requirement applies to prevention funding from the CDC's Global AIDS Program, the Child Survival and Health account, the Freedom Support Act account, and the GHAI account. However, when reporting to Congress on compliance with the spending requirement, OGAC reports only the allocation of funds under the GHAI account.

PEPFAR Strategy Also Includes Country Teams' Responses to Local Needs

Country teams' sexual transmission prevention strategies are shaped both by high-level requirements and local context. In each PEPFAR country, country teams design their sexual transmission prevention strategies in response to the ABC model and the abstinence-until-marriage spending requirement. At the same time, in accordance with OGAC's ABC guidance, the strategies take into account local factors such as the host nation's capacity to expand activities in the prevention program areas, the nature of the HIV/AIDS epidemic in the country, the average age when sexual activity begins, and the prevalence of certain social norms. For example, in a

⁴⁰As shown in figure 1, 11 of the 15 focus countries are experiencing generalized epidemics. In fiscal year 2006, 7 of the 15 focus countries had planned PEPFAR funding over \$75 million.

⁴¹See page 11 for a definition of PEPFAR prevention funding.

country where new HIV infections are largely occurring among high-risk groups, such as intravenous drug users or sex workers, the team determines how to effectively promote condom use to these populations while reserving the required percentage of prevention funding for AB activities. Likewise, in a country where sexual activity typically begins at a relatively low average age, the team decides how best to provide effective prevention messages to youths while taking into account the parameters that OGAC has established for delivering ABC messages to youths of different ages.

ABC Guidance and Abstinence-Until-Marriage Spending Requirement Present Challenges for Country Teams

Country teams face challenges related to two key drivers of the PEPFAR sexual transmission prevention strategy—OGAC’s guidance for applying the ABC model to country-level programs and the Leadership Act’s abstinence-until-marriage spending requirement. Although many country teams reported that they have found OGAC’s ABC guidance to be clear and several said that it did not present implementation challenges, two-thirds of focus country teams also reported that a lack of clarity in aspects of the guidance has led to interpretation and implementation challenges. OGAC officials told us that they are aware of these issues and plan to clarify the guidance. About half of the focus country teams indicated that adherence to the spending requirement can undermine the integrated nature of HIV/AIDS prevention programs. In addition, 17 of the 20 country teams required to meet the abstinence-until-marriage spending requirement, absent exemptions, reported that the requirement would prevent them from allocating prevention resources in accordance with local HIV/AIDS prevention needs. OGAC’s August 2005 policies implementing the spending requirement have allowed some of these country teams to address these concerns but have further constrained other teams from designing locally responsive HIV/AIDS prevention programs. Finally, OGAC’s policy of applying the spending requirement to all PEPFAR prevention funding, including funds not appropriated to the GHAI account, may further constrain country teams’ ability to address local prevention needs.

Unclear ABC Guidance Creates Challenges for Many Focus Country Teams

Interpreting and implementing OGAC’s ABC guidance has created challenges for most of the focus country teams. Although many teams told us that they generally found the guidance to be clear, and several said that it did not present implementation challenges, 10 of the 15 focus country teams we interviewed cited instances where components of the guidance were ambiguous and caused confusion.

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- *The guidance's definition of at-risk groups is open to varying interpretations, causing confusion about which groups may be targeted.*⁴² Six focus country teams and some implementing partners expressed uncertainty regarding the populations that should be considered at-risk in accordance with the ABC guidance. Five of these teams expressed concern that certain populations that need ABC messages in their countries might not receive them because they do not fit the ABC guidance definition of at-risk. For example, one team noted that the majority of HIV infections in its country are transmitted from one partner to another in either married or stable, cohabitating relationships. However, this team told us that they understood the ABC guidance on high-risk groups to be relevant only to a "limited epidemic" (unlike the generalized epidemic in which they were working) and that married couples do not count as high-risk under PEPFAR. As a result, they believed that a program designed to reach these individuals through ABC messages to a broad population would not be allowed. In addition, three teams questioned how to apply the definition of at-risk in a generalized epidemic.
 - *The guidance does not clearly delineate permissible C activities, causing confusion about proper use of PEPFAR funds.* OGAC's ABC guidance places restrictions on activities promoting condom use, but it does not clearly distinguish permissible and nonpermissible activities. For example, the guidance states that condom use programs should provide full and accurate information about correct and consistent condom use, including how to obtain them. The guidance also places restrictions on promoting or marketing condoms to youths;⁴³ however, it does not explain how providing condom information differs from condom promotion or marketing. Several NGOs that receive PEPFAR funding expressed concern to us about crossing the line between providing information about condoms and promoting or marketing condoms. For example, representatives of a PEPFAR-supported organization that runs a youth camp for students (aged 15-17) told us

⁴²According to the ABC guidance, at-risk groups include sex workers and their clients; sexually active discordant couples or couples with unknown HIV status; substance abusers; mobile male populations; men who have sex with men; people living with HIV/AIDS; and those who have sex with an HIV-positive partner or one whose HIV status is unknown.

⁴³The ABC guidance states that PEPFAR funds may not be used to physically distribute or provide condoms in school settings; for marketing efforts to promote condoms to youths in school settings; or for marketing campaigns that target youths and encourage condom use as the primary intervention for HIV prevention in any setting.

that condom use is addressed during camp sessions only when youths ask specific questions. However, staff said that they feel “constrained” when they hear these questions, because they do not want to say more than is allowed under PEPFAR guidelines. Another implementing partner representative said that although the organization views condom demonstrations as appropriate in some settings, it believes that condom demonstrations, even to adults, are prohibited under PEPFAR. OGAC’s guidance also does not explain whether ABC approaches for broader audiences in a generalized epidemic may include condom social marketing. Although a senior OGAC official told us that broad condom social marketing is appropriate in certain situations, five focus country teams reported that, in their understanding, PEPFAR funds may not be used for broad condom social marketing, even to adults in a generalized epidemic.

- *Guidance regarding mixed-age groups is absent, causing confusion about who may receive the ABC message.* The ABC guidance prohibits PEPFAR-funded programs in schools from providing condom information to youths younger than 15, but the guidance does not discuss the application of this age cutoff to groups that include youths younger and older than 15. Four focus country teams noted that the age cutoff for providing condom information to youths presents challenges because classrooms and out-of-school programs often include mixed-age groups. Two teams told us that, in these situations, only AB messages are typically provided to the entire group and, as a result, some older youths who need ABC messages may not receive them.

OGAC officials informed us that they were aware that certain components of the ABC guidance could be difficult to interpret. For example, they noted that they understood that it may be confusing for the definition of at-risk groups to include individuals who have sex with someone of unknown status. They explained that, although they had intended the guidance not to be overly prescriptive and looked to the country teams to determine how to apply rules in different situations, they planned to clarify certain parts of the guidance. In December 2005, OGAC officials provided us a document that gives country teams some additional clarification on how to apply the ABC guidance.⁴⁴ For example, the document addresses issues such as

⁴⁴Country teams received this document in August 2005. Although we conducted a follow-up round of structured interviews with the country teams after this date, we did not specifically ask each country team about this document.

preventing transmission among discordant couples and working within the context of a generalized epidemic. According to OGAC officials, they will update this document each year to respond to country teams' requests for additional clarification and to provide technical assistance as the teams prepare their operational plans. Country teams can provide feedback to OGAC on the ABC guidance and other issues through Washington-based interagency teams (core teams) specifically assigned to support them.

Meeting Abstinence-Until-Marriage Spending Requirement Presents Challenges for Majority of Country Teams

Satisfying the Leadership Act's abstinence-until-marriage spending requirement challenges many country teams' efforts to adhere to two principles of the PEPFAR sexual transmission prevention strategy. Country teams consistently told us that they value the ABC model, and several noted the importance of AB messages. At the same time, about half of the 15 focus country teams reported that meeting the abstinence-until-marriage spending requirement undermines their ability to integrate ABC programs as required by the guidance. In addition, most of the 20 PEPFAR teams required to meet the spending requirement or receive exemptions reported that fulfilling the requirement, including OGAC's 50 percent and 66 percent policies implementing it, presents challenges to their ability to respond to local epidemiology and cultural and social norms. Our analysis shows that OGAC should just reach the overall 33 percent target by granting exemptions to some country teams and requiring other teams to dedicate more than 33 percent of prevention funds to AB activities. Exempted teams are, to some degree, able to address the challenges they identified related to the spending requirement; however, country teams that are not exempted from the requirement face additional challenges, such as reduced funding for certain prevention programs. Our analysis suggests that "other prevention" allocations declined noticeably in country teams that were not exempted from the spending requirement but stayed constant in those that were. Finally, OGAC's policy of applying the spending requirement to all PEPFAR prevention funds—although it determined that, as a matter of law, the requirement applies only to funds appropriated to the GHAI account—may further constrain country teams' ability to address local prevention needs.

Country Teams Value the ABC Model

In several of our structured interviews, focus country teams endorsed the ABC model and noted the importance of AB messages. For example, one team told us that a balanced ABC approach was well within the host country's prevention approach, and another stated that each component of the model has a role to play. Another country team noted that, because of the country's high HIV/AIDS prevalence rate, abstinence is an appropriate

Spending Requirement Can Undermine Integration of Prevention Programs

message for both youths and adults. Several teams also emphasized the importance of AB messages. For example, one team told us that it has integrated AB messages throughout all prevention activities. Other teams noted the particular importance of AB messages for certain populations, consistent with the ABC guidance. One country team told us that, because it is focused on preventing HIV transmission among youths, its prevention programming focuses on AB activities. Similarly, another explained that youths in its country almost always receive exclusively AB messages. Finally, a U.S. government official in one of the focus countries we visited told us that abstinence is an important message for young girls in that country because of their lack of negotiating power in relationships.

Because it requires country teams to segregate AB funding from funding for “other prevention,” the abstinence-until-marriage spending requirement can undermine the teams’ ability to design and implement programs that integrate the components of the ABC model—one of the guiding principles of the PEPFAR sexual transmission prevention strategy. Eight of the 15 focus country teams indicated that segregating AB from “other prevention” funding compromises the integration of their programs. Examples of the problems they cited include the following:

- *Segregating program funding compromises the integration of ABC activities, especially for at-risk groups that need comprehensive messages.* One focus country team told us that artificially splitting programs for the military (traditionally considered an at-risk group) between AB and “other prevention” disaggregates what should be integrated and potentially lowers effectiveness. This team noted that there are clear links between programming and implementation. In other words, the way that a program is reported on paper affects the way that it is put into practice.
- *Segregating program funding limits some country teams’ ability to shift program focus to meet changing prevention needs.* One focus country team indicated that segregating program funding reduces the team’s ability to respond flexibly as program beneficiaries’ needs change over time. According to OGAC officials, once funds are designated as AB, they can be used only for AB purposes. This effectively locks teams into allocation decisions made when their operational plans were

approved.⁴⁵ A team that funds a prevention program for people living with HIV/AIDS stated that, although the program includes faithfulness messages, the team does not classify any funding for the program as AB, because it cannot predict the portion of the project that should be dedicated to the faithfulness component and does not want to lose its flexibility to “do what is appropriate.”⁴⁶ Another country team explained that its work with commercial sex workers will focus on correct and consistent condom use but will also include income-generation activities. Once the sex workers find an alternative means of income, AB messages become more relevant for them. This team stated that segregating program funding undermines the continuity inherent in integrated programs.

Country Teams Report That Meeting Spending Requirement Challenges Their Ability to Respond to Local Prevention Needs

A large majority of the 20 PEPFAR country teams required to meet the abstinence-until-marriage spending requirement or obtain exemptions reported that the requirement presents challenges to their efforts to respond to local prevention needs.⁴⁷ Seventeen of these teams reported—either through documents submitted to OGAC or through structured interviews—that meeting the spending requirement, including OGAC’s 50 percent and 66 percent policies implementing it, challenges their ability to develop interventions that are responsive to local epidemiology and social norms.⁴⁸

Between September 2005 and January 2006, 10 of these teams submitted documents to OGAC requesting exemption from the spending requirement as it was defined in OGAC’s August 2005 guidance. These documents highlight various challenges that the country teams associated with meeting the spending requirement, including the following:

⁴⁵Country teams can submit requests to OGAC to reprogram funds from one program to another.

⁴⁶Under direction from OGAC, this country team categorized the program entirely as palliative care.

⁴⁷The 20 PEPFAR teams discussed in this section comprise the 15 focus country teams and the 5 additional country teams required to meet the spending requirement because they receive at least \$10 million in PEPFAR funding.

⁴⁸Of the remaining three country teams, one reported that the spending requirement was in line with its prevention strategy; one indicated that, although it had some concerns about the prevention spending requirement, it had more concerns about the Leadership Act’s requirement that at least 55 percent of funds appropriated pursuant to the act be spent on treatment; and one did not respond to our request for information.

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- *Reduced spending for PMTCT.* Three country teams identified cuts in PMTCT as a constraint that they would face if required to meet the spending requirement. For example, one country team wrote that “reaching the sexual prevention and AB [spending requirements] would have required drastically reducing the PMTCT budget [from] \$1.4 million to \$350,000.”
 - *Limited funding to deliver appropriate prevention messaging to high-risk groups.* Several teams noted that AB messages are not well-suited for high-risk groups. According to one country team, “it is very important to direct a certain amount of prevention funding to high-risk groups located along transport corridors, and AB messaging is not always appropriate.”
 - *Lack of responsiveness to cultural and social norms.* Country teams identified specific characteristics about the epidemics in their countries that require a different allocation of funding than would be allowed under the spending requirement. For example, a team explained that dedicating a large portion of prevention funds to AB would be inappropriate, given conservative social norms—youths in their country “are not sexually active at an early age; the age of marriage and the age of first sexual experience were both estimated at 20 years.”
 - *Cuts in medical and blood safety activities.* One country team highlighted these cuts as a potential consequence of meeting the spending requirement.
 - *Elimination of care programs.* One country team wrote that care and “other policy programs” would be cut if it were held to the spending requirement.

In addition, seven teams that did not submit documents requesting exemption from the spending requirement—they did not meet OGAC’s proposed criteria for requesting exemptions⁴⁹—identified, in structured interviews, specific program constraints related to meeting the abstinence-until-marriage spending requirement. (While some of these teams

⁴⁹Each of these seven teams has PEPFAR funding over \$75 million, is working in a country with a generalized HIV/AIDS epidemic, or both. As noted on page 30, OGAC discourages these teams from submitting documents requesting exemption from the spending requirement.

commented specifically on the original 33 percent requirement, as written in the 2003 Leadership Act, others commented on OGAC's 50 percent and 66 percent policies implementing the Leadership Act's requirement.)

These constraints included the following:

- *Difficulty reaching certain populations with comprehensive ABC messages.* One country team stated that, because of the abstinence-until-marriage spending requirement, it had limited funding for comprehensive ABC messages to the general public. In this focus country, the AIDS epidemic is generalized but is largely fueled by populations determined to be most at risk of contracting HIV, such as commercial sex workers and truck drivers. Most of this country's "other prevention" funding is reserved for its most-at-risk populations. However, because one-third of prevention funding must be reserved for AB programs, the team had little sexual transmission prevention funding to deliver integrated ABC messages to those in the general population who, although at risk for contracting HIV, are not among the most-at-risk populations.
- *Limited or reduced funding for programs targeted at high-risk groups.*
 - A focus country team told us that, to meet the spending requirement, it had to cut "other prevention" funding by 50 percent. Team members explained that, as a result, services for married discordant couples, sexually active youths, and commercial sex workers were reduced. In general, this team noted that allocating funding in accordance with the spending requirement is not appropriate for the country's epidemic and has reduced the quality of the team's prevention programming.
 - In a focus country with one of the world's highest national HIV/AIDS prevalence rates, a team member told us that meeting the spending requirement had forced the team to substantially reduce planned funding for a prevention program for people living with HIV/AIDS.
- *Reduced funding for PMTCT services.*
 - In fiscal year 2005, the spending requirement led one country team to reduce planned funding for its PMTCT program, thereby limiting services for pregnant women and their children. (Although the

Leadership Act did not make the spending requirement mandatory until fiscal year 2006, OGAC encouraged country teams to spend 33 percent of prevention funds on AB activities prior to that year, consistent with the act's recommendation.⁵⁰) This focus country lacks a health care system for providing PMTCT services and, as a result, the team has had significant trouble reaching its target for preventing infections through PMTCT activities.⁵¹ However, at the start of fiscal year 2005, OGAC directed the country team to reduce planned funding for PMTCT and dedicate more funding to AB activities, because the team's allocation of prevention funds to AB fell short of 33 percent.

- In another country, where the U.S. government has been the largest supporter of the PMTCT program, the team told us that complying with the spending requirement would likely force it to shift resources away from PMTCT and thus reduce needed PMTCT commodities and services.⁵²
- *Difficulty funding programs for condom procurement and condom social marketing.*
- One focus country team told us that the spending requirement had complicated its efforts to address a condom shortage in the country. To reserve funding to procure condoms, the team was required to cut funding for other programs in the "other prevention" program area and to shift funds from the care category.

⁵⁰In fiscal year 2004, OGAC encouraged country teams to dedicate 7 percent of total PEPFAR funds on AB activities. This figure reflected the Leadership Act's recommendation that 20 percent of total funds appropriated pursuant to the act be spent on prevention (7 percent is 33 percent of 20 percent).

⁵¹A 2005 USAID IG report found that this country's reported number of PMTCT-prevented infections fell significantly short of the target of 3,500.

⁵²In this case, we communicated with the country team before it had made its final prevention allocations for the upcoming fiscal year.

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- Another focus country team stated that, because of the spending requirement, it would likely have to reduce funding for condom social marketing. In this country, the U.S. government has traditionally paid to market condoms socially, and a non-U.S. donor has paid to procure them.⁵³

OGAC's Policies Allow It to Meet the Overall 33 Percent Target

Our analysis shows that OGAC's policies implementing the 33 percent spending requirement should allow it to just fulfill the Leadership Act's spending requirement for fiscal year 2006, with the 20 country teams dedicating, in total, slightly more than 33 percent of reported planned prevention funds to AB activities.⁵⁴ OGAC officially approved exemptions for the 10 country teams that requested them. As a result, all but one⁵⁵ of these teams dedicated less than 33 percent of planned fiscal year 2006 prevention funds for AB activities—about 23 percent on average. At the same time, the 10 country teams that did not submit requests for exemption were generally required to spend more than 33 percent of planned prevention funds on AB activities; fiscal year 2006 data for these teams indicate that, on average, they will each spend around 37 percent of total reported planned prevention funding on AB activities. Under OGAC's policies implementing the spending requirement, any country team that spends more than half of prevention funding on sexual transmission prevention will have to spend more than 33 percent of its total prevention funding on AB. For example, a team that plans to spend 60 percent of prevention funding on sexual transmission prevention to meet local needs will have to spend at least 40 percent of total prevention funding on AB activities to comply with OGAC's 66 percent policy. For fiscal year 2006, all but two of the country teams that did not request exemptions planned to spend more than half of total prevention funds on sexual transmission

⁵³In this case, we communicated with the country team before it had made its final prevention allocations for the upcoming fiscal year.

⁵⁴Because of challenges and inconsistencies in country teams' categorization of funding for certain integrated ABC programs and some broad sexual transmission prevention activities, data on prevention allocations may reflect the variation in categorization methods, rather than actual differences. (See app. V.)

⁵⁵Unlike the other teams that submitted requests for exemption, one country team plans to spend over 90 percent of total prevention funds on sexual transmission prevention. Therefore, even though AB funds do not account for 66 percent of this country team's funds to prevent sexual transmission of HIV, the team still reserves at least 33 percent of prevention funds for AB activities.

OGAC's Policies Give Some Country Teams Greater Flexibility but Further Constrain Others

prevention—about 57 percent on average. As a result, these country teams also must spend more than 33 percent of prevention funds on AB.⁵⁶ According to an OGAC official, OGAC would have been unable to meet the 33 percent target if it had allowed many of the country teams with the largest amounts of PEPFAR funding to submit exemptions to the spending requirement. For fiscal year 2006, only one of the five top-funded focus country teams submitted an exemption request.

OGAC's policies implementing the abstinence-until-marriage spending requirement allow it to respond to the concerns of teams that received exemptions but prevent it from addressing the remaining country teams' concerns. Teams that received exemptions were, to some degree, able to avoid the challenges related to meeting the spending requirement that they had identified in requesting exemption. For example, a country team that requested exemption because "the epidemic in [this country] is still concentrated primarily among injection drug users and sex workers" planned to dedicate 89 percent of total prevention funds to "other prevention" and only 4 percent to AB. Another team whose exemption request noted that the epidemic in their country "requires that resources be directed towards high-risk populations, and populations likely to engage in risky sexual behaviors" received approval to limit AB funding to 28 percent of its total planned prevention funds and reserved 22 percent of planned prevention funds for "other prevention."

Under OGAC's policies, however, some nonexempted country teams are unable to avoid challenges presented by the spending requirement. As noted above, 7 of the 10 country teams that did not submit requests for exemption identified specific concerns about cutting or reducing funding for certain prevention programs. In allocating funds to meet the spending requirement, country teams are primarily limited to shifting resources among three prevention program areas—"other prevention," PMTCT, and AB. (This limitation occurs because the overwhelming majority of funds spent on safe medical injections and blood safety are centrally awarded funds, over which the country teams have no budgetary control.) If, for

⁵⁶This is not the case for one of the 10 country teams, which reported that it would dedicate 32 percent of planned prevention funds to AB for fiscal year 2006. Although this team planned to dedicate more than 50 percent of total prevention funds on sexual transmission prevention funds, it missed the 66 percent policy requirement, dedicating about 60 percent of sexual transmission funds to AB activities. Prior to receiving plus-up funds at the end of January and subsequently reallocating its prevention funds, this team met both the 50 percent and 66 percent policy requirements and therefore did not request exemption.

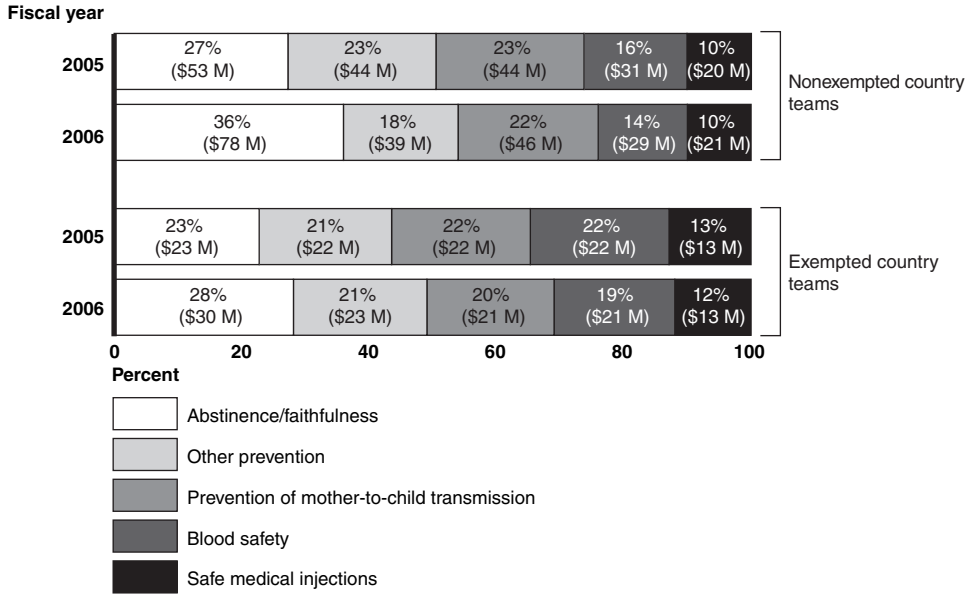
example, a country team's planned funding has a less than 2-to-1 ratio of AB funds to "other prevention" funds, the team can increase AB funding to reach the required ratio by reducing funds in "other prevention," PMTCT, or a combination of the two. The team can also consider taking funds from the treatment and care program areas and placing them in the AB category.

Data on total actual and planned spending allocations for the focus country teams that did not request exemption from the spending requirement⁵⁷ suggest a noticeable decline in "other prevention" funding between fiscal year 2005, when the spending requirement was not mandatory, and fiscal year 2006.⁵⁸ Although some of this shift may be due to varying methods of categorizing sexual transmission prevention programs and some changes in categorization methods across fiscal years (see app. V), the data demonstrate a common trend across these teams. For the nonexempted focus country teams, total funding for "other prevention" declined by about \$5 million from fiscal year 2005 to fiscal year 2006, falling from about 23 percent to about 18 percent of total prevention funding, while total funding for AB activities increased by about \$25 million, rising from about 27 percent to about 36 percent of total prevention funding. By contrast, in the focus country teams that received exemptions, total prevention funding for "other prevention" increased slightly by about \$700,000, remaining at around 21 percent of total prevention funding, and total prevention funding for AB activities increased by about \$7 million, from about 23 percent to about 28 percent of total prevention funding. Figure 11 shows the allocation of prevention funds by nonexempted and exempted focus country teams for fiscal years 2005 (actual funds) and 2006 (planned funds).

⁵⁷We do not have fiscal year 2005 data from the five additional country teams that were required to meet the spending requirement in fiscal year 2006. Therefore, we are unable to compare the prevention allocations in fiscal year 2005 with those in fiscal year 2006 for these teams.

⁵⁸Fiscal year 2005 data represent actual funding. Fiscal year 2006 data represent planned funding, which has not yet been approved by OGAC. For both fiscal years, central and country-level funds are included.

Figure 11: Prevention Allocations for Nonexempted and Exempted Focus Country Teams, Fiscal Years 2005 and 2006



Sources: GAO analysis of fiscal year 2005 country operational plans and OGAC's Country Operational Plan and Reporting System database.

Note: Fiscal year 2006 funding is planned. Because of data reliability issues discussed previously and in appendix V, these figures should be used only to understand general trends in data, rather than as precise percentage differences between program areas and fiscal years. Because of rounding, the percentages may not sum to 100.

Overall levels of PMTCT funding stayed relatively constant for both nonexempted and exempted focus country teams. Overall, the proportion of funding dedicated to PMTCT in the focus countries was about 23 percent in fiscal year 2005 and about 22 percent in fiscal year 2006. Focus countries' total PMTCT funding was \$66.3 million in fiscal year 2005 and \$67.5 million in fiscal year 2006.

OGAC's Application of Spending Requirement to All U.S. Prevention Funding May Further Challenge Country Teams

OGAC's decision to apply the abstinence-until-marriage spending requirement to all PEPFAR prevention funding—although it determined that, as a matter of law, the requirement applies only to funds in the GHAI account—may further challenge some country teams' ability to address HIV prevention needs at the local level. According to OGAC officials, they have chosen to apply the spending requirement to all PEPFAR prevention funding in response to a PEPFAR principle that HIV/AIDS programs should be integrated within and across agencies. These officials expressed the

opinion that allowing country teams to apply the spending requirement to only a portion of prevention funding would compromise this integration. The officials added that the amount of PEPFAR funding not appropriated to the GHAI account⁵⁹ is relatively small. For fiscal year 2006, non-GHAI prevention funds amount to about \$35 million (10 percent) of PEPFAR prevention funding—that is, about \$6 million (2 percent) of the focus country teams’ planned PEPFAR prevention funds and about \$29 million (82 percent) of the five additional country teams’ planned PEPFAR prevention funds.

Because of OGAC’s policy decision, country teams are constrained from allocating non-GHAI funding to meet local needs if the allocations do not comply with the spending requirement. For example, for fiscal year 2006, one focus country team received about \$1.5 million in prevention funding that was not covered by the GHAI account. As a country with a generalized epidemic and total PEPFAR funding exceeding \$75 million, this team did not submit a justification requesting exemption from the spending requirement, but it identified constraints resulting from meeting the requirement—specifically, that it would likely have to reduce funding for condom social marketing.⁶⁰ Because of OGAC’s policy regarding non-GHAI prevention funding, this country team will be unable to apply the \$1.5 million to the condom social marketing programs for which funding was likely reduced.

Conclusions

Responding to the severity and urgency of the global HIV/AIDS crisis, PEPFAR and its authorizing legislation, the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, significantly increased the United States’ commitment to fight the epidemic. Country teams consistently indicated that the ABC model is a useful tool for preventing sexual transmission of HIV, and many expressed the importance of AB messages for certain populations. However, the Leadership Act’s requirement that country teams spend at least 33 percent of prevention funding appropriated pursuant to the act on abstinence-until-marriage programs has presented challenges to country teams’ ability to adhere to the PEPFAR sexual transmission prevention strategy. In particular, it has

⁵⁹This includes funds appropriated to CDC’s Global AIDS Program, the Child Survival and Health Account, and the Freedom Support Act. See page 30.

⁶⁰See page 40.

challenged their ability to integrate the components of the ABC model and respond to local needs, local epidemiology, and distinctive social and cultural patterns. OGAC has established policies implementing the requirement that respond to these concerns while allowing it to meet the overall 33 percent spending target. Under these policies, some country teams have, to some degree, been able to avoid problems—such as limited funding to deliver appropriate prevention messages to high-risk groups—that would have occurred had they been subject to the spending requirement. However, other country teams, especially those with large amounts of PEPFAR funding and those facing generalized epidemics, have faced further constraints that have affected their ability to respond to local prevention needs. Finally, OGAC’s application of the spending requirement to \$35 million in funds not appropriated to the GHAI account may also hamper country teams’ ability to develop locally responsive prevention programs. OGAC may be able to address some of these constraints by reconsidering its policy of applying the spending requirement to all PEPFAR prevention funding; however, the amount of funding not covered by the GHAI account is relatively small. Reversing this policy would not enable OGAC to fully address the underlying challenges that country teams face in having to reserve a specific percentage of their prevention funds for abstinence-until-marriage programs.

Recommendation for Executive Action

Because meeting the 33 percent abstinence-until-marriage spending requirement can challenge country teams’ ability to allocate prevention resources in a manner consistent with the PEPFAR sexual transmission prevention strategy, we recommend that the Secretary of State direct the U.S. Global AIDS Coordinator to take the following action:

- collect information from the country teams each fiscal year on the spending requirement’s effect on their HIV sexual transmission prevention programming and provide this information in an annual report to Congress.
- This information should include, for example, the justifications submitted by country teams requesting exemption from the spending requirement.
- The information collected should be used by the U.S. Global AIDS Coordinator to, among other things, assess whether the spending requirement should be applied solely to funds appropriated to the

Global HIV/AIDS Initiative account, in line with OGAC's legal determination that the requirement applies only to these funds.

Matters for Congressional Consideration

Given the challenges that meeting the abstinence-until-marriage spending requirement presents to country teams attempting to implement locally responsive and integrated HIV/AIDS prevention programs, Congress, in its ongoing oversight of PEPFAR, should

- review and consider the information provided by OGAC regarding the spending requirement's effect on country teams' efforts to prevent the sexual transmission of HIV and
- use this information to assess the extent to which the spending requirement supports the Leadership Act's endorsement of both the ABC model and strong abstinence-until-marriage programs.

Agency Comments and Our Evaluation

The Department of State/OGAC, HHS, and USAID provided combined written comments on a draft of this report. (See app. VI for a reprint of their comments and our response.) In their letter, they highlighted the value of a comprehensive ABC approach in preventing sexual transmission of HIV and cited recent data from Kenya and Zimbabwe showing that where sexual behaviors have changed—as evidenced by increased primary and secondary abstinence, fidelity, and condom use—HIV prevalence has declined. Consistent with our report's discussion, they also stated that more work is needed to understand these data and to identify which interventions may have influenced them. In response to our finding that interpreting and implementing the ABC guidance has created challenges for most of the focus country teams, they stated that they are working to improve efforts to communicate policy to country teams through various methods, such as weekly e-mails and constant contact between the core team leaders and the field.

The agencies stated that the Leadership Act's emphasis on AB activities has helped move them toward a balanced ABC strategy. They also accepted our recommendation that, given challenges country teams face in allocating prevention resources, they should collect information from the country teams each fiscal year regarding the spending requirement's effect on their HIV sexual transmission prevention programming. The agencies disagreed with our recommendation to consider whether the Leadership Act's

spending requirement should be applied solely to funds appropriated to the GHAI account, in line with OGAC's legal determination that the requirement applies only to these funds. First, they stated that applying the spending requirement to only one part of the budget would harm their efforts to use a unified budget approach. Second, they stated that the issue is becoming less salient over time because non-GHAI funds have declined in the focus countries. As a result of the agencies' comments, we have clarified our recommendation to ask that they consider making this policy change after reviewing the information they collect on the effects of the spending requirement. We believe that this recommendation may be particularly relevant for the five additional country teams required, absent exemptions, to meet the spending requirement because non-GHAI funds represent over 80 percent of their total PEPFAR prevention funding. OGAC and USAID also provided technical comments, which we have incorporated where appropriate.

We are sending copies of this report to interested congressional committees. We also will make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>. If you or your staff have any questions, please contact me at (202) 512-3149 or gootnickd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VII.



David Gootnick
Director, International Affairs and Trade

List of Congressional Committees

The Honorable Arlen Specter
Chairman
Subcommittee on Labor, Health and Human Services,
Education, and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Richard G. Lugar
Chairman
The Honorable Joseph R. Biden, Jr.
Ranking Minority Member
Committee on Foreign Relations
United States Senate

The Honorable Edward M. Kennedy, Jr.
Ranking Minority Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Jim Kolbe
Chairman
The Honorable Nita M. Lowey
Ranking Minority Member
Subcommittee on Foreign Operations,
Export Financing, and Related Programs
Committee on Appropriations
House of Representatives

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

The Honorable Christopher Shays
Subcommittee on National Security, Emerging Threats
and International Relations
Committee on Government Reform
House of Representatives

The Honorable Tom Lantos
Ranking Minority Member
Committee on International Relations
House of Representatives

Scope and Methodology

Under the Comptroller General's authority, in this report we (1) review trends and allocation of the President's Emergency Plan for AIDS Relief (PEPFAR) prevention funding, (2) describe the PEPFAR strategy for preventing the sexual transmission of HIV, and (3) identify key challenges associated with applying the PEPFAR sexual prevention strategy. Our work focuses primarily on the 15 PEPFAR focus countries: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

As part of our efforts to collect information on all three objectives, we conducted structured interviews between June 2005 and January 2006 with key Department of State, U.S. Agency for International Development (USAID), Department of Health and Human Service—Centers for Disease Control and Prevention (HHS/CDC), and other U.S. agency staff responsible for implementing HIV/AIDS programs in the 15 focus countries.¹ We conducted 11 of these structured interviews over the telephone and 4 during site visits to Botswana, Ethiopia, South Africa, and Zambia in July 2005.

Our structured interview document contained open-ended questions related to each of our three objectives. To develop questions for the structured interview, we reviewed key documents from the Office of the U.S. Global AIDS Coordinator (OGAC) and other U.S. government agencies, as well as country teams' operational plans. We also interviewed key U.S.-based officials from OGAC, USAID, and HHS/CDC. We pretested our questions with four of our initial respondents and refined our questions based on their input. We conducted follow-up interviews with our respondents to obtain supplementary information.

To summarize the open-ended responses and develop categories for the analysis, we first grouped open-ended qualitative interview responses into a set of overarching issue areas and then, within each of those issue areas, we grouped the interview data into subcategories. To ensure the validity and reliability of our analysis, these subcategories were reviewed by a methodologist, who proposed modifications. After discussion of these suggestions, we determined a final set of subcategories. We then tallied the number of respondents providing information in each subcategory.

¹These officials spoke with us with the understanding that individual respondents and the countries where they serve would not be named in our discussion of the structured interviews.

We also requested information from the five additional PEPFAR country teams that receive at least \$10 million in PEPFAR funding. In October 2005, we sent standardized questions to these teams on three areas: (1) their PEPFAR funding (particularly how their prevention funding was broken down by spending account); (2) their experiences developing country operational plans; and (3) the effects, if any, of the abstinence-until-marriage spending requirement on their prevention programming. We received responses from two of these country teams.

To examine trends and allocation of PEPFAR prevention funding, we reviewed budget data provided to us by OGAC on fiscal year 2004 planned and approved country-level funding; OGAC's Country Operational Plan and Reporting System (COPRS), a central U.S. government data system developed to support the collection and analysis of data related to Emergency Plan planning and reporting requirements;² and data provided to us by OGAC on centrally awarded funding. To determine how country teams categorize funding for integrated programs that include AB and "other prevention" components in their country operational plans, we reviewed the *President's Emergency Plan for AIDS Relief FY06 Country Operational Plan Final Guidance* (revised Aug. 22, 2005), as well as country teams' operational plans. We determined that these data were sufficiently reliable for some purposes. (See app. V for a discussion of specific data limitations.) Finally, we interviewed U.S.-based officials from OGAC.

To describe the PEPFAR strategy for preventing the sexual transmission of HIV, we reviewed the 2003 Leadership Act; *The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy* (February 2004);³ OGAC guidance to country teams, including its *ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach to Preventing Sexually-*

²U.S. missions enter planning and reporting requirements, including the country operational plans, semiannual and annual progress reports, into the COPRS data system. The COPRS data system does not contain information on central (track 1) funding or on planned and approved funding for fiscal year 2004.

³The Office of the U.S. Global AIDS Coordinator prepared this report in collaboration with the Departments of State (including the U.S. Agency for International Development), Defense, Commerce, Labor, Health and Human Services (including the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, and the Office of Global Health Affairs); and the Peace Corps.

Transmitted HIV Infections within the President's Emergency Plan for AIDS Relief (March 2005); and each focus country team's 5-year HIV/AIDS strategy for PEPFAR. We also interviewed key U.S.-based officials from OGAC, USAID, and HHS/CDC.

To identify challenges associated with implementing the PEPFAR sexual transmission prevention strategy, we (1) interviewed nongovernmental organizations (NGOs) that receive PEPFAR prevention funding; (2) conducted site visits to Botswana, Ethiopia, South Africa, and Zambia in July 2005; and (3) reviewed country teams' requests for exemption from the spending requirement. Prior to conducting our fieldwork, we selected the top five NGO recipients of fiscal year 2005 PEPFAR funding for AB activities and the top five NGO recipients of fiscal year 2005 PEPFAR funding for "other prevention" activities to interview. Because two of these organizations were on both lists, we selected a total of eight organizations, of which we interviewed six, but were unable to meet with the remaining two.⁴ For our July 2005 fieldwork, we selected a targeted sample of PEPFAR focus countries to visit based on six criteria: (1) the amount of the country's fiscal year 2004 PEPFAR funding dedicated to HIV prevention; (2) the percentage of the country's fiscal year 2004 PEPFAR funding dedicated to HIV prevention; (3) the amount of the country's fiscal year 2004 PEPFAR funding dedicated to preventing the sexual transmission of HIV; (4) the percentage of the focus country's fiscal year 2004 PEPFAR funding for preventing sexual transmission of HIV dedicated to abstinence/faithfulness; (5) the percentage of the focus country's fiscal year 2004 PEPFAR funding for preventing sexual transmission of HIV dedicated to "other" prevention methods, such as condom promotion; and (6) HIV/AIDS prevalence. In the countries that we visited, we interviewed key U.S. government officials, host country government officials, nongovernmental organizations (NGOs), faith-based organizations, local community-based organizations, and program beneficiaries, and we observed programs in all five prevention program areas being implemented. The information we obtained during these site visits related primarily to challenges associated with interpreting and implementing the ABC guidance. Last, we reviewed excerpts of documents that country teams submitted requesting exemption from OGAC's policies implementing the abstinence-until-marriage spending requirement. These documents

⁴One of these organizations did not respond to our requests for an interview; the other agreed to meet with us but later cancelled the appointment.

were submitted by both focus country teams and some of the additional teams required to meet the requirement.

Finally, to further develop our understanding of challenges associated in general with preventing HIV/AIDS, we attended prevention conferences in Washington, D.C., and reviewed reports prepared by NGOs, private AIDS foundations, UNAIDS, and other multilateral and international institutions. We also interviewed representatives of some of these organizations.

We conducted our work from February 2005 to February 2006 in accordance with generally accepted government auditing standards.

AB and “Other Prevention” Programs in Four Focus Countries

Fiscal year 2005 program descriptions¹ of abstinence/faithfulness (AB) and “other prevention” programs in the four focus countries that we visited demonstrate the diversity of approaches that the President’s Emergency Plan for AIDS Relief (PEPFAR) country teams use to prevent HIV/AIDS. Country teams employ a host of methods to reach communities, such as mass media interventions, one-on-one communication, and capacity building for local organizations. The degree to which they emphasize these methods varies. For example, the Botswana team dedicates its largest single pot of AB funding to a capacity-building program, while the South Africa team dedicates its highest funded AB award to a mass media program. Because the congressional abstinence-until-marriage requirement and the Office of the U.S. Global AIDS Coordinator’s (OGAC) policies interpreting it were not in effect in fiscal year 2005, the funding amounts for each of the four country teams do not show a 2-to-1 ratio of AB to “other prevention” funding.

Botswana

For fiscal year 2005, the following four programs accounted for about 70 percent of the Botswana team’s total country-level AB funding:

- *\$800,000 to strengthen Botswana-based, nongovernmental organizations* through a central Botswana HIV/AIDS umbrella organization that will become a leading partner in the HIV/AIDS response and expand services provided by the sector. This umbrella organization works with local faith-based organizations, community-based organizations, and nongovernmental organizations (NGOs) to fund, among other programs, AB prevention activities.
- *\$550,000 to fund a radio drama* that models positive behaviors and provides information on various issues related to HIV/AIDS, such as abstinence, faithfulness, partner reduction, healthy relationships, and basic HIV information. The drama is reinforced with activities such as road shows, discussion groups, and contests. This program also receives funding under “other prevention.”
- *\$400,000 to conduct a social marketing campaign promoting the “be faithful” message.* This project also builds capacity of local partners to

¹Fiscal year 2005 program descriptions based on focus country teams’ country operational plans, dated Mar. 16, 2005.

develop behavior change community messages and promote AB messages.

- *\$350,000 to support a nationwide door-to-door community HIV education program*, which trains field officers to inform, educate, and mobilize the community on topics such as abstinence and faithfulness. This program also receives funding under “other prevention.”

For the same fiscal year, the following five programs accounted for about 70 percent of the Botswana team’s total country-level “other prevention” funding:

- *\$1,095,000 to fund a radio drama* that promotes counseling and testing, information on antiretroviral treatment and adherence, prevention of mother-to-child transmission (PMTCT), stigma reduction, disclosure of HIV status, and alcohol and domestic abuse. This program also receives funding under AB, as noted above.
- *\$375,000 to reduce HIV transmission among individuals with sexually-transmitted infections*. This program works with health care professionals and their clients to improve management of sexually transmitted infections, with the goal of better identifying populations at high risk for transmitting HIV and quickly linking them with HIV treatment and related services.
- *\$350,000 to support a nationwide door-to-door community HIV education program*, which trains field officers to inform, educate, and mobilize the community on topics such as condom use, voluntary counseling and testing, PMTCT, stigma reduction, and related life skills. This program also receives funding under AB, as noted above.
- *\$349,000 to fund technical assistance*. This program covers salaries for three staff members, travel, printing of technical materials to support “other prevention” projects, participation in domestic and international conferences, and temporary duty visits by colleagues based in the United States.
- *\$325,000 to lay the groundwork for potential implementation of four prevention programs areas*: provision of the antiretroviral treatment Tenofovir prior to exposure to HIV infection, male circumcision, commercial sex work, and gender and HIV/AIDS. For the first two program areas, the program works with key stakeholders to determine

how each service, if proven effective as a prevention strategy, would be introduced to the health care community and general population. For the second two program areas, the program gathers implementing partners and stakeholders to discuss some of the gender issues that inhibit HIV prevention efforts, to share best practices on these issues, and to outline research and programmatic needs and priorities.

Ethiopia

For fiscal year 2005, the following four programs accounted for about 70 percent of the Ethiopia team’s total country-level AB funding:

- *\$1,170,000 to continue and expand HIV/AIDS behavior change programs targeting youths with AB messages.* This program uses a youth action toolkit and a sports-related program to model and reinforce AB behaviors for primary school students aged 11-14, as well as in-school and out-of-school youths aged 15-20.
- *\$900,000 to reach high-risk groups and youths, teachers, and community leaders with behavior change communication messages.* This program targets three high-risk groups: short-distance minibuss drivers, taxi drivers, and their assistants; commercial sex workers; and a regional police force. AB is the primary prevention message for these groups. However, this program also receives funding under “other prevention” to provide non-AB messages for commercial sex workers.
- *\$420,000 to provide comprehensive prevention services along a transport corridor.* This program targets communities along the transport corridor between Addis Ababa and Djibouti with community prevention education programs promoting AB and reduction of stigma and discrimination. For example, the program targets 30,000 in-school youths living along the corridor with an abstinence-only education program called Lessons for Life. This program also receives funding under “other prevention.”
- *\$400,000 to promote AB messages through the media.* This program trains journalists to increase accurate knowledge of HIV/AIDS and reduce stigma and discrimination, focusing on the promotion of abstinence and faithfulness prevention messages.

For the same year, one program accounted for about 70 percent of Ethiopia’s total country-level “other prevention” funding.

-
- *\$2,900,000 to procure, distribute, and market condoms to population groups at risk of transmitting HIV.* This program will promote 100 percent condom use in targeted locations where high-risk groups congregate, such as bars and hotels, and will be supported by behavior change and social marketing campaigns. This program will also assure condom supplies at health facilities, such as hospitals and PMTCT centers, and supply condoms to kiosks and marketing outlets in urban settings.

South Africa

For fiscal year 2005, the following seven programs accounted for about 70 percent of the South Africa team’s total country-level AB funding:

- *\$3,100,000 to produce and broadcast HIV AB messages via television.* This program broadcasts AB messages to 350 waiting rooms in public health facilities, which are complemented by discussions facilitated by trained health care workers. It also produces a popular television drama series exploring the challenges and life experiences of young people living in a rural community, especially their struggles with HIV/AIDS and associated social problems. This program includes significant AB messaging. Themes in the television drama are linked with targeted community mobilization, such as discussion groups.
- *\$900,000 to promote and strengthen AB messages through churches, schools, community-based organizations, and NGOs.* This program conducts peer education activities, trains teachers in an AB-based curriculum, and holds community meetings and workshops to promote innovative HIV prevention programs that incorporate strong AB messages.
- *\$400,000 to implement three AB activities:* a school-based AB program, a program promoting mutual monogamy, and a program targeting AB preventative behaviors among orphans and vulnerable children. The school-based program integrates AB messages into “Life Skills” education in six schools. The monogamy program targets members of faith-based groups with an AB curriculum and peer support for abstinence and faithfulness, among other activities. The program for orphans and vulnerable children trains youth caregivers in prevention; developing, disseminating, and advocating AB messages; and promoting dialogue. This program also receives other funding through the prevention, care, and treatment program areas.

- *\$400,000 to implement AB-focused prevention programs through faith-based organizations and traditional leaders and to focus attention on the need for AB programs for men who have sex with men.* This program develops national HIV/AIDS strategies for five faith-based groups and aims to improve leadership among traditional leaders in the areas of HIV/AIDS advocacy and human rights. It also develops a national strategy to stimulate a programmatic and policy focus on providing AB prevention messages to men who have sex with men and holds a sensitization workshop to increase stakeholders’ capacity to implement successful programs that target these men.
- *\$400,000 to implement a door-to-door HIV prevention campaign.* This program recruits and trains 400 community members as peer educators and counselors to provide information to households on HIV/AIDS prevention and preventative behaviors. These educators and counselors promote voluntary counseling and testing services and PMTCT services, as well as teach proper condom use, when appropriate. These volunteers also mobilize communities to address stigma and discrimination associated with HIV/AIDS.
- *\$400,000 to produce mass media interventions with AB components.* The program supports development of a television program for the family audience that covers issues such as HIV/AIDS and all aspects of treatment; messages on prevention and stigma, such as abstinence/faithfulness and voluntary counseling and testing; and masculinity and gender as they relate to HIV/AIDS. It also supports development of television and radio programs and related materials for children and their parents. These programs and materials cover HIV/AIDS from a child’s perspective, focusing on the impact of HIV/AIDS on children’s lives and on the school system and promoting prevention messages, particularly abstinence/faithfulness. They also cover other topics such as nutrition, lifestyle, gender, and masculinity. These youth-focused programs are complemented by community mobilization interventions, such as youth clubs to discuss the issues presented in different episodes. This program also receives funding under the treatment program area.
- *\$350,000 to work with teachers’ unions on a prevention peer education and AIDS management prevention program.* This program uses trained school union representatives to facilitate weekly discussion groups among teachers on issues such as self-awareness, an understanding of one’s own sexuality, and decision-making skills as they

relate to abstinence, faithfulness, and sex. The program also receives other funding through the prevention, care, and treatment program areas.

For the same year, the following five programs accounted for about 70 percent of the South Africa team’s total country-level “other prevention” funding:

- *\$2,800,000 to produce and broadcast AB and other prevention messages via television.* See program description above under the AB program area.
- *\$1,400,000 to train “Master Trainers” from public and private health sector unions.* Master trainers will conduct HIV and AIDS prevention education programs for union membership, senior union leadership, and others. This program will also implement a young workers’ campaign involving life skills-based education to help young workers embrace a healthy lifestyle, including adoption of safe sexual practices.
- *\$500,000 to support the sexually transmitted infections and HIV prevention unit of the National Department of Health.* Support includes providing logistics, management, and technical assistance in the procurement, warehousing, distribution, and teaching of the national male and female condom programs.
- *\$449,259 to provide technical assistance to government health programs, support the distribution of condoms, and operate programs targeting high-risk groups.* The program provides support and technical advice on the development and rollout of government programs, including comprehensive HIV management services, such as HIV prevention services and sexually transmitted infection prevention and treatment services. The program also supports a commercial sex workers project, which provides condoms, sexually transmitted infection treatment, and support for leaving sex work.
- *\$365,000 to address the HIV/AIDS prevention needs of youths and underserved groups, such as drug users.* This program conducts an assessment in three cities to better understand and respond to populations that are vulnerable to HIV infection. The program also funds a specialist to develop a youth prevention strategy for the National Department of Health and to build the capacity of local youth-serving organizations to provide skill-building and youth specific interventions.

Zambia

For fiscal year 2005, the following two programs accounted for about 65 percent of the Zambia team’s total country-level AB funding:

- *\$2,000,000 to strengthen the capacity of local community organizations to implement AB programs* that target youths with comprehensive skills-based AB prevention activities. This program provides training for teachers on HIV/AIDS prevention, with an AB emphasis. It also reviews existing AB prevention curricula and programs and assists the Zambian Ministry of Education in introducing new modules on preventing gender-based sexual violence. In addition, the program establishes a school-managed student-driven grants program to implement AB prevention activities for youths and involve parents. Finally, the program distributes leaflets and life skills booklets in support of an AB message.
- *\$1,480,000 for a consortium of faith-based and community-based organizations to implement abstinence promotion activities.* The focus of this program is a small grants program for organizations to work with youths. These organizations combine abstinence messaging with business management and vocational training in order to decrease economic vulnerability among youths. The organizations also use sports camps and “coming of age” ceremonies to reach youths. Finally, the program promotes fidelity and partner reduction among adults through extensive home-based care programs and district-level training sessions.

For the same year, two programs accounted for about 75 percent of the Zambia team’s total country-level “other prevention” funding.

- *\$3,379,574 for prevention interventions for at-risk groups living and working at border and high transit sites.* This program targets sex workers and their clients, truck drivers, mini bus drivers, and uniformed personnel at border and high-transit sites with services including sexually transmitted infection management, counseling and testing, referrals for antiretroviral treatment, behavior change interventions that promote partner reduction and condom use, and condom social marketing. Communication methods used include peer education, outreach work, drama, one-on-one counseling, group discussion, mass media, and local-based promotional activities. This program also receives funding under the AB program area.
- *\$2,600,000 to provide HIV prevention messages to adults and youths.* This program will provide support to discordant couples through

Appendix II
AB and “Other Prevention” Programs in Four
Focus Countries

faithfulness and condom-use messages. It will also expand activities targeting at-risk groups with messages on healthy practices and correct and consistent condom use. For example, the program will use community outreach activities such as education sessions with transport workers, uniformed personnel, and police on personal risk-assessment skills and condom-negotiation skills. In addition, this program supports in-school anti-AIDS clubs and a youth radio program that provides A, B, and C messages. This program also receives funding under the AB program area.

Prevention Program Indicators and Methods of Measuring PEPFAR Prevention Program Results

The Office of the U.S. Global AIDS Coordinator (OGAC) requires country teams to report the number of individuals reached through specific prevention programs, but assessing overall progress toward reaching prevention goals presents major challenges. OGAC requires that country teams report on indicators such as the number of individuals reached by the program. OGAC plans, over time, to estimate progress toward the President's Emergency Plan for AIDS Relief (PEPFAR) prevention goal by using U.S. Census Bureau statistical modeling of countries' HIV/AIDS prevalence trends, but these estimates may not be available for several years and will not link averted infections to specific types of prevention programs. OGAC had initially planned to use an alternative modeling approach that linked results to types of programs within the countries, but it dropped that approach because of limited research data on the effectiveness of particular prevention activities.

OGAC Tracks the Number of Individuals Reached by Prevention Programs as a Performance Indicator

OGAC requires country teams to report several performance indicators, which generally capture the number of individuals reached or trained for each prevention program aimed at sexual transmission. Specifically, for abstinence/faithfulness (AB) activities they report on the

- number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful,
- number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence, and
- number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful.

For "other prevention" activities, they report on the

- number of targeted condom service outlets,
- number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful, and
- number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.

OGAC tracks similar indicators for prevention programs outside the sexual transmission area. These include four indicators for prevention of mother-to-child transmission (PMTCT), two for blood safety, and one for safe injections.¹

**OGAC Will Estimate
Progress Toward Infections
Averted Goal Using
Statistical Model**

OGAC plans, over time, to estimate progress toward the PEPFAR goal of averting 7 million infections by 2010 by using a statistical model of epidemiological trends developed by the U.S. Census Bureau. The model will compare “expected” HIV incidence rates in particular countries with “actual” incidence rates and use those comparisons to estimate the number of infections that have been averted through PEPFAR and related prevention programs. This model attempts to estimate the number of infections averted over time, but it cannot attribute this change to any specific intervention or to the success of particular types of programs.

Specifically, the model estimates entail the following elements for each country:

- Establish “baseline” projections of HIV incidence for future years, using country data on prevalence rates through 2003 to make projections. This baseline prevalence is what would theoretically occur in the country in the absence of interventions such as PEPFAR. The prevalence data used to make these projections are obtained primarily from surveys in prenatal clinics.² The projections are made using assumptions about the rate of transmission of the virus in different segments of the population and about other factors such as death rates.

¹The indicators for PMTCT are number of service outlets providing the minimum package of PMTCT services according to national and international standards; number of pregnant women who received HIV counseling and testing for PMTCT and received their test results; number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting; and number of health workers trained in the provision of PMTCT services according to national and international standards. For blood safety, the indicators are number of service outlets carrying out blood safety activities and number of individuals trained in blood safety. The safe medical injections indicator is the number of individuals trained in medical injection safety.

²The prevalence data used in the Census projection are derived from a statistical database (the estimates and projections package) that in turn incorporates the country prenatal clinic survey data. Use of these data to estimate countrywide incidence assumes that the prevalence rate among pregnant women is highly correlated with the prevalence rate in the general population. Other organizations such as the Joint United Nations Programme for HIV/AIDS also use these data in their prevalence estimates.

Appendix III
Prevention Program Indicators and Methods
of Measuring PEPFAR Prevention Program
Results

- Estimate actual HIV prevalence trends in countries in future years, using country survey data from the prenatal clinics, beginning with data collected in 2004.
- Calculate the number of infections averted in each country as the difference between (1) the number of new infections each year that would be associated with the baseline prevalence rates and (2) the number of new infections each year that would be associated with the prevalence rates observed after implementation of PEPFAR and other prevention efforts.

Thus, if the Census model projected, for example, that based on trends in place prior to the initiation of PEPFAR programs, there would be 300,000 new HIV infections in Kenya between 2005 and 2008, and actual survey data in future years indicated there were 200,000, then PEPFAR would be assumed to have contributed to averting 100,000 infections in Kenya during that period.

Estimating infections averted over time using OGAC's modeling approach involves substantial challenges and the reliability of the estimates is not known, according to Census officials. A key challenge is the lack of data on prevalence rates in many developing countries. Because of that lack of data, a single long-term study of prevalence trends in Musaka, Uganda, serves as the basis for several assumptions that underlie Census projections on baseline prevalence rates. These assumptions include, for example, the average age when individuals begin to be sexually active and infection rates among migrant populations. In addition, estimating changes in prevalence rates over time, and thus, infections averted, is complicated by the fact that impacts of behavioral change programs can occur over a period of time. For example, the impact on prevalence rates of providing life skills programs targeted at younger students who are not sexually active might not be observed for some period of time. Thus, prevalence data gathered in 2008, for example, may not show the full impact of PEPFAR prevention programs over the previous year or two.

OGAC Considered
Alternative Method of
Measuring Infections
Averted

In March 2004, OGAC convened a technical modeling group to determine a methodology for measuring infections averted under PEPFAR.³ The group assessed alternative modeling approaches and initially considered the Goals Model (developed by the Futures Group)⁴ as an appropriate tool. The Goals Model is based on published research studies of the effectiveness of various prevention strategies and on conversion factors that translate dollars spent on a given prevention intervention into the number of infections averted.⁵ In contrast to the Census model described in the previous section, the GOALS model links estimates of infections averted to specific types of prevention programs carried out under PEPFAR and their spending levels.

In September 2004, the Futures Group presented estimates of infections that would be averted during PEPFAR's first year to the Technical Modeling Group. The Futures Group estimated, based on country operational plans, that between 550,000 and 580,000 infections would be averted in the initial 14 focus countries in fiscal year 2004 and that condom promotion and voluntary counseling and testing programs were more likely to avert infections than other prevention interventions.

There was debate within the Modeling Group about the merits of applying the Goals Model. Of particular concern were limitations in the research underlying the model on the effectiveness of different types of programs in preventing HIV transmission. For example, the research included very few studies that assessed the effectiveness of abstinence programs in limiting

³The modeling group, chaired by the U.S. Census Bureau, included representatives from U.S. agencies, such as the U.S. Agency for International Development, the Centers for Disease Control and Prevention, and OGAC, as well as independent think tanks and the United Nation's Children's Fund.

⁴The Futures Group is a privately held company that designs and implements public health and social programs for developing countries.

⁵The Goals Model assesses the impact of 13 specific interventions including, in part, mass media, community outreach, school-based programs, condom social marketing, and outreach to injection drug users. For each of these interventions, the model estimates the effects of these interventions in changing behaviors. Separate estimates of behavior change are made for high-risk, medium-risk, and low-risk populations. The model then estimates the reductions in new infections that result from the specific changes in behaviors in each of the groups. The numerical effects of the 13 interventions on behavior change, and of behavior change on the number of new infections, derive from peer-reviewed studies.

HIV transmission.⁶ Although some working group members believed that the Goals Model, despite being an imperfect tool, could provide needed insights regarding prevention programs' progress in averting infections, OGAC concluded that the model could yield misleading results and was not the best method to adopt.

**OGAC Is Planning Some
Limited Targeted
Evaluations of Prevention
Programs**

To acquire information about the effectiveness of specific PEPFAR prevention programs, especially in the AB area, OGAC plans to carry out and fund targeted evaluations on a very limited scale. According to OGAC, targeted evaluations are rapid studies that can provide evidence-based information to improve prevention programming in the near term. In the sexual transmission prevention area, these evaluations will be done on a small sample of AB programs. The bulk of the funding for targeted evaluations comes through central PEPFAR funds. In 2004, OGAC invested about \$2 million in targeted evaluations of AB programs to be carried out over 2 years. Some country teams are also doing some limited targeted evaluations of AB programs through their country operational plans. According to an OGAC official, the targeted evaluations will have limited use because of their small scale and the amount of time before results are available.

⁶The Goals Model incorporates a limited amount of information about the impacts of certain interventions on behaviors and infection rates because of a lack of evidence from studies. In addition, some of the numerical effects specified in the model are based on only one or two studies. Because of this lack of evidence, researchers disagree about the numerical effects that should be used in the model.

PEPFAR Planning and Reporting Process

The operational plans that the President's Emergency Plan for AIDS Relief (PEPFAR) country teams submit to the Office of the U.S. Global AIDS Coordinator (OGAC) each year identify, among other things, the organizations that will implement the proposed activities and program descriptions. When OGAC receives the operational plans, it implements a three-part review process, including a technical review, a programmatic review, and a principals' review.¹ At the conclusion of the reviews, OGAC submits a notification to the relevant congressional committees,² informing them of the activities it plans to implement under PEPFAR in the current fiscal year.³ Once Congress approves the notification, funds can be transferred to the field for obligation. The process for transferring and obligating funds and the length of time it takes to complete this process varies by agency,⁴ but all implementing partners are instructed to expend their funds within 12 months of receiving them.

In addition to submitting operational plans, country teams are required to submit semiannual and annual progress reports to OGAC each fiscal year. These reports identify obligations that have occurred in the past fiscal year, as well as results of the various activities. Figure 12 provides a time line of OGAC's planning and reporting requirements and the PEPFAR funding cycle.

¹According to OGAC, the principals are the Global AIDS Coordinator and his deputy, the director of the Office of Global Health Affairs and Special Assistant to the Secretary for International Affairs at the Department of Health and Human Services/Centers for Disease Control and Prevention, the acting Assistant Administrator for the Bureau of Global Health at the U.S. Agency for International Development, the Deputy Assistant Secretary of Defense, the Special Assistant to the Secretary for International Affairs, and the Peace Corps AIDS Relief Coordinator.

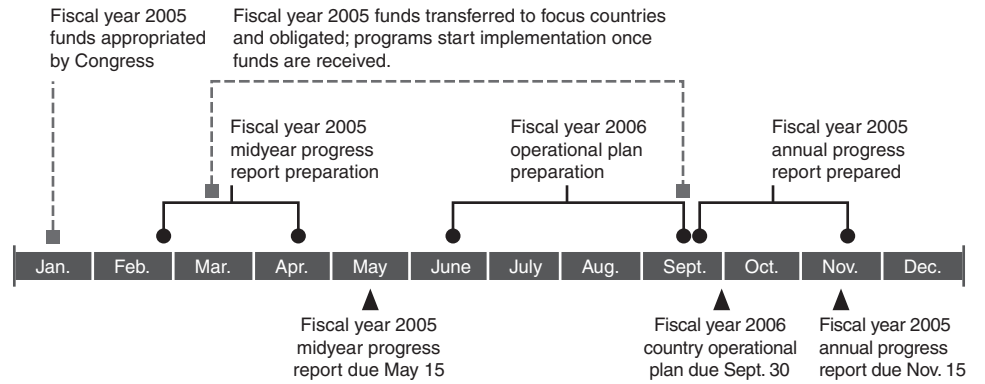
²The committees are the Senate Committee on Foreign Relations, the House Committee on International Relations, and the Senate and House Committees on Appropriations.

³OGAC may submit more than one congressional notification. For example, for fiscal year 2006, OGAC plans to submit a congressional notification before completing the operational plan review process to fund programs for which the country teams have requested early funding.

⁴Each U.S. agency operating under PEPFAR processes grants, contracts, and cooperative agreements differently. Procurements may occur centrally by agency headquarters, by country U.S. government offices, or by regional U.S. government offices. In addition, the type of grant, contract, or cooperative agreement affects how it is processed.

Appendix IV
PEPFAR Planning and Reporting Process

Figure 12: OGAC Planning and Reporting Requirements for Fiscal Years 2005 and 2006



Sources: GAO analysis of structured interviews with focus country teams; Fiscal Year 2006 Country Operational Plan Guidance; and interview with OGAC officials.

Note: Dates for midyear progress report preparation and operational plan preparation are approximate.

Methods for Reporting Allocations among PEPFAR Prevention Program Areas

Country teams have used varying methods to categorize funding for certain integrated abstinence/faithfulness/condom use (ABC) programs¹ and to categorize funding for broader sexual transmission prevention components that are not clearly defined as abstinence/faithfulness (AB) or “other prevention,” owing to challenges they face in categorizing these programs. Because of the teams’ varying methods for categorizing this funding, the reported allocations for the AB and “other prevention” program areas are of limited reliability.

In our structured interviews, 10 of the 15 focus country teams noted the difficulty of categorizing funding for certain integrated ABC programs. For example, some officials told us that, although they do the best they can to estimate the portion of funding for an integrated ABC program that will be used for AB versus “other prevention” activities, it can be difficult to predict in advance how much funding will be used for AB or “other prevention” activities when a program provides a variety of HIV prevention messages that may vary based on the needs of program participants.

A review of fiscal year 2006 country operational plans indicates that, within the sexual transmission prevention program area,² country teams use different methods for categorizing integrated programs that have ABC components in their plans. Some country teams have categorized integrated ABC programs entirely as “other prevention,”³ while others have divided some or all of these programs between AB and “other prevention” (with the C component categorized under “other prevention” and the AB component categorized as AB). For example, one country team’s fiscal year 2006 operational plan shows one of its integrated ABC programs split between the AB and “other prevention” program areas but two of its integrated ABC programs placed entirely in the “other prevention” program area. Another country team placed all of its integrated ABC programs

¹An integrated ABC program often addresses a range of issues, including abstinence; faithfulness; nutrition; sexually-transmitted infections; peer pressure; stigma reduction; child, spouse, and substance abuse; alcohol addiction; condom negotiation; and correct and consistent condom use.

²Programs outside of the sexual transmission prevention program area, such as prevention of mother-to-child transmission or voluntary counseling and testing programs, may also include ABC components.

³In fiscal year 2006, no country teams have categorized integrated ABC programs entirely in the AB program area.

entirely in the “other prevention” program area rather than split these programs between the AB and “other prevention” areas.

Our structured interviews also showed that country teams have used different methods for categorizing funding for integrated ABC programs for planning and reporting.⁴ Following are methods used by country teams we interviewed:

- Twelve of the 15 country teams told us that they split at least some of their integrated ABC programs into the AB and “other prevention” program areas. Most of these teams told us that they do not split all of their integrated programs into the different prevention program. Instead, some of these teams told us that they categorize some integrated programs entirely in the “other prevention” program area, while some also said that they had placed entirely in the AB program area some programs that primarily focus on AB but may provide limited information on condoms.⁵
- The other three country teams told us that, in general, they do not split any of their integrated ABC programs; instead, they categorize these programs entirely in the “other prevention” program area. These three teams said that, in general, they categorize only programs that include AB components, but no C component, in the AB program area.
- Three country teams reported that they categorize some integrated ABC programs based on the target group; for example, integrated programs for youths may be categorized entirely in the AB program area, while integrated programs for most-at-risk groups may be categorized entirely in the “other prevention” program area.

⁴Some structured interviews took place prior to submission of the fiscal year 2006 operational plans; discussions, therefore, revolved around categorization methods used in fiscal year 2005 operational plans. Based on these structured interviews and our review of fiscal year 2006 operational plans, it appears that there was some change in country teams’ categorization methods between the fiscal years.

⁵Office of the U.S. Global AIDS Coordinator (OGAC) officials told us that, in reviewing fiscal year 2005 proposed operational plans, they found that some countries mistakenly categorized programs with C components entirely in the AB program area. However, OGAC will not approve this categorization and has instructed country teams that they should split the entire C component of any ABC programs into the “other prevention” program area.

In addition, we found that certain broader components of sexual transmission prevention programs that are not clearly defined as AB or “other prevention” may appear in either program area. For example, activities addressing issues such as stigma reduction, peer pressure, and child, spouse, or substance abuse may be categorized as either AB or “other prevention,” depending on the country team’s judgment and factors such as a program’s focus or target population. Although these activities could be considered AB because they address social and community norms related to abstinence and faithfulness, they could also arguably be considered “other prevention.” One country team’s proposed fiscal year 2006 operational plan illustrates how the same types of broad prevention activities may fall under AB or “other prevention,” depending on the specific program. This operational plan contains one program categorized entirely as AB that aims to strengthen the capacity of military chaplains to provide counseling on issues including child, spouse, and substance abuse; management of family crisis, illness, death, and trauma; and alcohol addiction. This program also plans to develop abstinence-based literature and toolkits for the chaplains to disseminate to military personnel and their families and to support anti-AIDS youth clubs that provide HIV/AIDS education on abstinence and antidiscrimination against people living with HIV/AIDS. This country team’s operational plan also contains a program categorized entirely as “other prevention” that supports drama groups to provide messages to the country’s defense forces on topics including abstinence and faithfulness; HIV counseling and testing; stigma reduction; child and spousal abuse; and alcohol-related issues, as well as correct and consistent use of condoms.

Because of the varying methods used by country teams to categorize integrated ABC prevention programs and because of the inclusion of certain broad prevention activities (such as stigma reduction) in both AB and “other prevention,” a country team’s reported AB spending may not truly reflect the amount of funding actually supporting AB activities. Likewise, a country team’s “other prevention” spending may not be a clear indicator of how much funding is going to non-AB sexual prevention activities. Some AB activities are occurring in the “other prevention” program area, suggesting that country teams may be implementing more AB activities than first appear in their operational plans. At the same time, however, activities that can be categorized as AB or “other prevention,” depending on a country team’s judgment, are also occurring in the AB program area. Overall, we consider these data to be sufficiently reliable for the purposes of this engagement. In particular, while there are some limitations in the reliability of these reported data, they are useful for

Appendix V
Methods for Reporting Allocations among
PEPFAR Prevention Program Areas

identifying general trends and patterns across fiscal years and program areas.

Joint Comments from State, USAID, and HHS

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



United States Department of State
Assistant Secretary and Chief Financial Officer
Washington, D.C. 20520

MAR 21 2006

Ms. Jacquelyn Williams-Bridgers
Managing Director
International Affairs and Trade
Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548-0001

Dear Ms. Williams-Bridgers:

We appreciate the opportunity to review your draft report, "GLOBAL HEALTH: Spending Requirement Presents Challenges to HIV/AIDS Prevention Programs Funded under the President's Emergency Plan for AIDS Relief," GAO Job Code 320334.

The enclosed Department of State comments are provided for incorporation with this letter as an appendix to the final report.

If you have any questions concerning this response, please contact Elisa Catalano, Legislative Compliance Officer, Office of Global AIDS Coordinator, at (202) 663-2420.

Sincerely,

Bradford R. Higgins

cc: GAO – Elizabeth Singer
OGAC – Randall Tobais
State/OIG – Mark Duda

Department of State, Health and Human Services,
and USAID Comments
(GAO-06-395, GAO Code 320334)

On behalf of the Departments of State and Health and Human Services (HHS) and the United States Agency for International Development (USAID), the Office of the U.S. Global AIDS Coordinator (OGAC) appreciates the opportunity to comment on the draft General Accounting Office (GAO) report, *Global Health: Spending Requirement Presents Challenges to HIV/AIDS Relief* (GAO-06-395) (the Report).

Effective prevention is central to the President's Emergency Plan for AIDS Relief (PEPFAR)

Only a vigorous and comprehensive prevention approach will turn the tide against the global HIV/AIDS pandemic – the mission of the Emergency Plan. Effective prevention is the only way to stop the human suffering caused by HIV infection and limit the number of people who will require treatment in the future. Ultimately, it is the only way to achieve the elusive goal of an HIV/AIDS-free generation.

In the three years since President Bush's announcement of the Emergency Plan, the United States has demonstrated historic leadership in implementing the most diverse HIV/AIDS prevention strategy of any international partner, with programs linked to treatment and care for a holistic response. The lessons learned from the intensive application of the Emergency Plan in the 15 focus countries are now being extended to over 120 countries, helping to fuel transformation of HIV/AIDS responses in nations around the world.

This unprecedented initiative dwarfs the pre-PEPFAR baseline levels of prevention spending and has allowed for a wide-ranging portfolio of high quality, sustainable, evidence-based prevention programs. The President's budget request of approximately \$4 billion in HIV/AIDS funding for fiscal year 2007 will provide the necessary support to keep these prevention programs on track to reach the Emergency Plan's five-year goal of supporting prevention of 7 million new infections, as well as for it to achieve the goals of support for treatment for 2 million HIV-infected people and care for 10 million individuals.

Reflecting the importance of prevention, the Emergency Plan supports programs that address a broad range of HIV transmission mechanisms. In addition to programs to prevent mother to child transmission, ensure a safe blood supply, and prevent infections through unsafe injections, PEPFAR supports the ABC approach to prevent the sexual transmission of HIV.

ABC – Abstinence, Be Faithful and Correct and Consistent Condom Use - is the most effective, evidence-based approach to sexual transmission of HIV infection

Recent data from Zimbabwe and Kenya, not discussed in the Report, mirror the earlier success of Uganda's ABC approach to preventing HIV. These three countries with generalized epidemics (epidemics where HIV has spread beyond concentrated groups, such as prostitutes) have demonstrated reductions in HIV prevalence, and in each country the data point to significant AB behavior change and modest but important changes in C. Where sexual behaviors have changed, as evidenced by increased primary and secondary abstinence, fidelity, and condom use, HIV prevalence has declined.

In Zimbabwe, *Science* reported in February 2006 that among men aged 17 to 29 years in eastern Zimbabwe, HIV prevalence fell by 23% from 1998 to 2003. Even more impressively, the prevalence among women aged 15 to 24 dropped by a remarkable 49%.

- Abstinence (delay in sexual debut): Among men aged 17 to 19, the percentage who had begun sexual activity dropped from 45% to 27%, and among women aged 15 to 17, it dropped from 21% to 9%.
- Being faithful: Among those men who were sexually experienced, the proportion reporting a recent casual partner fell by 49%.
- Condoms: The proportion of women reporting an increase in condom use with casual partners rose from 26% to 36%. The proportion of men reporting condom use with casual partners remained essentially unchanged, as did the proportion among both sexes reporting condom use with regular partners.

In Kenya, the Ministry of Health estimates that HIV prevalence dropped from approximately 10% in 1998 to approximately 7% in 2003. This decline

correlates with a broad reduction in sexual risk behavior. Among the findings:

- **Abstinence:** There was a delay in average sexual debut among young women (with median age of sexual debut rising from 16.7 to 17.8. Among both teenage boys and girls, there were high levels of both primary abstinence (with a minority of boys and girls in the 15-17 age group, and a minority of girls in the 18-19 age group, reporting any prior sexual activity) and secondary abstinence (in both age groups, a minority of those who reported prior sexual activity reported any sexual activity in the last year).
- **Being faithful:** Male faithfulness, as measured by the percentage of men who report more than one sexual partner in the preceding year, increased. In the key 20-24 age group, the percentage dropped from over 35% to less than 18%.
- **Condoms:** Condom use among women who engage in risky activity grew, as the number of women who reported condom use in their last higher-risk sexual encounter rose from 16% to 24%.

As Dr. Peter Piot of UNAIDS remarked with respect to these two countries, "[T]he declines in HIV rates have been due to changes in behaviour, including increased use of condoms, people delaying the first time they have sexual intercourse, and people having fewer sexual partners." More work is needed to understand these data, and to identify which interventions may have influenced them. Fundamentally, however, it is clear that people in some countries have begun to change their sexual behavior in ways that reduce their risk of infection. It is thus urgent to identify and scale up initiatives to help even more people choose healthy behaviors.

The national strategies of many host nations included the ABC approach, delivered in culturally-sensitive ways, even before the advent of the Emergency Plan. The new evidence is highly relevant to PEPFAR's work with these nations: most of Sub-Saharan Africa, and 13 of the 15 focus countries, are experiencing generalized epidemics. Host nations are moving to balance campaigns to promote awareness of HIV with a broader public health approach that provides people with comprehensive information, services, and support that will enable them to make healthy decisions about how to protect themselves. Indeed, providing people with this level of

information, support and services is not merely good public health practice – it can help promote the democratic value of personal responsibility that leads to healthy behaviors.

Congressional directives have helped focus U.S. Government (USG) prevention strategies to be evidence-based

Because of the data, ABC is now recognized as the most effective strategy to prevent HIV in generalized epidemics. One of the most striking findings of the Report is the consensus among USG field personnel that ABC is the right approach to prevention.

The authorizing legislation directs that, for fiscal years 2006-2008, 33% of prevention funding be allocated to abstinence-until-marriage programs. In 2004, PEPFAR notified Congress that it counts programs that focus on abstinence and faithfulness for this purpose, as A and B messages should always be delivered together except in programming for young children.

The legislation's emphasis on AB activities has been an important factor in the fundamental and needed shift in USG prevention strategy from a primarily C approach prior to PEPFAR to the balanced ABC strategy. The Emergency Plan has developed a more holistic and equitable strategy, one that reflects the growing body of data that validate ABC behavior change. PEPFAR has followed Congress' mandate that it is possible and necessary to strongly emphasize A, B, and C, while also seeking to support prevention of mother to child transmission and other critical prevention interventions.

Financing for all methods of prevention have increased under PEPFAR

PEPFAR's unparalleled financial commitment has permitted the USG to support a balanced, multi-dimensional approach – one that was not possible with pre-PEPFAR spending levels. The total annual spending in the areas of HIV/AIDS prevention, as well as treatment and care, has continually increased since the passage of the Leadership Act. If Congress enacts the President's request for \$4 billion in HIV/AIDS funding for fiscal year 2007, that will represent a total increase of \$740 million from that appropriated in fiscal year 2006 (\$3.2 billion) and almost \$1.2 billion from that appropriated in fiscal year 2005 (\$2.8 billion). In addition, these levels of funding represent a quantum leap over the pre-PEPFAR baseline levels of

See comment 1.

funding for global HIV/AIDS (U.S. funding totaled \$3.87 billion for fiscal years 2000-2003).

PEPFAR prevention funding increased from \$213 million in FY 2004, to approximately \$294 million in FY 2005, to over \$350 million planned for FY 2006. With the vast increase in funding represented by PEPFAR, of course, even as the amount of funding dedicated to a program area rises, the percentage of overall funding dedicated to it may decline. An important consideration in this regard is that before the advent of PEPFAR, the USG was supporting very few programs in care and treatment. With the massive and highly successful scale-up of these services, which PEPFAR now supports, the percentage of resources dedicated to prevention has necessarily declined. Yet the USG commitment to global HIV/AIDS prevention is now clearly stronger than it has ever been.

Full funding for focus country budgets will limit the need for trade-offs

Perhaps the most important contribution the Report will make is to highlight the effect of budget issues on prevention funding. The President's FY 2007 budget request for the focus countries is, in part, an attempt to recover from the effects on focus country programs of the redirection of almost \$527 million from focus country programs to the Global Fund and other components of the Emergency Plan over PEPFAR's first three years. The effect of this trend has been to force country teams to make difficult trade-offs among prevention, treatment, and care (and within prevention, among sexual transmission, mother-to-child transmission, and medical transmission programs).

We appreciate the report's candor about the seemingly impossible decisions these budget constraints have forced upon country teams. In FY 2007 and beyond, full funding for focus country activities is essential if PEPFAR is to meet the 2-7-10 goals, including the prevention goal.

"Counting" ABC allocations does not affect programming

The report reflects misunderstanding of the relationship between PEPFAR programming and reporting mechanisms. PEPFAR is required to count the amounts it allocates to different types of prevention programming for purposes of accountability to Congress. But it is not the case that each program must be only AB, or only C. Many PEPFAR-supported programs

See comment 2.

integrate all of the ABC strategies, and these programs are encouraged to report on the different pieces to the extent possible, because accountability is key component of the success of PEPFAR. For a program to be a truly integrated ABC program, of course, it must genuinely include all three elements, rather than overwhelmingly emphasize only one or two elements. PEPFAR is currently working to strengthen its reporting conventions in this area through its Technical Working Groups and through the programmatic review.

Guidance on ABC is strong – it addresses most key issues and is being clarified as needed

OGAC is quoted in the report as saying that further clarification of the ABC Guidance will be provided as needed, and we welcome this Report's contribution to the ongoing dialogue between PEPFAR headquarters and the field. The ABC Guidance had been issued approximately two to five months prior to the country teams' interviews for this report. It may be expected that adjusting to newly-distributed guidance may generate questions and a need for more clarity in the short term. The Emergency Plan has since refined the Guidance to clarify issues and will continue to do so, updating it on an ongoing basis to meet the needs of the country teams. Even as it is updated, however, the Guidance will continue to represent the USG's unwavering support for ABC as the key evidence-based approach to prevent HIV infection in generalized epidemics.

PEPFAR is committed to continually improving its efforts to communicate policy to the field via numerous channels, including weekly emails, constant contact between the core team leaders and the field, the annual Implementers' Meeting, and others. In addition, each Country Operational Plan is developed with significant assistance from headquarters, providing another venue for issues to be communicated & worked through.

It is important to note that certain examples provided in the report to demonstrate confusion regarding the ABC Guidance are in fact clearly spelled out in the Guidance. In these cases, the issues are actually related to implementation, not to the Guidance document. One important area, which the Guidance addresses at length, is the need to focus on "high-risk activity" rather than "high-risk groups," because in a generalized epidemic, much of the population can be at risk.

See comment 3.

See comment 4.

Now on p. 32.

-On page 29, one country team is quoted as referring to lack of clarity regarding support under PEPFAR for programs to address discordant couples. Yet on page 28 of the Report, the authors directly quote from the Guidance which spells out (in bullet number two) that it is appropriate to target discordant couples with prevention activity: "Discordant couples should be encouraged to use condoms consistently and correctly so as to protect the HIV-negative partner from becoming infected. Likewise, prevention messages should strongly support preventative behaviors such as eliminating extra partners and maintaining a faithful relationship."

Now on p. 32.

-On page 27, the Report references concern that anyone engaging in sexual activity is not considered a "high-risk group." Yet again, on page 28, the Report references the Guidance, which says that "to achieve the Emergency Plan prevention goal, we must introduce combinations of interventions and adapt them to reach, engage, and provide the means to enable at-risk populations to reduce their risk-taking behaviors in a range of settings (community and facility-based)."

Now on p. 33.

-On page 28, the Report references apparent confusion regarding messages that can be delivered to mixed groups of students (including youth from age 10 to older than 14) in a single classroom. The Guidance is very clear (see Report pages 28 and Guidance pages 6-7) that students aged 14 and under may receive certain messages and that only students 15 and older can receive additional messages. This is not an issue of the ABC Guidance, but of implementation -- how best to separate students of different ages when prevention is taught. Our interagency Prevention Working Group will work with the field on this implementation issue.

PEPFAR has ensured compliance with the Congressional directive while tailoring implementation to country circumstances

As noted above, the Emergency Plan recognizes the importance of tailoring prevention efforts to the particular epidemic of each country, consistent with the requirement that 33% of prevention funding support AB activities. This requirement is applied across all the focus countries collectively.

See comment 5.

As the Report notes, PEPFAR offers each focus country team the opportunity to propose, and provide justification for, a different prevention funding allocation based on the circumstances in that country. In fiscal year 2005, all countries that proposed such allocations received PEPFAR approval for them. These countries included Cote D'Ivoire, Guyana, Haiti, Mozambique, Rwanda, Tanzania, and Vietnam. PEPFAR was able to approve these while continuing to ensure that the focus countries as a whole continue to comply with the Congressional directive. (Contrary to the report's suggestion, PEPFAR has been able to approve the allocations of countries that submitted justifications without requiring other countries to make offsetting adjustments to their proposed prevention allocations.)

It is important to remember that most focus countries have generalized epidemics, for which the ABC approach is the most effective, data-based strategy. Every country has the opportunity to submit a justification, but in those with generalized epidemics for which ABC has been proven to be so effective, the justification for a different allocation must be particularly strong. It is also important to remember that the USG is not the only source of funding in-country, and that partners can seek funding from other sources for to balance their mix of prevention interventions if they find that necessary.

See comment 6.

The ABC approach has clearly represented a change in USG practice, and change always involves a period of transition. Yet we have asked some of the country teams that did not submit justifications if they wanted to do so and the answer was, emphatically, no. As country teams have become more experienced in the ABC approach and familiar with the data that supports it, they have become more comfortable implementing it.

The Emergency Plan accepts the report's recommendation to collect information on the effects of the Congressional directive, and the information gathered will inform our adjustments to guidance. As in all areas, the Emergency Plan will continue to refine implementation as issues are identified, through such mechanisms as the fiscal year 2007 Country Operational Plan guidance.

The Congressional directive is appropriately applied to all accounts

The Emergency Plan does not agree with the Report's recommendation that the Congressional directive should be applied only to

funds appropriated through the Global HIV/AIDS Initiative Account (GHAI).

See comment 7.

First, one of the principal objectives of the Emergency Plan legislation was to integrate the activities of all USG agencies with respect to HIV/AIDS programming. One of the Coordinator's tools to achieve this has been a unified budget approach, irrespective of the source of funding, in planning and approving country activities. Applying the spending requirement to only a part of the budget would signal a step backward in the integration of USG agencies' activities.

See comment 8.

Second, the issue is becoming less salient over time. With respect to focus country budgets, as the Report states, non-GHAI funds have fallen to "slightly more than \$5 million (2 percent) of the focus country teams' planned PEPFAR prevention funds," and only 1 percent if central program dollars spent in focus countries is included. The suggested change would thus have little impact.

Conclusion

Effective prevention is at the heart of the Emergency Plan, and in generalized epidemics, the evidence-based ABC approach is at the heart of effective prevention. Among the most encouraging developments in many years in the global fight against HIV/AIDS is the growing body of evidence demonstrating that ABC behavior change is possible – and that it can reduce HIV prevalence on a large scale.

This report reflects another very encouraging development – the consensus support for the ABC strategies on the part of USG personnel in the field. The Congressional directive, which itself reflects an understanding of the importance of ABC, has helped to support PEPFAR's field personnel in appropriately broadening the range of prevention efforts. Solid policy guidance from PEPFAR on prevention has helped to address many issues of concern, and in implementing ABC consistently with the legislative provision, PEPFAR will continue to be responsive to the needs of personnel as they respond to circumstances in-country.

The first two years of the Emergency Plan have demonstrated that high-quality prevention programs can work – and are working – in many of the world's most difficult places. Through PEPFAR, the American people

have become true leaders in the world's effort to turn the tide against HIV/AIDS.

The following are GAO's comments on the joint letter from the Department of State, the U.S. Agency for International Development, and the Department of Health and Human Services, dated March 21, 2006.

GAO Comments

1. In their letter, the agencies stated that “financing for all methods of prevention have increased under PEPFAR” and that, “even as the amount of funding dedicated to a program area rises, the percentage of overall funding dedicated to it may decline.” Although PEPFAR funding in the 15 focus countries increased substantially in all five prevention program areas between fiscal years 2004 and 2005, figure 8 of our report shows that funding dropped in two prevention program areas between fiscal years 2005 and 2006. Specifically, PEPFAR funding for “other prevention” in the 15 focus countries declined from \$65.8 million to \$61.6 million, and blood safety funding declined from \$53.3 million to \$50 million. In addition, funding for prevention of mother-to-child transmission stayed relatively constant, with \$66.3 million in fiscal year 2005 and \$67.5 million in fiscal year 2006.
2. The agencies commented that our report reflects misunderstanding of the relationship between PEPFAR programming and reporting mechanisms, noting that “it is not the case that each program must be only AB, or only C.” Our report acknowledges that country teams have funded integrated ABC programs through PEPFAR. We explain that these programs are often split between the AB and “other prevention” program areas for reporting purposes, but we do not suggest that each program must be AB only or C only. Rather, we note, for example, that once funds are designated as AB, they can be used only for AB purposes, effectively locking teams into allocation decisions made when their operational plans were approved. In other words, the ratio of AB to “other prevention” funding within an integrated ABC program cannot change over the course of a funding year. Eight of the 15 focus country teams indicated that segregating AB funding from “other prevention” program areas compromises the integration of their programs. For example, it can limit their ability to shift program focus to meet changing prevention needs. Because of this potential, one country team chose not to split funding between AB and “other prevention” for a prevention program for persons living with HIV/AIDS that includes faithfulness messages because it could not predict the portion of the project that should be dedicated to the faithfulness component and did not want to lose flexibility to “do what is appropriate.”

3. The agencies stated in their letter that “the ABC guidance had been issued approximately 2 to 5 months prior to country teams’ interviews.” As we note in our report, country teams first received the draft ABC guidance in January 2005. The final guidance, distributed to country teams in March 2005, differed from the draft guidance only in its discussion of human papilloma virus. We conducted an initial round of structured interviews with the focus country teams in June and July 2005. We conducted a follow-up round of structured interviews with the focus country teams between August 2005 and January 2006.
4. The agencies commented that “it is important to note that certain examples provided in the report to demonstrate confusion regarding the ABC guidance are in fact clearly spelled out in the guidance. In these cases, the issues are actually related to implementation, not the guidance document.” Our report states that both interpreting and implementing OGAC’s ABC guidance has created challenges for country teams. For example, while the guidance clearly states that “discordant couples should be encouraged to use condoms consistently and correctly,” it does not stipulate whether broad condom social marketing programs are therefore appropriate when much of a country’s population consists of discordant couples. Similarly, while the guidance clearly states that in-school youths 14 and younger should not receive condom-related information, it does not address the issue of how youth groups that cross this age divide should be handled. We recognize that guidance on a subject as complex as prevention of sexual HIV transmission will naturally lead to questions and believe that the agencies’ commitment to continually improve their efforts to communicate policy to the field should help resolve these questions.
5. The agencies’ letter stated that they have “been able to approve the allocations of countries that submitted justifications without requiring other countries to make offsetting adjustments to their proposed prevention allocations.” However, in our structured interviews, seven country teams that were not exempted from the abstinence-until-marriage spending requirement identified specific program constraints related to the requirement. As we note in our report, some of these teams commented specifically on OGAC’s 50 percent and 66 percent policies implementing the Leadership Act’s requirement. For example, one country team told us that, because of OGAC’s policies, it was required to cut funding for programs in the “other prevention” program area and to shift funding from the care category in order to address a condom shortage in that country. Another country team told us that,

because of OGAC's policies, it had been required to substantially reduce the amount of funding it had planned to dedicate to a prevention program for people living with HIV/AIDS. These examples illustrate the adjustments to prevention programming that some country teams have had to make to offset the effects of programming decisions made by teams exempted from the spending requirement. Further, OGAC could not meet the Leadership Act's overall 33 percent target without requiring that, overall, more than 33 percent of prevention funds in nonexempted countries be spent on AB activities.

6. The agencies commented that they had asked some of the country teams that did not submit justifications if they wanted to do so and that they said no. We also did not ask all country teams that did not submit justifications whether they had wanted to do so. However, one country team told us that, although it was struggling to meet the spending requirement, OGAC officials had made it clear that submitting a justification was not an option.
7. The agencies stated that applying the spending requirement only to funds appropriated to the Global HIV/AIDS Initiative (GHAI) account would signal a step backward in the integration of U.S. government agencies' activities. We recognize that exercising this option may entail some trade-offs and, as a result, have modified our recommendation to ask that the agencies consider this change after reviewing information collected on the effects of the spending requirement.
8. The agencies also stated that applying the spending requirement solely to funds appropriated to the GHAI account would have little impact because non-GHAI funds account for between 1 and 2 percent of focus country teams' budgets. We acknowledge in our conclusions that the amount of overall PEPFAR funding not appropriated to the Global HIV/AIDS Initiative account is relatively small. We also acknowledge that reversing this policy would not enable OGAC to fully address the underlying challenges that the country teams face in having to reserve a specific percentage of their prevention funds for abstinence-until-marriage programs. However, unlike the focus country teams, which receive very limited funding not appropriated to the GHAI account, the five additional country teams that OGAC requires to meet the spending requirement—unless they receive exemptions—receive more than 80 percent of their PEPFAR prevention funds in non-GHAI funding.

GAO Contact and Staff Acknowledgments

GAO Contact

David Gootnick (202) 512-3149

Staff Acknowledgments

In addition to the individual named above, Celia Thomas (Assistant Director), Elizabeth Singer, Elisabeth Helmer, David Dornisch, Mary Moutsos, Reid Lowe, Kay Halpern, and Etana Finkler made key contributions to this report.

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