

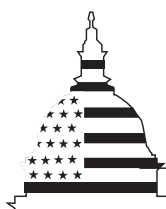
GAO

Report to the Chairman, Subcommittee
on African Affairs, Committee on Foreign
Relations, U.S. Senate

March 2001

GLOBAL HEALTH

U.S. Agency for International Development Fights AIDS in Africa, but Better Data Needed to Measure Impact



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Abstract The Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) is the leading cause of death in the countries of sub-Saharan Africa, where more than two-thirds of the people who are infected with HIV live. Despite efforts by the international community to reduce the spread of HIV/AIDS in sub-Saharan Africa, the National Intelligence Council estimates 1 that as many as one-quarter of the population of the hardest-hit countries in that region will die from AIDS over the next 10 years. Further, given the scale of the epidemic, AIDS has grown beyond a public health problem to become a humanitarian and developmental crisis. For example, the National Intelligence Council concluded that the persistence of infectious diseases, such as HIV/AIDS, is likely to aggravate and in some cases provoke economic decline, social fragmentation, and political destabilization. In addition, the Council found that the epidemic threatens to weaken the military capabilities of countries and because of the involvement of sub-Saharan African troops in international peacekeeping efforts it could hinder those activities as well. Since the 1980s, the U.S. Agency for International Development has provided assistance to help fight AIDS in sub-Saharan Africa.		
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Abbreviations	
GDP	Gross domestic product
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
USAID	U.S. Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS



United States General Accounting Office
Washington, D.C. 20548

March 23, 2001

The Honorable Bill Frist, M.D.
Chairman, Subcommittee on African Affairs
Committee on Foreign Relations
United States Senate

Dear Mr. Chairman:

The Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) is the leading cause of death in the countries of sub-Saharan Africa, where more than two-thirds of the people who are infected with HIV live. Despite efforts by the international community to reduce the spread of HIV/AIDS in sub-Saharan Africa, the National Intelligence Council estimates¹ that as many as one-quarter of the population of the hardest-hit countries in that region will die from AIDS over the next 10 years. Further, given the scale of the epidemic, AIDS has grown beyond a public health problem to become a humanitarian and developmental crisis. For example, the National Intelligence Council concluded that the persistence of infectious diseases, such as HIV/AIDS, is likely to aggravate and in some cases provoke economic decline, social fragmentation, and political destabilization. In addition, the Council found that the epidemic threatens to weaken the military capabilities of countries and because of the involvement of sub-Saharan African troops in international peacekeeping efforts it could hinder those activities as well. Since the 1980s, the U.S. Agency for International Development has provided assistance to help fight AIDS in sub-Saharan Africa.

The Agency for International Development allocated a 53-percent increase in funding, from \$114 million to \$174 million, for fiscal year 2001 to expand its HIV/AIDS efforts in sub-Saharan Africa.² This report responds to your

¹ "The Global Infectious Disease Threat and Its Implications for the United States," No. NIED 99-17 of the National Intelligence Estimates (Washington, D.C.: National Intelligence Council, Jan. 2000).

² Under the Foreign Operations Appropriations Act for Fiscal Year 2001 (P.L. 106-429), Congress appropriated \$330 million for the U.S. Agency for International Development's HIV/AIDS programs worldwide, which included \$15 million earmarked for orphans and vulnerable children.

request that we examine the agency's current efforts to reduce the spread of the HIV/AIDS epidemic in sub-Saharan Africa. Specifically, we (1) identified the development and impact of the HIV/AIDS epidemic in sub-Saharan Africa and the challenges to slowing its spread, (2) assessed the extent to which the U.S. Agency for International Development's initiatives have contributed to the fight against AIDS in sub-Saharan Africa, and (3) identified the approach the agency used to allocate increased funding and the factors that may affect the agency's ability to expand its HIV/AIDS program in sub-Saharan Africa.

As part of our review, we spoke with key U.S. Agency for International Development officials and reviewed written responses to GAO questions from the 19 agency field missions and 3 regional offices in sub-Saharan Africa that conducted HIV/AIDS activities. To supplement this work, we also visited U.S. Agency for International Development missions in Malawi, Tanzania, Uganda, and Zimbabwe. More detailed information about our scope and methodology is in appendix I.

Results in Brief

The AIDS epidemic has had a significant negative impact in sub-Saharan Africa, reducing population growth and offsetting gains from investment in social and economic development. Since 1993, the number of people infected with HIV/AIDS in sub-Saharan Africa has tripled to 25.3 million, and more than 17 million people have died, according to the Joint United Nations Programme on HIV/AIDS. Life expectancy in nine countries in the region is also declining dramatically. According to the U.S. Census Bureau, a child born in 2000 in Botswana can expect to live only 39 years. Without AIDS, that child would have a life expectancy of 71 years. Further, the Joint U.N. Programme on HIV/AIDS estimated that by the end of 1999, approximately 13 million children worldwide had been orphaned by AIDS, with 95 percent of them in Africa. While efforts have been made to stem the disease's spread, the U.S. Agency for International Development and United Nations officials have identified several challenges that have hindered their ability to reduce HIV/AIDS in Africa. These challenges include limited funding available to combat the epidemic, social stigma and cultural and social customs that make it difficult to discuss traditional sex practices that facilitate the spread of HIV, the low socioeconomic status of women in sub-Saharan Africa, weak national health care systems, difficulty reaching African militaries with high infection rates, and the slow response of African leaders to recognize and address the issue.

The U.S. Agency for International Development has contributed to the fight against HIV/AIDS in sub-Saharan Africa, focusing on proven effective interventions such as providing information and counseling to encourage behavior change in high-risk groups; promoting increased condom use; and supporting prevention, diagnosis, and treatment of sexually transmitted diseases.³ Some countries have shown declines in disease prevalence rates,⁴ which the U.S. Agency for International Development attributes in part to its activities. However, an overall picture of the agency's contribution is difficult to determine due to several factors. Although agency officials informed us that the agency's country-level missions use data to track day-to-day operations, the agency's missions do not always use consistent indicators to measure progress in combating the disease, do not routinely gather comprehensive program performance data, and do not regularly report those data to headquarters. As a result, decisionmakers in the agency's headquarters lack the information needed to measure the overall impact on reducing HIV transmission in the region, target the agency's resources to their best possible use, and identify best practices.

The U.S. Agency for International Development has developed an approach for expanding its HIV/AIDS program in response to the 53-percent increase in funding for fiscal year 2001. This approach included new HIV/AIDS prevention efforts and the development of a monitoring and evaluation plan. However, agency officials cited several internal and external factors that may limit their ability to expand the program. These factors include limitations associated with the agency's procurement and contracting processes and capacities, its reliance on weak national health care systems, and the unknown capabilities of indigenous nongovernmental organizations to conduct prevention activities. The agency has identified steps to help mitigate some of these factors.

This report makes recommendations to improve how the U.S. Agency for International Development can measure its effectiveness in reducing HIV transmission in Africa through greater use of consistent performance indicators and data collection efforts. In written comments on a draft of

³ With support from USAID and other donors, experts identified interventions that, when implemented in a culturally appropriate manner and combined in a coordinated effort, have been proven through clinical trials and longitudinal studies to have an impact on the spread of AIDS.

⁴ The prevalence rate is the percentage of the adult population that is currently infected with HIV.

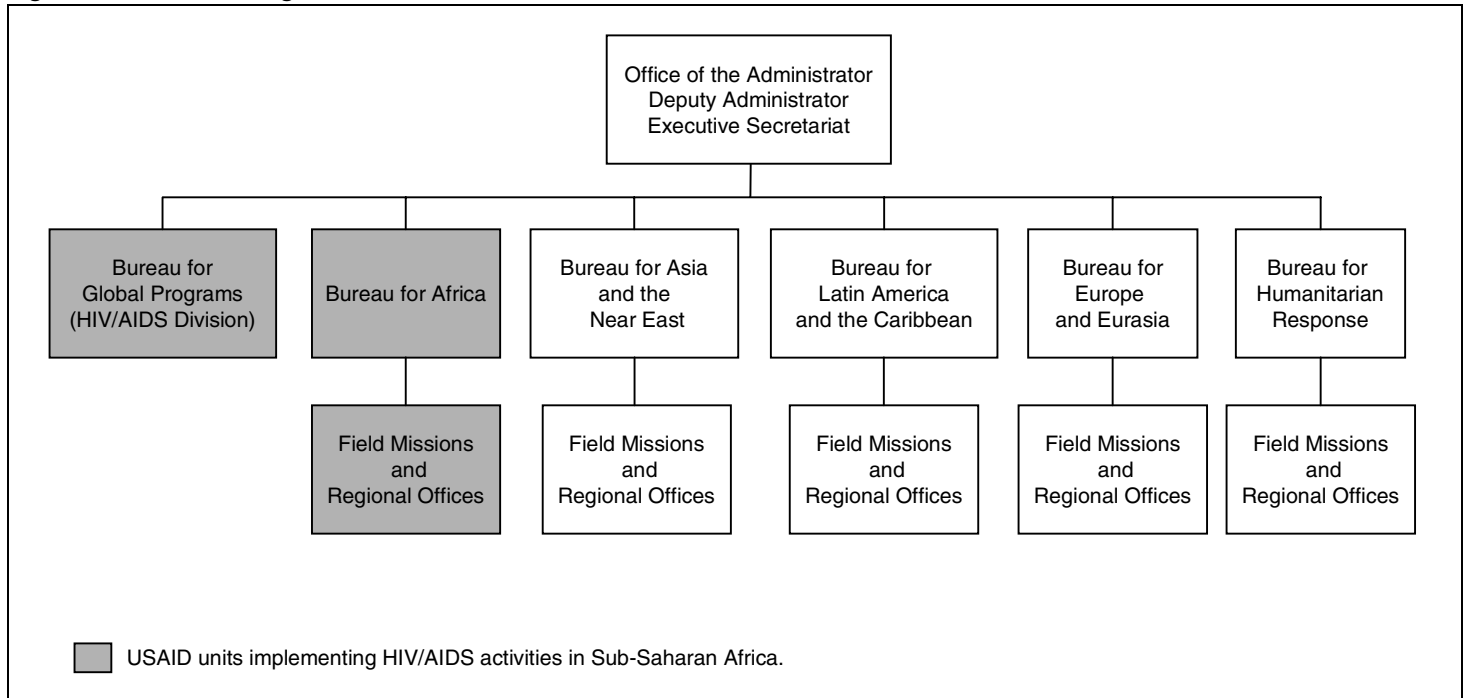
this report, the U.S. Agency for International Development acknowledged our key concern that performance indicators at the country level were inconsistent to measure progress over time and stated that it is taking action to facilitate the collection and dissemination of comparable national data.

Background

The United States has been the largest single donor to HIV/AIDS prevention in developing countries, contributing over \$500 million in Africa between fiscal year 1988 and 2000 through the U.S. Agency for International Development (USAID). The agency's efforts have mainly been directed at specific target groups to reduce the spread of the disease through behavior change communication activities; promotion of increased condom use; and improved prevention, diagnosis, and treatment of sexually transmitted infections. In July 2000, USAID also began to fund other activities—such as treatment for tuberculosis and other opportunistic infections and care for AIDS orphans—aimed at mitigating the impact of the disease.

USAID has a decentralized organizational structure (see fig. 1), which vests most of the authority for developing and implementing programs in the country offices, or missions. Four regional bureaus, such as the Africa Bureau, support field mission activities through the provision of technical, logistical, and financial assistance. The Global Bureau's HIV/AIDS Division negotiates contracts, grants, and cooperative agreements with private voluntary organizations that missions can access for particular expertise, such as development of HIV/AIDS prevention communication campaigns. The Global Bureau also funds research that can be used to improve mission programs, supports the Joint United Nations Programme on HIV/AIDS (UNAIDS), and coordinates efforts by other U.S. government agencies, such as the Centers for Disease Control, to address the epidemic in developing countries. At the time of this review, USAID conducted HIV/AIDS activities at 19 missions in sub-Saharan Africa and implemented activities in other countries in the region from three of its regional offices.

Figure 1: The USAID Organizational Structure



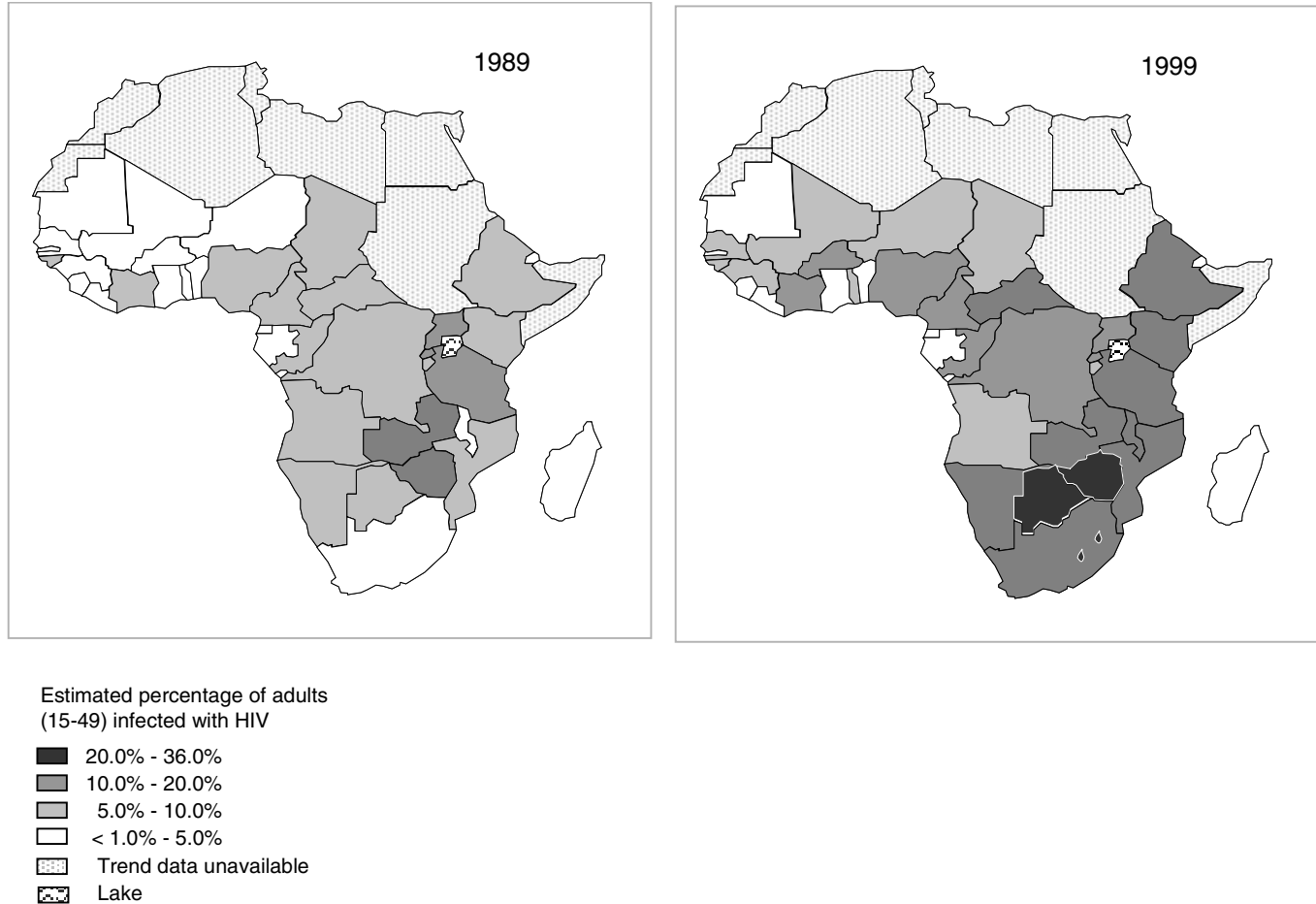
Source: GAO based on USAID documentation.

AIDS Has Negatively Affected Sub-Saharan Africa, but Slowing the Epidemic Presents Challenges

Throughout the 1990s HIV/AIDS prevalence continued to increase in most of the countries in sub-Saharan Africa (see fig. 2).⁵ The increasing prevalence of HIV/AIDS has had a substantial impact on the region's population, resulting in (1) high death rates, (2) increased infant and child mortality, (3) reduced life expectancy, and (4) large numbers of orphans. The epidemic has also offset gains from investment in social and economic development. Despite the efforts of USAID and international donors, however, several challenges to slowing the epidemic's spread remain. These include social, cultural, and political issues endemic to the region.

⁵ According to USAID, due to the combined efforts of donors and host governments, HIV prevalence rates have decreased from 12 percent to 8 percent in Uganda between 1994-1999 and stabilized below 2 percent in Senegal between 1997-1999.

Figure 2: The Evolution of HIV Prevalence in Africa from 1989 to 1999



Source: GAO based on UNAIDS map.

Effect of the AIDS Epidemic on the Population of Sub-Saharan Africa

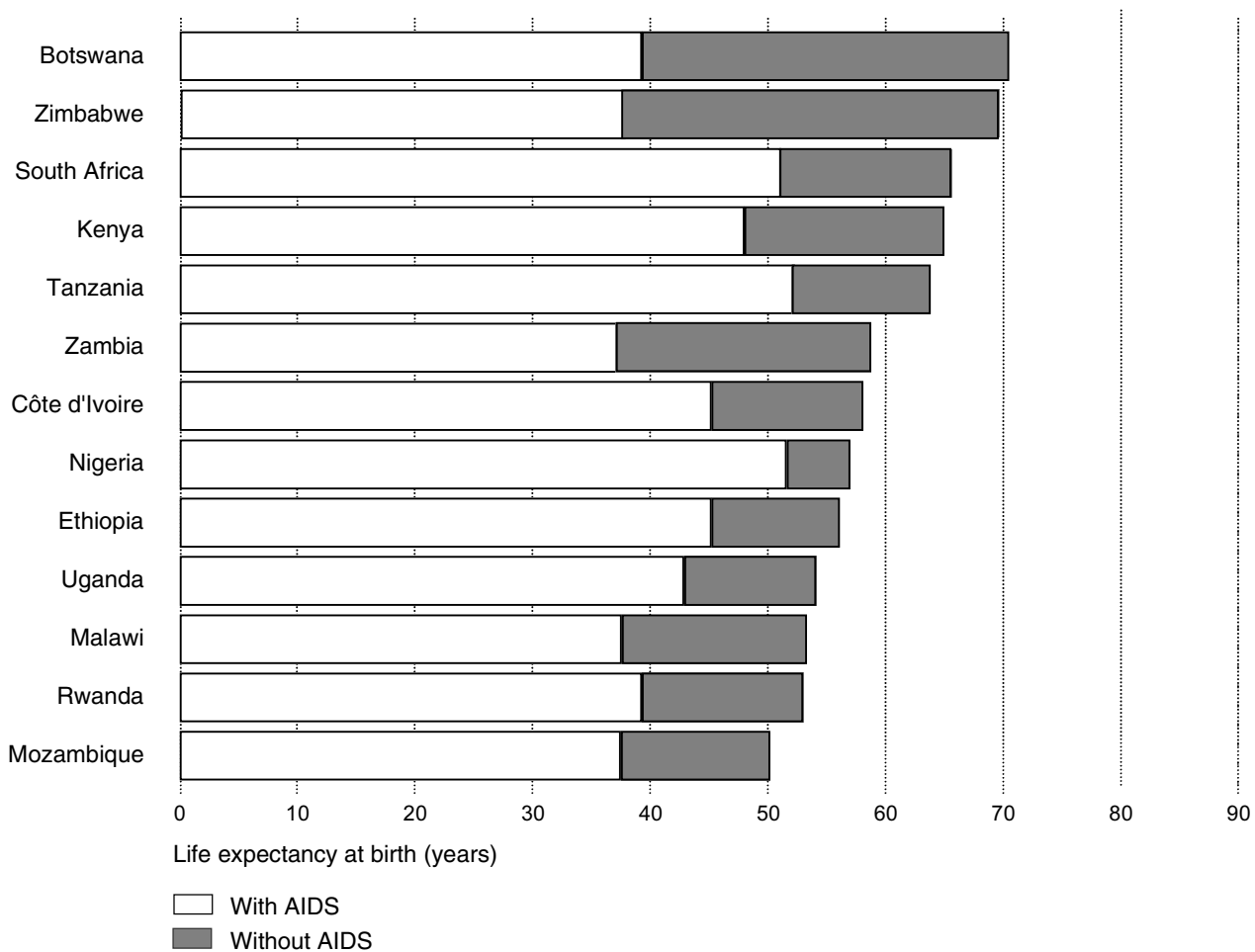
The most direct impact of AIDS has been to increase the overall numbers of deaths in affected populations. UNAIDS estimates that since 1993, the number of people infected with HIV/AIDS in sub-Saharan Africa has tripled to 25.3 million and more than 17 million people have died. According to the U.S. Census Bureau, estimated death rates have increased by 50 to 500 percent in eastern and southern Africa over what they would have been without AIDS. For example, in Kenya the death rate is twice as high, at 14.1 per 1,000 population, as opposed to the 6.5 per 1,000 it would have been without AIDS.

According to the U.S. Census Bureau, infant and child mortality rates⁶ in sub-Saharan Africa are also significantly higher than they would have been without AIDS. For example, in Zimbabwe infant mortality without AIDS would have been 30 per 1,000 in 2000. With AIDS, the infant mortality rate in 2000 was 62 per 1,000. The Census Bureau estimates that by 2010, more infants in Botswana, Zimbabwe, South Africa, and Namibia will die from AIDS than from any other cause. Rising child mortality rates due to AIDS are most dramatic in countries where death from other causes, such as diarrhea, had been significantly reduced. For example, in South Africa, Census Bureau data show that 45 percent of all deaths among children under age 5 in 2000 were AIDS related. In Zimbabwe, 70 percent of child deaths in 2000 were AIDS related, and AIDS-related deaths there are expected to increase to 80 percent by 2010.

According to the World Bank, one of the most disturbing long-term trends associated with the HIV/AIDS epidemic is reduced life expectancy. By 2010 to 2015, life expectancy is expected to decline 17 years in nine countries in sub-Saharan Africa, to an average of 47 years. For example, the Census Bureau estimates that a child born in 2000 in Botswana can expect to live only 39 years. Without AIDS, that child would have a life expectancy of 71 years. In addition, the Census Bureau estimates that life expectancy in Botswana will decline to 29 years by 2010, a level not seen since the beginning of the 20th century. This dramatic decrease in life expectancy in the region represents a reversal of the gains of the past 30 years. Figure 3 shows the impact of AIDS on longevity in 13 sub-Saharan African countries.

⁶ Infant mortality rates are defined as deaths of children under 1 year of age. Child mortality rates are defined as deaths of children under 5 years of age.

Figure 3: The Effect of AIDS on Life Expectancies in 13 Sub-Saharan African Countries, 1999



Source: U.S. Bureau of the Census.

Also, because of AIDS, children in sub-Saharan Africa are being orphaned in increasingly large numbers. According to UNAIDS, by the end of 1999, approximately 13 million children worldwide had been orphaned by AIDS,⁷ with 95 percent of them in Africa. Further, according to a report prepared for USAID, orphans will eventually comprise up to 33 percent of the

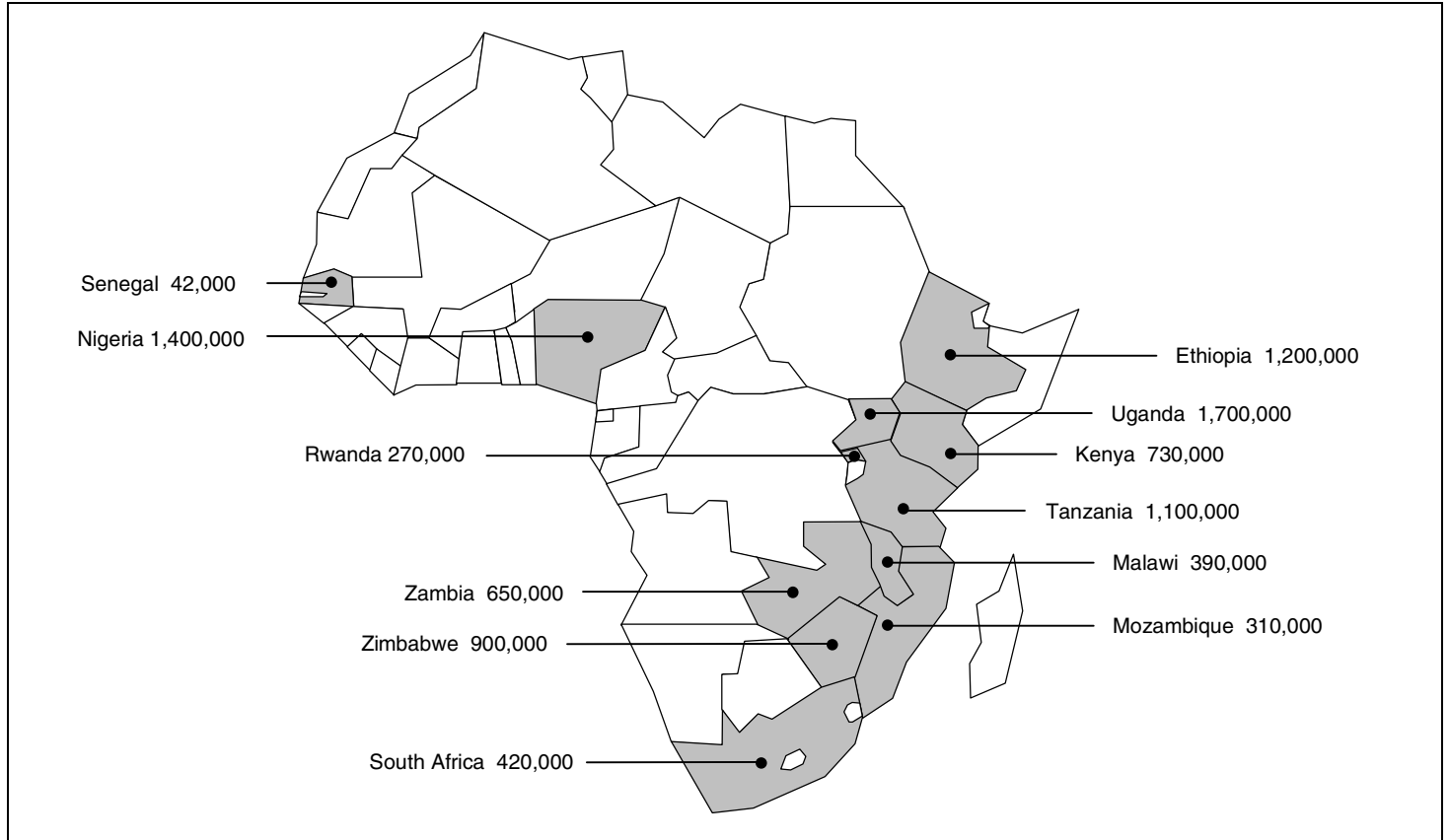
⁷UNAIDS defines AIDS orphans as children who lose their mother to AIDS before reaching the age of 15 years.

population under age 15 in some African countries.⁸ While orphans in Africa have traditionally been absorbed into extended families, the advent of the HIV/AIDS epidemic has caused these family structures to be overburdened, leaving many children without adequate care. The World Bank notes that orphans are more likely to be malnourished and less likely to go to school. According to UNAIDS, orphans are frequently without the means to survive and therefore may turn to prostitution or other behaviors that heighten their risk of contracting HIV themselves. Figure 4 shows the numbers of AIDS orphans in 12 African countries⁹ in 1999.

⁸ “Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS,” TVT Associates (Washington, D.C.).

⁹ These 12 countries and India were included in the Leadership and Investment in Fighting an Epidemic (LIFE) initiative, which increased funding for HIV/AIDS activities in fiscal year 2000.

Figure 4: Numbers of AIDS Orphans in 12 African Countries, 1999



Source: UNAIDS.

The spread of HIV/AIDS has begun to negatively affect population growth rates in sub-Saharan Africa. Typically, developing countries experience a population growth rate of 2 percent or greater, compared with much lower rates in developed countries. As late as 1998, the Census Bureau predicted that the AIDS epidemic would have no effect on population growth in sub-Saharan Africa because of the region's high fertility rate. However, the Census Bureau now predicts that by 2003, Botswana, South Africa, and Zimbabwe will all be experiencing negative population growth due to high prevalence of HIV and the low fertility and high infant and child mortality rates in these three countries. By 2010, the Census Bureau estimates that the growth rate for these countries will be (-1) percent, the first time that negative population growth has been projected for developing countries. Population growth is expected to stagnate in at least five other countries in

the region, including Lesotho, Malawi, Mozambique, Namibia, and Swaziland.

Effect of AIDS Epidemic on Social and Economic Development

AIDS has had a significant effect on social and economic development in the region as increasing numbers of people in their most productive years have died. For example, according to USAID, AIDS directly affects the education sector as the supply of experienced teachers is reduced by AIDS-related illness and death. The World Bank estimates that more than 30 percent of the teachers in Malawi and Zambia are already infected with HIV. According to UNAIDS, during the first 10 months of 1998 1,300 teachers in Zambia died of AIDS—the equivalent of about 66 percent of all new teachers trained annually. In addition, fewer children are attending school. The death of a parent is a permanent loss of income that often requires the removal of children from school to save on educational expenses and to increase household labor and income.

The agriculture sector has also been affected by the epidemic. Agriculture, the biggest sector in most African economies, accounts for a large portion of economic output and employs the majority of workers. However, as farmers become too ill to tend their crops, agricultural production declines for the country. For example, according to UNAIDS, in Côte d'Ivoire, many cases of reduced cultivation of crops such as cotton, coffee, and cocoa have been reported. Likewise, in Zimbabwe, agricultural output has fallen by 50 percent over a 5-year period during the late 1990s, due in part to farmers becoming sick and dying from AIDS.

In addition, the cost of doing business in Africa has increased in many sectors of the economy due to HIV/AIDS. The epidemic's costs to employers include expenditures for medical care and funeral expenses. A 1999 report prepared for USAID¹⁰ found that because of the increased levels of employee turnover due to HIV/AIDS, employers also are experiencing greater expenses due to the recruitment and training of new employees. According to the United Nations International Labour Office, to combat increased costs, some employers in sub-Saharan Africa have begun to hire or train two or three employees for the same position because of the concern that employees in key positions may get sick and die from AIDS.

¹⁰ "Economic Impact of AIDS," The POLICY Project of The Futures Group International (Mar. 16, 1999).

Several Challenges Have Hindered International Efforts to Slow the Spread of HIV/AIDS in Sub-Saharan Africa

While international organizations have worked to stem the spread of the disease, funding constraints, cultural and social traditions, the low socioeconomic status of women, weak health care infrastructure, difficulty reaching men in uniform, and the slow response of national governments have impeded their efforts.

Donor Spending Falls Short of Need

In 2000, UNAIDS estimated that at least \$3 billion is needed annually for HIV prevention and care in sub-Saharan Africa. By contrast, according to USAID, international donors contributed less than 20 percent of what was needed in fiscal year 2000 to support HIV/AIDS activities in the region. USAID—which has been the largest international donor to fight HIV/AIDS in Africa—spent \$114 million in the region in fiscal year 2000, of its total worldwide HIV/AIDS budget of \$200 million. As shown in table 1, USAID efforts translated into per capita expenditures for 23 sub-Saharan African countries in fiscal year 2000 ranging from \$0.78 in Zambia to \$0.03 in the Democratic Republic of the Congo.

Table 1: USAID's Fiscal Year 2000 HIV/AIDS Funding in 23 African Countries, in Order of Per Capita Spending

Country	Total funding (millions)	Total population (millions)	Per capita spending
Zambia	\$7.0	9.0	\$0.78
Namibia	1.0	1.7	0.59
Rwanda	3.5	7.2	0.49
Malawi	5.0	10.7	0.47
Zimbabwe	5.0	11.5	0.43
Senegal	3.7	9.3	0.40
Uganda	6.9	21.2	0.33
Mozambique	5.1	19.2	0.27
Guinea	1.7	7.4	0.23
Mali	2.5	11.0	0.23
Ghana	4.0	19.7	0.20
Kenya	5.7	29.5	0.19
Tanzania	6.0	32.8	0.18
Benin	1.0	5.9	0.17
South Africa	5.7	39.8	0.14
Eritrea	0.5	3.7	0.14
Ethiopia	6.7	61.1	0.11
Angola	1.0	12.5	0.08
Nigeria	6.8	109.0	0.06
Madagascar	0.8	15.5	0.05
DR Congo	1.5	50.4	0.03
Liberia	N/A	2.9	N/A
Somalia	N/A	9.7	N/A

N/A = Not available.

Source: USAID and UNAIDS.

Social Stigma and Traditional Beliefs Contribute to the Spread of HIV/AIDS

The social stigma surrounding issues of sex and death in African culture makes it difficult to discuss the risks of HIV/AIDS and measures to prevent the disease. A 2000 report by the Congressional Research Service¹¹ notes that unwillingness by religious or community leaders to discuss condom

¹¹ Raymond W. Copson, "AIDS in Africa" (Washington D.C.: the Congressional Research Service, June 2000).

Low Socioeconomic Status of Women Impedes Their Ability to Take Precautions Against Infection

use or risky behavior limits efforts to introduce condoms or HIV testing as ways to prevent further spread of the disease. According to UNAIDS, discrimination may also lead people who are infected to hide their status to protect themselves and their families from shame. For example, a 2000 UNAIDS report¹² stated that in 1999 in Rusinga Island, Kenya, children whose parents had died of AIDS would tell others that witchcraft or a curse had been the cause of death instead. Traditional beliefs and practices in sub-Saharan Africa also contribute to the spread of the disease and limit the effectiveness of prevention programs. For example, a common custom promoted by traditional healers in Zambia is for a widow to engage in sexual relations to “cleanse” herself of the spirit of the deceased.

Transmission of HIV in sub-Saharan Africa is primarily from heterosexual contact and, unlike other places in the world where men have higher rates of infection, 55 percent of people with AIDS in the region are women. According to UNAIDS, African girls aged 15 to 19 are approximately eight times more likely to be HIV positive than are boys their own age. Between the ages of 20 and 24, women are still three times more likely to be infected than men their age. These young women are usually infected by older men, often through coerced or forced sex, according to the Congressional Research Service. The higher infection rates among women are due, in part, to the higher vulnerability of the female reproductive tract to infection. However, according to UNAIDS, high infection rates are also caused by women’s limited ability to make informed choices to prevent the disease, due to their low socioeconomic status. Low levels of education for women in the region make it more difficult for them to find work, forcing them to rely on men for economic sustenance. According to USAID, laws in some countries, such as Kenya, do not allow women to inherit property. As a result, with no job skills or education, a woman may choose prostitution to support her children following the death of her spouse. In addition, because women lack economic resources of their own and may fear abandonment by or violence from their male partners, they have little or no control over how and when they have sex. According to UNAIDS, a woman may be fearful to ask her male partner to use a condom because he may interpret her actions as implying that she knows of his infidelities or that she has been unfaithful.

¹² “Report on the Global HIV/AIDS Epidemic” (Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS, June 2000).

Weak Health Care Systems Make It Difficult to Stem the Epidemic

The epidemic is overwhelming the already fragile health care systems in sub-Saharan Africa,¹³ and weak health care infrastructure is a barrier to diagnosis, treatment, and care of the affected populations. For example, in many countries in the region, up to one-half of the population does not have access to health care. The countries of the region frequently lack basic commodities such as syringes as well as safe drug storage, laboratories, and trained clinicians. Further, according to USAID, mother-to-child transmission of HIV is increased by the lack of access to drugs that block HIV replication, while this treatment has reduced mother-to-child transmission to less than 1 percent in developed countries. According to UNAIDS, AIDS patients take up a majority of the hospital beds in many cities, leaving non-AIDS patients without adequate care. For example, a 2000 World Bank report¹⁴ notes that in Côte d'Ivoire, Zambia, and Zimbabwe, HIV-infected patients occupy 50 to 80 percent of all beds in urban hospitals.

Military and Police Have Been Difficult to Reach With Prevention Efforts

According to the National Intelligence Council, HIV prevalence in African militaries is considerably higher than that of the general population. The Council estimates prevalence rates of 10 to 60 percent among military personnel in the region. For example, the HIV infection rate for the armed forces of Tanzania is estimated to be 15 to 30 percent, compared with about an 8 percent prevalence rate for the general population. According to USAID, in developing countries, military and police forces generally tend to be a young and highly mobile population that spends extended periods of time away from families and home communities. As a group, this population is likely to have more contact with casual sexual partners and commercial sex workers and engage in high-risk sexual behavior. As a result, the group is at increased risk of acquiring HIV/AIDS and transmitting it to the general population. Military and police forces have constant interaction with civilian populations where they are posted; therefore, they have been identified as an important target group for campaigns for the prevention and mitigation of HIV/AIDS. However, according to USAID, militaries have been unwilling to release detailed reports on HIV prevalence among troops, which has limited the ability of donor assistance

¹³ In 2000, the World Health Organization ranked the overall health system performance of its 191 members using factors such as health expenditures per capita. Of 40 sub-Saharan African countries, 38 ranked between 132 and 191, in the bottom third of rankings. The remaining two countries, Senegal and Benin, ranked 59th and 97th, respectively.

¹⁴ *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis* (Washington, D.C.: The World Bank, 2000).

groups such as USAID from working with African militaries and police forces.

Another factor limiting USAID in working with African military and police forces is a legislative restriction prohibiting assistance for training, advice, or financial support to foreign military and law enforcement forces.¹⁵ In 1996, USAID's General Counsel took the position that the restrictions do not prohibit participation of foreign police or military forces in USAID's HIV/AIDS prevention programs if three conditions are met: (1) the programs for police and military forces are part of a larger public health initiative, and exclusion of these groups would impair achievement of the overall public health objectives; (2) the programs must be the same as those offered to the general population; and (3) neither the programs nor any commodities transferred under them can be readily adapted for law enforcement, military, or internal security functions. A USAID official in one country told us that the USAID legal adviser in her region requires a justification for each activity directed toward police or military forces and that this is a disincentive to pursuing such activities. Overall, we found that only 8 of the 19 missions reported working with the military or police forces. The mission in Nigeria indicated that it has provided HIV/AIDS prevention and impact mitigation services to military and police personnel. Also, the USAID missions in Ethiopia and Guinea have promoted condom acceptability and use among military personnel.

National Governments Have Been Slow to Respond

Most national governments in sub-Saharan Africa have been slow to put effective HIV/AIDS policies in place. According to the World Health Organization, many countries in sub-Saharan Africa have not developed or completed a national strategic plan for reducing HIV/AIDS or provided sufficient resources or official support for HIV prevention efforts. For example, until 1999, the President of Zimbabwe denied that AIDS was a problem, and the President of Kenya did not endorse the use of condoms as a prevention method. In contrast, the President of Uganda has led a successful campaign against AIDS in his country, which, according to the Director of the Office of National AIDS Policy, contributed to the decrease in HIV prevalence.

¹⁵ Section 660 of the Foreign Assistance Act of 1961, as amended (22 U.S.C. 2420), prohibits the provision of training, advice, or financial support for police, prisons, or other law enforcement forces, subject to the exceptions of the act's section 660. In addition, principles of appropriation law generally prohibit the use of foreign assistance funds for military purposes.

USAID Made Contributions but Has Difficulty Measuring Its Overall Impact on Reducing HIV Transmission

USAID has contributed to the fight against HIV/AIDS in sub-Saharan Africa, particularly through country-level activities, including education and counseling; condom promotion and distribution; and improved prevention, diagnosis, and treatment of sexually transmitted infections. In addition, USAID's Global and Africa bureaus supported various activities in the areas of research, capacity building, integration of HIV/AIDS prevention activities into other development efforts, and advocacy for policy reform. (See app. II for a description of specific contributions made by the Global and Africa bureaus in these areas.)

However, measuring the impact of HIV/AIDS interventions on reducing transmission of the virus is difficult, according to experts at Family Health International and the University of California Los Angeles. Overlapping contributions of HIV/AIDS prevention programs of national governments and of other donors make direct causal linkage of behavior or prevalence changes to USAID's activities hard to measure. To assess its programs, USAID must rely on proxy measures because HIV has a long latency period, and limited surveillance data are available in the region. Generally accepted proxy measures include knowledge of HIV/AIDS and sexual behavior changes, such as increased condom use. However, gaps in data gathering and reporting, including the inconsistent use of indicators and the lack of a routine system for reporting program results, further limit USAID's ability to measure its overall impact on reducing HIV transmission.

USAID Activities Focused on Three Key Interventions Targeted to High-Risk Groups

USAID has focused its HIV/AIDS prevention activities in sub-Saharan Africa on three interventions that have been proven to be effective in the global fight against the epidemic: behavior change communications, condom social marketing, and treatment and management of sexually transmitted infections. USAID missions and regional offices in sub-Saharan Africa targeted their HIV/AIDS prevention activities to high-risk groups, such as commercial sex workers and interstate truck drivers. USAID maintains that a targeted approach remains the best way to reduce the number of new infections in the general population and to allow for more efficient use of limited HIV/AIDS prevention funds. Because of the difficulty obtaining accurate information on incidence and prevalence, however, USAID must rely on proxy indicators to measure the impact of its HIV/AIDS programs.

Behavior Change Communications

USAID promotes behavior change through voluntary counseling and information campaigns to heighten awareness of the risks of contracting

HIV/AIDS and spreading it to others. Specifically, these activities are to help motivate behavior change, heighten the appeal of health products and services, and decrease the stigma related to purchase and use of condoms. For example, the mission in Nigeria reported supporting an information campaign among sex workers, transport workers, and youth to increase condom use. In addition, the mission in Malawi supported voluntary HIV testing and counseling services in two cities, Lilongwe and Blantyre.

Ten USAID missions and one regional office that conducted behavior change communication activities reported increased knowledge and awareness about HIV/AIDS, to measure the effectiveness of these types of programs. For example, six missions and one regional office provided information that showed an increase in knowledge of condoms as a means of preventing HIV infection among people surveyed. The mission in Ghana reported that there was an increase in the proportion of people who knew that a healthy-looking person could have HIV (from 70 percent of women and 77 percent of men in 1993 to 75 percent and 82 percent, respectively, in 1998) but reported no change in the proportion who were aware of mother-to-child transmission (82 percent of women and 85 percent of men in 1993; 83 percent and 85 percent, respectively, in 1998). Moreover, surveys conducted for the mission in Tanzania showed that, between 1994 and 1999, the percentage of women who could name three ways to avoid getting HIV/AIDS increased from 11.4 percent to 24.2 percent. In the same country, the increase for men was from 22.6 percent to 28.6 percent.

USAID has also attempted to measure the effectiveness of behavior change communication activities to help change sexual behavior. In seven countries where USAID undertook such prevention programs, surveys suggested reductions in risky sexual behavior. For example, in Senegal, more men and women who were surveyed reported having used a condom in 1999 than in 1992. More male youth surveyed reported that they were using condoms with their nonregular sex partners in 1998 than in 1997. The same sexual behavior survey of female commercial sex workers showed an increased use of condoms with regular clients; however, female commercial sex workers also reported less frequent use of condoms with their nonregular partners. Also in Senegal, a greater percentage of girls reported in 1998 that they had never had sex compared to a prior survey conducted in 1997. However, there was no change for boys. In Zambia, more sexually active women who were surveyed in 1998 reported having ever used a condom than in a similar survey in 1992, and in 1998, fewer married men in Zambia's capital city reported having had extramarital sex than in a survey conducted 8 years earlier.

Condom Social Marketing

Condom social marketing, which relies on increasing the availability, attractiveness, and demand for condoms through advertising and public promotion, is another intervention that USAID supports at the country level. It is well established that condoms are an effective means to prevent the transmission of the HIV virus during sexual contact. The challenge for HIV/AIDS prevention then is one of expanded acceptance, availability, and use by high-risk groups. USAID projects in sub-Saharan Africa encourage production and marketing of condoms by the private sector to ensure the availability of affordable, quality condoms when and where people need them.

USAID uses sales of condoms marketed through its program as a measure of the results of its condom promotion activities. USAID missions in 15 of 19 countries and one of three regional offices reported increased condom sales, with decreased sales reported in Malawi and Uganda.¹⁶ According to a USAID contractor, sales of condoms promoted under USAID's program decreased in Malawi because of an economic downturn in that country and because another donor was providing free condoms. Sales in Uganda were affected by the introduction of a competing brand of condoms distributed by another donor. Between 1997 and 1999, the number of condoms sold more than doubled in Benin, from 2.9 million to 6.5 million, and increased in Zimbabwe from 2 million to 9 million. Condom sales in the Democratic Republic of the Congo grew more than 800 percent, from about 1 million in 1998 to 8.4 million in 1999. The number of sales outlets carrying socially marketed condoms also increased in Benin, Guinea, Malawi, and Mozambique. In addition to male condom marketing, five missions conducted social marketing of female condoms. Between 1998 and 1999, female condom sales increased in three of the four countries for which data were available but decreased in Zambia.

Management of Sexually Transmitted Infections

Management of sexually transmitted infections through improved prevention, diagnosis, and treatment is another important component of USAID's HIV/AIDS efforts, because the risk of HIV transmission is significantly higher when other infections, such as genital herpes, are present. USAID has continued to support standardized diagnosis and treatment of sexually transmitted infections. For example, in Madagascar, USAID's program supported improved diagnosis and treatment by targeting

¹⁶ USAID missions in Mali and Rwanda and the USAID East Africa and Southern Africa regional offices were in the process of collecting condom sales data at the time of this review.

interventions to high-risk populations. USAID has also worked to integrate the teaching of how to prevent sexually transmitted infections into its existing reproductive health and outreach activities.

As a way to measure the impact of its activities to improve management of sexually transmitted infections, USAID tracks the number of people trained in prevention, diagnosis, and treatment in that area. Seven USAID missions in sub-Saharan Africa reported assisting in the expansion of services for management of sexually transmitted infections. For example, USAID reported that it worked in 10 primary health facilities in Kenya to develop guidelines for diagnosing symptoms typical of sexually transmitted infections, and to develop health worker training materials. A total of 1,112 outreach workers and 55 health care providers were trained in sexually transmitted disease case management. In addition, the mission in Ghana stated that in 1999 it trained more than 200 medical practitioners and a total of 502 health care workers in public health facilities in the management of sexually transmitted infections. In Ghana's police services, USAID trained 12 health care providers to recognize symptoms of sexually transmitted infections, trained 65 police peer educators, and helped establish an HIV/Sexually Transmitted Disease Unit at the police hospital.

Other Prevention Activities

In addition to these three main prevention interventions, USAID missions also implemented activities in other areas. A few missions had activities aimed at improving the safety of blood for transfusions. In 2000, for example, the mission in Tanzania began collaborating with the U.S. Centers for Disease Control and the Tanzanian Ministry of Health to improve blood safety and clinical protocols. The mission in Ethiopia continued programs that are directed at strengthening the capacity of nongovernmental organizations in the region to provide HIV services, while other missions worked to promote community involvement in providing care to those persons living with HIV.

Twelve USAID missions and two regional offices promoted host government advocacy for improved HIV/AIDS policy environments. Some missions, such as Malawi, conducted workshops with key decisionmakers focusing on specific policy issues such as HIV testing and drug treatment for AIDS patients. The mission in Ghana sought to improve policies for reproductive health services through advocacy and policy development. According to USAID, its advocacy and policy development activities in Ghana led to the development of a national AIDS policy, which at the time of our review was available for parliamentary approval. Also, the mission in Nigeria indicated that its advocacy work on behalf of orphans and

vulnerable children led the Nigerian President to announce in 2000 his intention to pursue free and compulsory education for them. The mission in Nigeria also reported helping establish three regional networks of people living with HIV/AIDS that later served as the precursor for a national HIV/AIDS support network.

Gaps in Data Collection and Reporting Hinder USAID's Ability to Measure Overall Impact on Reducing HIV Transmission in Sub-Saharan Africa

Although USAID has collected data about its HIV/AIDS activities, in reviewing the information we received from USAID, we found that the agency's overall monitoring and evaluation efforts are weak in three areas: (1) missions and regional offices use inconsistent indicators to measure program performance, (2) data collection is sporadic, and (3) there is no requirement for missions and regional offices to regularly report the data they collect.

Inconsistent Indicators Are Used to Measure Outcomes

USAID's response to our request for baseline and trend data to demonstrate program results showed that missions and regional offices did not use indicators of program outcomes that were consistent over time. Unless the scope of the missions' surveys and the questions asked remained constant over time, comparing results would be difficult. For example, a 1994 survey in Ethiopia asking females to cite at least two ways to prevent HIV focused on females living in urban areas, whereas a 2000 survey focused on females nationwide. In another example, ever-use of condoms among men in Zimbabwe in 1999, as an indicator, did not directly relate to the proportion of men who in 1994 reported currently using condoms. The missions also did not link each prevention activity to a performance indicator, as we had requested, in their written responses to our questions. This made it difficult for us to assess the progress of the activities. For example, the mission in Mozambique provided training to health care and non-health care providers in the treatment of sexually transmitted infections but did not link specific performance indicators related to these activities.

Data Collection Is Sporadic

Information obtained from USAID showed that the amount and frequency of data collection on HIV/AIDS prevention activities varied considerably. Several missions had implemented activities only recently, so baselines had not been established or trend data were still being collected. Ten missions¹⁷ were still in the process of gathering baseline or trend data for many of

¹⁷ The USAID missions in Benin, the Democratic Republic of the Congo, Ghana, Guinea, Kenya, Madagascar, Malawi, Mozambique, Uganda, and Zambia.

their activities. For example, although the mission in Mozambique provided us with baseline and trend data on condom sales and a baseline for risky sexual behavior, comparison data for the latter measure will not be available until 2001. The Democratic Republic of the Congo and Madagascar have conducted activities in a number of areas, such as treatment of sexually transmitted infections, but only provided data to us for condom sales. Three missions that indicated having blood safety programs did not provide output or outcome measures to evaluate those programs.

These inconsistencies in data collection hindered our ability to assess whether USAID's HIV/AIDS prevention activities were meeting USAID's objectives in sub-Saharan Africa. For example, we could not evaluate 2 of the 19 missions and two of the three regional offices with HIV/AIDS programs because they did not provide any data.¹⁸ Four missions only provided information on condom sales and distribution. Eleven missions and one regional office offered a much broader range of information, although the data provided did not directly relate to all of each program's indicators or major activities, making it too difficult to evaluate fully the result of each activity. For example, USAID's Mozambique mission provided data on condom sales and distribution but not on mission-supported voluntary counseling and testing activities or on stigma reduction efforts.

USAID Has Few Monitoring and Evaluation Reporting Requirements

According to USAID, missions are not required to produce comprehensive monitoring and evaluation reports for each HIV/AIDS activity or indicator. Although in 1998 the Global Bureau established a repository for collecting and tracking performance data available to USAID organizational structures, including missions, there is no requirement for the missions to provide information to that database. Each mission provides USAID's Africa Bureau with an annual Results Review and Resource Request, in which the mission presents some results from the previous year in order to justify budget requests. However, according to senior USAID officials in headquarters, this report is not a monitoring and evaluation tool.

According to an epidemiologist from the University of California and a USAID contractor specializing in HIV/AIDS evaluation, surveillance, and epidemiological research, regular monitoring and evaluation of HIV

¹⁸ These missions and regional offices could not provide baseline and trend data because their HIV/AIDS indicators were relatively new at the time of this review.

prevention programs is necessary to prevent wasting resources on programs that do not function properly. USAID officials noted that while its missions use data to track day-to-day operations, the lack of a reporting requirement affects the agency's ability to generalize about agency performance and make management and funding decisions based on the data. This lack also inhibits sharing best practices because the agency cannot compare across countries which approach may be best. Therefore, allocation of resources may not be optimal because the agency does not necessarily know which programs could benefit the most from financial investments. Without a reporting requirement, the agency has a limited ability to demonstrate the effectiveness of its programs. For example, USAID was unable to provide sufficient information as a basis for determining if it met its 1999 performance goal of reducing HIV transmission and impact in developing countries to meet the requirements of the Government Performance and Results Act of 1993.¹⁹

Internal and External Factors May Limit USAID's Ability to Expand its HIV/AIDS Activities in Sub-Saharan Africa

USAID has developed a three-pronged approach for programming the 53-percent funding increase from fiscal year 2000 to fiscal year 2001 (\$114 million to \$174 million) for HIV/AIDS prevention in sub-Saharan Africa. Under this approach, USAID (1) provided additional funds to countries designated in need of assistance, (2) allowed missions to expand or implement new activities and services, and (3) developed a plan for expanded monitoring and evaluation of the programs. To rank countries for funding priorities and allocations, USAID's approach used several criteria, such as HIV/AIDS prevalence in a country, and economic impacts from the disease. Separately, USAID identified several internal and external factors that may affect its ability to expand its HIV/AIDS activities. USAID has identified steps to mitigate some of the problems associated with these factors.

USAID's Approach for Allocating HIV/AIDS Program Funding and Activities

USAID identified three categories of countries that are to receive expanded HIV/AIDS assistance based on their relative priority for action. Four "Rapid Scale-Up Countries" were designated as those that will receive significant increases in assistance for prevention, care, and support activities "to achieve measurable impact within 1-to-2 years." Eleven "Intensive Focus

¹⁹ *Observations on the U.S. Agency for International Development's Fiscal Year 1999 Performance Report and Fiscal Years 2000 and 2001 Performance Plans* (GAO/NSIAD-00-195R, June 2000).

Countries” (including one regional program) will receive a significant scaling-up of prevention activities and expanded services that will provide care and support. USAID’s plans are to work with other donors in these two country categories to expand programs to cover at least 80 percent of their populations with a comprehensive package of prevention and care services. USAID also plans to expand the scope, targeted populations, and geographic coverage of current HIV/AIDS programs in 10 countries in the “Basic Program Countries” (including two regional programs).

To determine which countries to include under each category, USAID used a number of criteria and conducted a worldwide survey of all USAID missions and regional offices. The criteria included

- the relative severity of the epidemic in the country,
- the magnitude of the epidemic in the country,
- the impact of the epidemic on the economy and society,
- the risk of a rapid increase in HIV prevalence,
- the availability of other funding sources,
- U.S. national interests, and
- strength of host country partnerships.

USAID planners then supplemented these criteria with the missions’ and regional offices’ survey responses. Factors considered were the total level of resources that could be effectively obligated, the rapidity for obligating those funds, the likely programmatic impacts, the nature of new and expanded activities, and the personnel constraints that might be encountered, among other items. Table 2 shows the amount of increased funding from fiscal year 2000 to fiscal year 2001, by mission and regional program by category of country.

Table 2: Funding for USAID HIV/AIDS in Sub-Saharan Africa, by Mission or Regional Office for Fiscal Years 2000 and 2001

Dollars in millions			
Mission/regional program	Fiscal year 2000 funding ^a	Fiscal year 2001 funding ^b	Percent increase ^c
Rapid scale-up countries			
Uganda	\$6.9	\$13.5	95.7
Zambia	7.0	13.0	85.7
Kenya	5.7	10.5	84.2
Intensive focus countries			
Nigeria	6.8	11.9	76.3
South Africa	5.7	9.5	66.7
Namibia	1.0	1.5	50.0
Rwanda	3.5	5.2	48.6
Malawi	5.0	7.3	45.0
Mozambique	5.1	6.7	31.4
Senegal	3.7	4.7	27.0
Tanzania	6.0	7.5	25.0
Ethiopia	6.7	8.2	22.4
Ghana	4.0	4.5	12.5
West Africa region	7.4	8.1	9.8
Basic program countries			
Eritrea	0.5	1.5	200.0
Southern Africa region	1.5	4.0	166.7
Democratic Republic of Congo	1.5	3.5	133.3
Benin	1.0	2.0	97.6
Madagascar	0.8	1.5	87.5
Angola	1.0	1.5	50.0
East/southern region	1.2	1.7	41.7
Zimbabwe	5.0	6.5	30.0
Guinea	1.7	2.2	29.0
Mali	2.5	3.2	28.0
Support to field programs			
Global Bureau	19.4	30.6	58.1
Africa Bureau	3.3	4.0	21.2
Total^d	\$113.9	\$174.4	53.1

^a Does not include funding for vulnerable children.

^b Includes funding for vulnerable children. The total for HIV/AIDS programs is \$162.2 million, and the total for vulnerable children programs is \$12.3 million.

^c Percent increase based on actual, not rounded, funding levels.

^d Totals may not add due to rounding.

Source: USAID.

New and expanded activities under USAID's scaled-up efforts will include

- prevention of HIV transmissions from mother to child;
- development of community-based programs designed to provide care to children affected by HIV/AIDS;
- provisions of treatment and prevention of tuberculosis and other opportunistic diseases; and
- development of multisectoral programs, such as for girls' education and finance for economic development efforts.

USAID's approach for scaling-up its HIV/AIDS programs in fiscal year 2001 included a plan for expanded monitoring and evaluation of the agency's HIV/AIDS programs.²⁰ Under the plan, USAID expects all missions receiving HIV/AIDS funding to collect and report data annually on HIV prevalence rates for 15- to 24-year-olds, and on condom usage with the last non-regular sexual partner. Depending on USAID activities in country, USAID missions may also be required to report periodically on additional indicators, such as total condoms sold, the percent of target populations requesting HIV tests, and others included in USAID's "Handbook of Standard Indicators." According to USAID, when implemented, these efforts will be conducted at routine intervals ranging from annual assessments to surveys conducted every 3 to 5 years. While the monitoring and evaluation plan applies to all country missions receiving HIV/AIDS funding, initial priority will be placed upon rapid scale-up and intensive focus countries. However, it is not clear when USAID plans to require the remaining countries to apply the standard indicators and collect and report the performance data. In addition, the plan does not specify to whom these performance data will be reported beyond the mission level or how the information will be used, for example, for resource allocation or identification of best practices.

²⁰ The Global Bureau and the Centers for Disease Control will provide funding and technical expertise; missions will be expected to provide some funding to support the monitoring and evaluation efforts.

Internal Factors May Affect USAID's HIV/AIDS Program Expansion

While USAID's approach provides criteria for funding new USAID activities to reduce the spread of HIV/AIDS, USAID officials reported that a number of factors internal to USAID may hamper its efforts to expand HIV/AIDS programs in sub-Saharan Africa. These factors include problems with contracting and procurement, and reported declines in program and technical staff in both missions and headquarters.

Contracting and Procurement Problems

To deliver HIV/AIDS assistance programs, USAID uses competitive contracts and grants, including cooperative agreements. These agreements are generally made between USAID and private voluntary organizations, not-for-profit organizations, research centers, universities, and international organizations. The agreements involve substantial interaction between USAID and the recipient organization during performance of the assistance programs.

USAID contracting officials reported that, on average, it takes 210 days for concluding cooperative agreements for the Global Bureau's population, health, and nutrition activities, which include HIV/AIDS. This is one of the longest cycles for such agreements within the federal government. The officials further reported that USAID has been unable to recruit and retain sufficient numbers of qualified contract specialists, both in the missions and in Washington, and, as a result, the workload for the current specialists is high. For example, USAID reported that in 1998 its procurement personnel were responsible for \$18.3 million worth of agreements per specialist. This was relatively higher than for procurement specialists in other federal agencies, such as the Departments of the Treasury and of Transportation (\$5.3 million per specialist) and the Department of Energy (\$2.9 million per specialist). In addition, USAID reported that currently each specialist is responsible, on average, for 26 distinct types of agreements, while some contract specialists in the field are responsible for procurements in multiple missions and regional programs. USAID officials said that the agency has worked to lessen the workload burden on contract specialists by taking such actions as developing a vehicle that allows missions to contract directly with contract awardees rather than through USAID headquarters.

Agency officials reported that the requirement to "Buy American" is a second procurement issue that could affect the timing of USAID's program expansion. According to USAID officials, when purchasing commodities for assistance programs, USAID is required to buy those made in the United States. USAID officials stated that although this rule may be waived when a

specific commodity required for the program can only be purchased from a foreign manufacturer, a waiver must be sought each time the commodity is purchased. According to these officials, the waiver process can take up to 4 weeks for each waiver, depending on the workload of the contracting specialist, the location of the office applying for the waiver, and the amount of the purchase. In January 2001, USAID instituted a policy to grant source and origin waivers for extended periods of time in emergency situations. For example, under this policy, USAID has approved an extended waiver through 2007 for HIV testing kits manufactured off shore. According to USAID, these kits allow for quicker test results and cost significantly less than those manufactured in the United States.²¹

Personnel Shortages

Another factor USAID identified that may affect program expansion is the lack of sufficiently experienced personnel in missions to staff the scaled-up programs. From the end of fiscal year 1992 to the end of fiscal year 1999, total staff levels of USAID foreign service employees working overseas declined by 40 percent, from just over 1,080 to about 650. Between the end of fiscal year 1992 and the end of fiscal year 1999, the total number of overseas foreign service employees working in program management declined by 41 percent, while those working in support management (such as financial management and contracts) declined by almost 31 percent. USAID has tried to compensate for the loss of experienced personnel by entering into personal service contracts, particularly for support management positions like procurement. These contracts are short term, however, and officials stated that the contractors generally lack the experience, capabilities, and organizational knowledge of permanent employees.

In addition, USAID reported it lacks sufficient personnel in some missions with the specialized, technical skills necessary for conducting new activities. For example, programs designed to reduce the incidence of mother-to-child HIV transmissions will require professionals experienced in medical fields, particularly those with nursing and pharmacological backgrounds. USAID also reports that in developing countries, the labor pool from which to draw individuals with medical backgrounds is small. Professionals were often recruited from organizations that provided similar

²¹ The applicable statute and regulations covering USAID's waiver of the "buy American" requirements for pharmaceuticals (including test kits) can be found in section 604(a) of the Foreign Assistance Act of 1961, as amended, ADS section 312.5(a), and in 22 C.F.R. 228.

services—the United Nations, other multinational assistance agencies, and private voluntary organizations.

External Factors May Also Affect USAID's HIV/AIDS Program Expansion

USAID also faces external factors related to the weak health care infrastructure common in sub-Saharan Africa that may affect the agency's ability to expand its programs. These factors include a lack of surveillance, response, and prevention systems; limited numbers of skilled health care workers; and underdeveloped pharmaceutical distribution capabilities. Further, the capability of local, nongovernmental organization sectors to expand the scope of current services and deliver new services is not known.

Weak Health Care Systems

The low level of health care spending as a proportion of gross domestic product (GDP) derived from publicly financed health care spending has resulted in poor health care infrastructure and could affect USAID's efforts to expand and create HIV/AIDS programs. In 1999, the U.S. Armed Forces Medical Intelligence Center reported that, with the exception of South Africa, sub-Saharan governments view health care as a low national priority. World Health Organization data indicate that in 1995, 1.7 percent of total GDP in sub-Saharan Africa derived from publicly financed health care spending. This rate was 35 percent lower than the proportion of GDP derived from publicly financed health care spending for all World Health Organization member states and 74 percent lower than the Organization's figures for publicly financed health care spending in the United States. The Armed Forces Medical Intelligence Center reported that as a result of the low levels of publicly financed health care spending, the majority of sub-Saharan African countries have only rudimentary or no domestic systems for epidemiological surveillance, response, or prevention.

Few Skilled Health Care Workers

Another external factor that could affect USAID's efforts to improve care and treatment for people with AIDS is the low numbers of skilled health care workers. In a 1998 report, the World Health Organization showed that in the sub-Saharan African countries in which USAID maintains missions, the number of physicians per 100,000 people ranged from a low of 2.3 per 100,000 people in Liberia (1997) to a high of 56.3 per 100,000 people in South Africa (1996).²² As a comparison, the ratio for the United States in

²² While the report was issued in 1998, data reflect the most current information possessed by the Organization, some of which dated to 1994.

1995 was 279 physicians per 100,000 people. The number of nurses per 100,000 people is similarly low. South Africa showed the highest ratio, with 472 nurses per 100,000 people (1996), still less than one-half the rate of 972 per 100,000 in the United States (1996). Without adequate numbers of health care personnel, it will be difficult for USAID to meet its goals to improve care and treatment for people with AIDS.

Limited Pharmaceutical Delivery Capabilities

Underdeveloped pharmaceutical distribution and delivery capabilities could also affect USAID's ability to provide the drugs needed for the prevention of mother-to-child HIV transmission and other care and treatment programs for opportunistic diseases. As stated in a 1999 GAO report, problems associated with these networks include outdated refrigeration units; a lack of reliable delivery trucks; and health care workers who have not been trained in the storage, handling, and usage of the pharmaceuticals.²³ These factors tend to lead to low coverage rates for people needing the medicines, as well as high costs due to large amounts of wasted product.

Unknown Capacities of Nongovernmental Organizations

Most indigenous nongovernmental organizations currently delivering HIV/AIDS services in sub-Saharan Africa are small and operate solely in their home localities. However, missions do not routinely assess nongovernmental organization capacity on a countrywide basis. Therefore, it is unclear whether in the short term existing nongovernmental organizations have the capacity to expand their services either to new geographic areas or by increasing efforts within the presently served area. In addition, it is unclear whether capacity and technical expertise exist among nongovernmental organizations to provide new services, such as those for the prevention of mother-to-child transmission and other treatment and care. According to USAID, some of the new programmatic activities for this year's increase will be directed toward helping nongovernmental organizations develop both technical expertise and managerial systems so that future year funding increases may be absorbed more readily.

Conclusions

The AIDS epidemic in sub-Saharan Africa has grown beyond a public health problem to become a humanitarian and developmental crisis. USAID has

²³ *Global Health: Factors Contributing to Low Vaccination Rates in Developing Countries* (GAO/NSIAD-00-195R, Oct. 15, 1999).

contributed to the fight against HIV/AIDS in sub-Saharan Africa by focusing on interventions proven to slow the spread of the disease. However, USAID's ability to measure the impact of its activities on reducing transmission of HIV/AIDS is limited by (1) inconsistent use of performance indicators, (2) sporadic data collection, and (3) lack of routine reporting of results to headquarters. As part of its approach for allocating the 53-percent increase in funding (\$114 million to \$174 million) for HIV/AIDS prevention activities in sub-Saharan Africa for fiscal year 2001, USAID prepared a plan to expand monitoring and evaluation systems in "rapid scale-up" and "intensive focus countries"—countries designated as in need of significant increases in assistance. However, when implemented, the monitoring and evaluation requirements in the plan will not initially include all countries where USAID missions and regional offices in sub-Saharan Africa implement HIV/AIDS programs. Further, the plan does not specify to whom these data will be reported or how the information will be used. Failure to address these issues not only inhibits USAID's ability to measure the performance of its HIV/AIDS activities but also hinders the agency's decision-making regarding allocation of resources among missions and regional offices and limits efforts to identify best practices.

Recommendations for Executive Action

To enhance USAID's ability to measure its progress in reducing the spread of HIV/AIDS in sub-Saharan Africa and better target its resources, we recommend that the Administrator, USAID, require that all missions and regional offices that conduct HIV/AIDS prevention activities

- select standard indicators to measure the progress of their HIV/AIDS programs;
- gather performance data, based on these indicators, for key HIV/AIDS activities on a regular basis; and
- report performance data to a unit, designated by the Administrator, for analysis.

Agency Comments

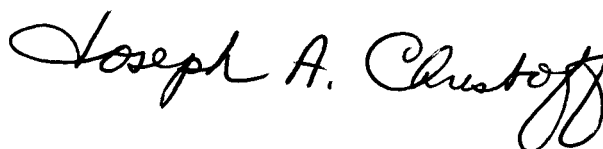
We received written comments on a draft of this report from the U.S. Agency for International Development that are reprinted in appendix III. The agency acknowledged our key concern that performance indicators at the country level were inconsistent to measure progress over time and agreed that more comparable data are needed to assure better measurement of the overall impact of its HIV/AIDS programs. The agency stated that it is taking important steps, as recommended in the report, to

facilitate the collection and dissemination of comparable national data. We modified our draft where appropriate to better reflect the agency's contributions and actions it has recently taken to address some of the problems identified in our report. In addition, the agency also provided technical comments to update or clarify key information that we incorporated, where appropriate.

We are sending this report to appropriate congressional committees and to the Administrator of USAID. We will also make copies available to other interested parties upon request.

If you or your staff have any questions concerning this report, please call me at (202) 512-8979. Other GAO contact and staff acknowledgments are listed in appendix IV.

Sincerely yours,

A handwritten signature in black ink, reading "Joseph A. Christoff". The signature is written in a cursive style with a large, stylized "J" and "C".

Joseph A. Christoff, Director
International Affairs and Trade

Objectives, Scope, and Methodology

At the request of the Chairman of the Senate Subcommittee on African Affairs, Committee on Foreign Relations, we examined the U.S. Agency for International Development's (USAID) efforts to reduce the spread of the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic in sub-Saharan Africa. Specifically, we (1) identified the development and impact of the HIV/AIDS epidemic in sub-Saharan Africa and the challenges to slowing its spread, (2) assessed the extent to which the U.S. Agency for International Development's initiatives have contributed to the fight against AIDS in sub-Saharan Africa, and (3) identified the approach the agency used to allocate increased funding and the factors that may affect the agency's ability to expand its HIV/AIDS program in sub-Saharan Africa in response to this funding.

To identify the development and impact of the HIV/AIDS epidemic in sub-Saharan Africa and the challenges to slowing its spread, we spoke with senior officials from the U.S. Agency for International Development's Washington, D.C., headquarters (the Global Bureau's HIV/AIDS Division and the Africa Bureau), the U.S. Bureau of the Census, the Office of National AIDS Policy, the State Department, and the Joint United Nations Programme on HIV/AIDS (UNAIDS). We reviewed relevant documents and reports from these agencies and from the U.N. International Labour Office; the National Intelligence Council; the World Bank; the World Health Organization; summaries of papers presented at the XIII International AIDS Conference in Durban, South Africa, in July 2000; and articles from scientific journals.

To assess the extent to which USAID initiatives have reduced HIV transmission in sub-Saharan Africa, we reviewed USAID program documents that described the agency's objective to reduce the transmission and mitigate the impact of HIV/AIDS. We reviewed documentation from the Global Bureau's HIV/AIDS Division that described the activities and accomplishments of its portfolio of HIV/AIDS programs, and we held discussions with key USAID officials and contractors, including Family Health International, Population Services International, TVT Associates, and the Futures Group. To assess the contributions of the agency's Africa Bureau, we reviewed the Results Review and Resource Request for the bureau and discussed performance data with key officials. At the country level, we sent a list of questions about activities, performance indicators used, and results achieved through fiscal year 2000 to the Africa Bureau, which distributed the questions to those missions and regional offices in sub-Saharan Africa that had implemented HIV/AIDS activities. We reviewed and consolidated the answers received from

19 USAID field missions and 3 regional offices that had HIV/AIDS activities. We examined program performance based on data received, which included results from local activity records and surveys, demographic and health surveys, behavioral surveillance surveys, and condom sales. We included country-specific information gathered from mission and regional Results Review and Resource Requests for fiscal year 2002, the Global Bureau's HIV/AIDS Division, Population Services International, and Family Health International. We also contacted several missions via e-mail to follow up on and clarify information they provided in response to our questions. In addition, we supplemented our work by visiting USAID missions in Malawi, Tanzania, Uganda, and Zimbabwe and held discussions with the USAID Population, Health, and Nutrition officers to verify data provided in the written responses to our questions and to follow up on some key points. We chose these four countries to work in conjunction with other ongoing GAO work on disease surveillance in the region. These countries have some of the highest HIV/AIDS prevalence rates in the region and provide perspective on countries with new and established USAID HIV/AIDS programs. To discuss the impact of limited monitoring and evaluation data on USAID strategic planning, budgeting, and dissemination of best practices, we met with officials from USAID's Bureau of Policy and Program Coordination.

To identify the process USAID used to allocate increased funding and the factors that may affect how quickly USAID can expand its HIV/AIDS programs in the region, we held discussions with officials at USAID headquarters in Washington from the Global Bureau's HIV/AIDS Division, Africa Bureau, and the Office of Procurement. We also conducted interviews of mission officials based in Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe, and personnel employed by private voluntary organizations providing HIV/AIDS services under cooperative agreements with USAID. In addition, we reviewed budgetary, personnel, and contracting documentation and examined mission responses to a field survey on implementation of HIV/AIDS fiscal year 2001 that was conducted by the Africa Bureau, and planning documents based upon these surveys. Finally, we reviewed additional information provided by USAID, foreign governmental health ministries, the United Nations, and other multilateral assistance agencies.

We conducted our work from April 2000 through January 2001 in accordance with generally accepted government auditing standards.

Contributions of USAID's Global and Africa Bureaus

In sub-Saharan Africa, USAID primarily implemented HIV/AIDS programs through three of its organizational structures: the Global Bureau's HIV/AIDS Division, the Africa Bureau, and the field missions and regional offices. This appendix focuses on the key contributions of USAID's Global and Africa Bureaus. The Global Bureau provided leadership in the areas of operations research, technical assistance, and capacity building for surveillance. The Africa Bureau led the effort to integrate HIV/AIDS activities into other sectors of country development programs. We discussed field mission contributions in the body of this report.

Global Bureau Contributions

In conducting operations research, the bureau is currently supporting 60 ongoing studies to test solutions to problems in the areas of management of sexually transmitted infections, care and support services, and policy analysis and change. Another Global Bureau project, started in 1995, has helped reform host government HIV/AIDS policies. For example, the project assisted Ethiopia in developing the regulations that established its National AIDS Council, which is responsible for coordinating and integrating HIV/AIDS initiatives. In addition, the project provided technical assistance, equipment, and training to the secretariats of the Addis Adaba Regional AIDS Council, which was formed in February 2000, and the Amhara Regional HIV/AIDS Task Force, formed in 1999.

The Global Bureau provided technical assistance through several initiatives. For example, one project, begun in 1998, provides technical assistance to the Global Bureau's HIV/AIDS Division, the regional bureaus, and the field missions. In addition to being a resource for the expertise needed to design HIV/AIDS strategic objectives and plans, the project was initiated to monitor processes, outcomes, and impacts of HIV/AIDS prevention programs. To achieve this goal, the project established a database to aggregate and disseminate research, implementation, and evaluation assessment findings. Another initiative was the development of a handbook of standard indicators, completed in March 2000, for measuring and evaluating HIV/AIDS prevention activities. This handbook is an important step toward providing universal measurement of HIV/AIDS prevention programs and could be used for comparison and tracking of program successes worldwide.

The Global Bureau is also working in concert with the U.S. Centers for Disease Control to assist countries in sub-Saharan Africa develop appropriate HIV/AIDS surveillance guidelines; carry out research to address how to best measure HIV incidence,¹ and estimate national HIV prevalence; and provide assistance to USAID missions to develop, improve, and use HIV/AIDS surveillance systems. According to USAID, the improved national surveillance systems should be in place to allow for annual measurement of HIV prevalence beginning in 2001.

Africa Bureau Contributions

The Africa Bureau provided technical assistance to support mission activities and led the effort to promote the integration of HIV/AIDS prevention efforts into other development activities, such as economic growth, democracy and governance, education, and agriculture. Because of the impact of HIV/AIDS on the economies of the most affected countries, according to Africa Bureau officials, USAID's strategy for economic growth must integrate HIV/AIDS activities to reach successful results. In the same way, the Africa Bureau is supporting the integration of HIV/AIDS activities into democracy and governance programs, including human rights, particularly those that advocate for women. According to USAID, it is important to integrate HIV/AIDS activities into the education sector because much of the progress made in developing countries over the past three decades has been due to greater numbers of youth going to school. Agriculture and natural resource development is important, since sustainable agriculture is necessary for economic development, and HIV/AIDS is a factor that leads to decreased production as more and more people get sick and die.

To help national governments understand the effects of HIV/AIDS on various sectors and to help missions advocate for the development of sector-specific responses to the epidemic, the Africa Bureau funded the development of a set of toolkits and briefs. For example, the AIDS toolkit for the Ministry of Education helps officials recognize the internal and external impacts of HIV/AIDS—such as higher employee absenteeism and reduced school enrollment—and identify appropriate action responses. The commercial agriculture brief indicates how AIDS affects human resources and agricultural operations and provides some suggestions for contingency planning to deal with the impact of HIV/AIDS. The toolkits

¹ Incidence is the number of new infections.

were discussed at two regional workshops organized by the University of Natal as part of a USAID contract held in Durban, South Africa, in 2000. The first workshop on education resulted in the formation of a task force. The purpose of the task force was to help ministries of education in different countries assess the impact of HIV/AIDS and apply the toolkit. The second workshop was for officials from the ministries of Planning and Finance. It offered a forum to discuss the impact of HIV/AIDS on the economy and changes in the government and development strategies that may be necessary to meet the crisis.

Comments From the U.S. Agency for International Development

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



U. S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

FEB 23 2001

Mr. Joseph A. Christoff
Director
International Affairs and Trade Division
U.S. General Accounting Office
441 G Street, NW – Room 4155A
Washington, D.C. 20548

Dear Mr. Christoff:

I am pleased to provide the U.S. Agency for International Development's (USAID's) formal response on the draft GAO report entitled "Global Health: U.S. Agency for International Development Fights AIDS in Africa, but Better Data Needed to Measure Impact" (January 2001).

The Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) is the most serious crisis facing Africa today. USAID, as a recognized world leader in the fight against AIDS, has placed this problem at the top of its development assistance agenda for Africa. We have reviewed the draft report and have identified three major concerns with the report.

USAID's Contributions to the Fight Against HIV/AIDS Are Underreported

- The introduction and conclusion sections of the report do not reflect USAID's accomplishments, as presented in the body of the report and Appendix 2. People who are not familiar with USAID's work in AIDS or the 1998 GAO report¹ on USAID's role in the fight against AIDS may be misled by the lack of information on USAID's contributions in these two important sections.

USAID Uses Data for Decision-Making and Sharing Lessons Learned

- The report fails to acknowledge USAID's extensive use of data to target resources, improve program effectiveness, and share lessons learned. USAID established criteria and analyzed comparative data to allocate its increased resources to countries

¹ "Despite the continued spread of HIV/AIDS in many countries, USAID has made important contributions to the fight against HIV/AIDS. USAID-supported research helped to identify interventions proven to curb the spread of HIV/AIDS that have become the basic tools for the international response to the epidemic. Applying these interventions, USAID projects have increased awareness of the disease; changed risky behaviors and increased access to treatment of sexually transmitted diseases and to condoms which have helped slow the spread of the disease in target groups." Page 4, "HIV/AIDS: USAID and UN Responses to the Epidemic in the Developing World (GAO/NSIAD-98-202).

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in Fiscal Year (FY) 2001. This is explained in “USAID’s Expanded Response to the Global HIV/AIDS Pandemic” document, which was approved by the Office of Management and Budget, the Office of National AIDS Policy, the National Security Council, and shared with the State Department, the Centers for Disease Control and Prevention, and others. USAID field missions use data (e.g. surveys, evaluations, operations research, routine service delivery statistics, etc.) extensively to manage programs, improve program effectiveness, and make resource allocation decisions.

USAID Has Taken Action to Improve Monitoring and Evaluation, Including Using Standardized Indicators

- The report does not acknowledge important actions USAID is taking to address some of the constraints identified in such areas as procurement, staffing, and monitoring and evaluation. USAID is already moving forward to implement the report’s “executive action” recommendations, which include selecting standardized indicators and routine collection and reporting of these indicators to a central unit in Washington. In fact, USAID has already established a set of standardized HIV/AIDS indicators and published these in a handbook.

USAID’s Contributions to the Fight Against HIV/AIDS Are Underreported

One of the report’s stated objectives is to assess the extent to which USAID’s initiatives have contributed to the fight against AIDS in sub-Saharan Africa. Unfortunately, much of the information related to USAID’s leadership role has been relegated to Appendix 2. The information on the performance of USAID’s country programs (pages 15-19) is not fully reflected in the introduction or conclusion of the report. USAID’s substantial contributions in addressing this pandemic include:

- Expanding services and increasing available information to prevent transmission and provide care for those infected and affected by HIV/AIDS through support to host country governments, non-governmental organizations and private citizen groups. In the three countries that are acknowledged to be successes in the fight against AIDS, Senegal, Uganda and Zambia, USAID has been the lead donor;
- Identifying feasible, affordable, effective interventions to slow transmission through a sustained investment in practical, applied clinical and field-based behavior research; and
- Increasing world awareness and knowledge of the nature and extent of the pandemic through our support and work with other U.S. agencies like the Census Bureau and the Centers for Disease Control (CDC) as well as U.S. universities, research institutions, and international organizations like UNAIDS.

See comment 1.

See comment 2.

USAID Uses Data for Decision-Making and Sharing Lessons Learned

USAID appreciates the GAO team's focus on the need for more comparable data on HIV/AIDS prevalence and related behaviors across countries so that USAID will be able to more scientifically document the overall impact of AIDS intervention programs. The report, however, does not acknowledge the different types of data that are currently collected and utilized for decision-making both in the field and in Washington. It fails to report that USAID missions routinely monitor program performance and utilize evaluations, surveys, and service delivery data for improving program effectiveness and resource allocation decisions. USAID established criteria (listed on pages 23–24 of the draft GAO report), and analyzed comparative data to allocate its increased resources to countries in FY 2001. This is explained in "USAID's Expanded Response to the Global HIV/AIDS Pandemic" document, which was approved by the Office of Management and Budget, the Office of National AIDS Policy, the National Security Council, and shared with the State Department, the Centers for Disease Control and Prevention, and others.

The report also suggests that USAID does not have the necessary information to share lessons learned across countries or determine the effectiveness of its interventions. USAID provided the team with a UNAIDS document (supported with USAID funds) entitled *Best Practices in Africa in HIV/AIDS Prevention and Care* which shared lessons learned² from 16 different African countries (USAID funded many of the activities which led to the development of this document).

USAID Has Taken Action to Improve Monitoring and Evaluation, Including Using Standardized Indicators

USAID agrees with the GAO that performance indicators at the country level in some cases were inconsistent to measure progress over time. Many of the changes in the indicators reflected increasing knowledge about how best to measure performance, and served critical management needs at the country level. The GAO report does not cite, however, some very important actions that USAID has taken to develop standardized indicators based on lessons learned³. The *USAID Handbook of Indicators for HIV/AIDS/STI Programs* now provides USAID with a set of standardized indicators. Each country will report to Washington on a subset of USAID's standardized indicators, depending on the specific mix of interventions. This will enable USAID to compare performance across countries with similar programs. In addition, Missions will continue to collect local indicators necessary to properly manage their specific country programs. It is important to recognize that each country is at a different stage of the epidemic; vulnerable populations may differ significantly; and the constellation of interventions must be tailored to the characteristics of that specific epidemic.

² The GAO team was furnished with a list of 48 on-going operations research studies, which are testing and documenting the effectiveness of alternative approaches to HIV/AIDS prevention and care.

³ USAID was an international leader with UNAIDS in developing a manual of standardized HIV/AIDS indicators entitled, *National AIDS Programs, A Guide to Monitoring and Evaluation*, which has become the global standard for monitoring and evaluating national HIV/AIDS programs worldwide.

See comment 3.

USAID takes its responsibilities under the Government Performance and Results Act⁴ seriously and will continue to take steps to improve our work in this area. Under our Expanded Response to the Global HIV/AIDS pandemic, we committed to working with other donors toward achieving international targets that include:

- reducing or keeping prevalence stable,
- increasing access to services which reduce mother to child transmission, and
- helping local institutions provide basic care and psychosocial support services to HIV infected persons and community support for orphans and other vulnerable children. Some of these prevention and care services are new and will require the development and careful testing of new performance indicators before data and reporting can be standardized.

As recommended in the report, USAID is taking steps with CDC and other partners to facilitate the collection and dissemination of comparable national data. This spring, we will work with missions to develop national HIV/AIDS monitoring and evaluation plans, which use these standard indicators. USAID/Washington is also making available additional technical assistance from its direct hire and contract staff to help missions strengthen their own performance monitoring and evaluation systems and to support some of the costs of additional behavioral surveys.

USAID Takes Steps to Address Procurement, Staffing and Other Constraints

The report correctly identifies a few key internal USAID factors that could hinder USAID's HIV/AIDS program expansion. These constraints include procurement delays; too few staff; and the lack of a system to provide comprehensive and comparable information on all HIV/AIDS affected countries for USAID/Washington managers. The report falls short, however, in identifying the important steps that USAID has already taken to overcome these constraints, using the additional resources provided by Congress over the last year. These include:

- Recruiting and hiring additional specialized USAID staff as feasible within the Agency's operating expense budget. USAID is increasing the number of contracting officers in Washington and in the field. USAID is also hiring additional personal service contractors and Technical Advisors in AIDS and Child Survival (TAACS) to manage HIV/AIDS programs.
- Streamlining procurement and making it possible to procure worldwide new HIV/AIDS products such as improved HIV/AIDS diagnostic test kits. USAID has authorized the extension of existing non-competitive grants and cooperative agreements for up to a two-year period and the awarding of new grants and cooperative agreements using less than fully competitive procedures.

⁴ USAID was pleased last year when its performance report was judged the best report produced by any U.S. federal agency.

See comment 4.

Appendix III
Comments From the U.S. Agency for
International Development

- Improving the approaches, tools and systems used to track the pandemic and to measure changes in behavior and access to key services and commodities. In order to provide guidance on use of the manual, *National AIDS Programs, A Guide to Monitoring and Evaluation*, USAID and CDC will expand access to technical assistance to country missions and will sponsor three workshops on monitoring and evaluation in Sub-Saharan Africa for USAID and CDC health officers and their host country counter-parts in 2001.

Thank you for the opportunity to respond to the GAO draft report and for the courtesies extended by your staff in the conduct of this review.

Sincerely,



Richard C. Nygard
Acting Assistant Administrator
Bureau for Management

Enclosure: Technical Comments on the GAO's Draft Report

The following are GAO's comments on the U.S. Agency for International Development's letter dated February 23, 2001.

GAO Comments

1. USAID commented that the introduction and conclusions sections of the report did not reflect its accomplishments as presented in the body of the report. To highlight their accomplishments, USAID noted that the agency is the single largest donor in Uganda, Senegal, and Zambia, countries where the fight against AIDS has been successful. However, the agency fails to note that other sub-Saharan African countries, where USAID has HIV/AIDS programs, have not been as successful in the fight against AIDS. USAID acknowledges that success in countries is the result of the combined efforts of national governments, USAID, and other donors, not exclusively the work of one donor. Finally, appendix II of the report recognizes many of USAID's contributions in operations research, technical assistance, and partnerships with other organizations, such as the U.S. Centers for Disease Control. Nonetheless, we have modified the report to describe the agency's accomplishments contained in the body of the report.
2. USAID stated that the report did not fully recognize that performance data is collected and utilized for decision-making at both the mission and headquarters and for sharing lessons learned. We modified the report to clarify that USAID's country-level missions use data to manage day-to-day operations. However, we found that inconsistent performance indicators and the lack of routine reporting of results to headquarters limits USAID's ability to assess its overall policies and approaches and thereby develop lessons learned from across all its missions. The UNAIDS publication cited by USAID is a summary of USAID supported research efforts shared with its partners. This document does not address our concern that USAID, based on information reported by its missions, develop a lessons learned assessment of best practices in combating AIDS that USAID headquarters can disseminate to all its missions.
3. USAID commented that the report did not cite important actions it has taken, such as developing a handbook of standardized indicators for HIV/AIDS programs. This handbook was discussed in the body of the report and highlighted among the contributions we cited in appendix II. The report recognized the handbook as an important step toward providing universal measurement of HIV/AIDS prevention programs. We have made no additional changes to the report.

4. USAID commented that the report did not include some important steps that USAID has taken to overcome internal factors that could hinder HIV/AIDS program expansion. USAID provided documentary evidence to support its assertion that the agency has streamlined its procurement policies for purchasing HIV/AIDS diagnostic kits. We therefore modified our report to add a specific reference to USAID's initiation of a policy in January 2001 that extends a waiver of the "Buy American Act" requirements to allow for the purchase of HIV products manufactured offshore.

GAO Contact and Staff Acknowledgments

GAO Contact

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