

April 2008

# GLOBAL HIV/AIDS

## A More Country-Based Approach Could Improve Allocation of PEPFAR Funding



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**Highlights**

Highlights of [GAO-08-480](#), a report to the Chairman, Committee on Foreign Relations, U.S. Senate; and the Chairman, Committee on Foreign Affairs, House of Representatives

**Why GAO Did This Study**

The President’s Emergency Plan for AIDS Relief (PEPFAR) provides assistance for combating HIV/AIDS in 15 focus countries and elsewhere, with global targets for prevention, treatment, and care. The U.S. Leadership Against HIV/AIDS, TB and Malaria Act of 2003, which authorizes the \$15 billion program, contains directives to guide the Office of the U.S. Global AIDS Coordinator’s (OGAC) allocation of this funding. The act expires in September 2008. The President announced his intention to ask Congress to authorize \$30 billion for these efforts for the next 5 years. In 2007, the Institute of Medicine (IOM) recommended eliminating the directives. GAO was asked to describe (1) the views of HIV/AIDS experts on these directives, (2) an alternative approach to allocating funds, and (3) potential challenges related to this approach. GAO interviewed 22 experts, surveyed PEPFAR officials in the 15 focus countries, and reviewed pertinent documentation.

**What GAO Recommends**

If Congress decides to remove spending directives, it should encourage OGAC to adopt a more country-based approach to allocating funds, with OGAC guidance. GAO recommends that the Secretary of State direct OGAC to provide guidance to PEPFAR country teams on using cost information in their planning and budgeting. State agreed with this recommendation and noted that elements of a country-based approach to funding are in place.

To view the full product, including the scope and methodology, click on [GAO-08-480](#). To view the e-supplement online, click on [GAO-08-534SP](#). For more information, contact David Gootnick at (202) 512-3149 or <mailto:GootnickD@gao.gov>.

**GLOBAL HIV/AIDS**

**A More Country-Based Approach Could Improve Allocation of PEPFAR Funding**

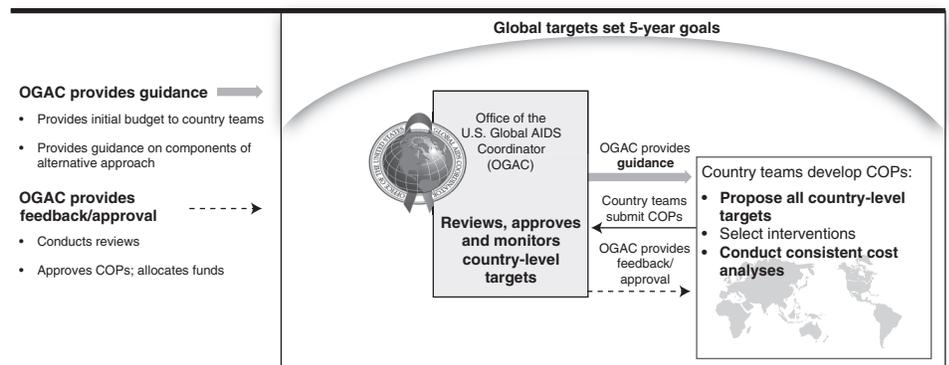
**What GAO Found**

HIV/AIDS experts recognized that the Leadership Act’s spending directives have ensured funding for prevention and treatment. However, many expressed concern about a directive to spend 33 percent of prevention funding on activities promoting abstinence and fidelity. Overall, the experts advocated replacing PEPFAR’s current allocation process—based on the spending directives—with an approach based more on country-level data and needs. Experts also advocated that OGAC continue providing guidance and technical assistance to PEPFAR country teams.

An alternative approach to allocating PEPFAR funds would include three elements of the current allocation process—setting targets, selecting interventions, and considering costs—but give country teams more responsibility for planning PEPFAR programs. OGAC would retain its leadership role, including reviewing and approving country plans. Teams would use country-level data to propose targets, and OGAC would work with teams to ensure these targets align with PEPFAR’s global targets. Teams would select interventions to meet the proposed targets, without the constraints of spending directives but subject to OGAC review. Teams would consider country-specific data on interventions’ costs using a consistent, OGAC-defined methodology; teams currently identify and analyze costs in varying ways. OGAC has not provided formal guidance or a methodology for identifying and analyzing costs, in contrast to federal standards that call for use of consistent methodologies to develop cost information.

Most country team officials surveyed reported that the alternative approach to allocating funds would be feasible. However, some officials noted that reaching consensus on targets with external partners and within country teams could be a challenge. Officials also noted some ongoing challenges—including lack of host country capacity and limited cost data—that they would likely continue to face in implementing the alternative approach.

**Alternative Approach to PEPFAR Funding Allocation Process**



COPs Country Operational Plans

Sources: GAO analysis of OGAC data; Map Resources (clip art and map).

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## Abbreviations

AB	abstinence/faithfulness
ABC	Abstain, Be faithful, or use Condoms
ARV	antiretroviral drugs
CDC	Centers for Disease Control and Prevention
COP	country operational plan
COPRS	Country Operational Plan and Reporting System
IOM	Institute of Medicine
NIH	National Institutes of Health
OGAC	Office of the U.S. Global AIDS Coordinator
OVC	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
TB	tuberculosis
UNAIDS	Joint United Nations Programme for HIV/AIDS
USAID	U.S. Agency for International Development
WHO	World Health Organization

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United States Government Accountability Office  
Washington, DC 20548

April 2, 2008

The Honorable Joseph R. Biden, Jr.  
Chairman  
Committee on Foreign Relations  
United States Senate

The Honorable Howard L. Berman  
Chairman  
Committee on Foreign Affairs  
House of Representatives

The President's Emergency Plan for AIDS Relief (PEPFAR) is a \$15 billion, 5-year initiative to combat the global HIV/AIDS epidemic. Since its inception in 2003, PEPFAR has been credited with enabling the significant expansion of access to HIV/AIDS prevention, treatment, and care services in the 15 countries where it operates, while continuing to support other bilateral programs around the world.<sup>1</sup> The U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (Leadership Act),<sup>2</sup> which authorizes PEPFAR, expires on September 30, 2008. PEPFAR's global targets call for preventing 7 million new HIV infections by 2010, treating 2 million HIV-infected individuals by 2009, and caring for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, by 2009. In May 2007, the President announced his intention to ask Congress to authorize the appropriation of \$30 billion to continue PEPFAR's efforts over the next 5 years.<sup>3</sup>

The Leadership Act calls for an HIV/AIDS Coordinator to have primary responsibility for overseeing and coordinating PEPFAR resources and activities; in 2004, the Office of the U.S. Global AIDS Coordinator (OGAC)

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<sup>1</sup>Approximately two-thirds of funds appropriated for PEPFAR are directed to HIV/AIDS initiatives in 15 focus countries: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

<sup>2</sup>Pub. L. No. 108-25, 117 Stat. 711.

<sup>3</sup>The President's announcement proposes to revise PEPFAR's global targets to prevent 12 million infections, treat 2.5 million infected individuals, and provide care for 12 million people affected by HIV/AIDS by 2013.

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was established in the Department of State to carry out these functions.<sup>4</sup> In addition, the act contains directives to guide the allocation of PEPFAR funding for HIV/AIDS prevention, treatment, and care. These spending directives include, among others, (1) a recommendation that 20 percent of funds appropriated to PEPFAR be dedicated to HIV/AIDS prevention<sup>5</sup> (prevention directive) and a requirement that at least 33 percent of prevention funds be spent on programs promoting abstinence until marriage (AB directive<sup>6</sup>); (2) a requirement that at least 55 percent of the appropriated funds be dedicated to therapeutic medical care of HIV-infected individuals (treatment directive) and a recommendation that at least 75 percent of treatment funds be used to procure antiretroviral drugs (ARV directive); and (3) a recommendation that 15 percent of the appropriated funds be spent on palliative care for those living with HIV/AIDS. These directives guide OGAC's allocation of funds for prevention, treatment, and care.<sup>7</sup>

In April 2006, we reported that the directive to spend 33 percent of PEPFAR prevention funding on AB programs had challenged the efforts of U.S. officials implementing PEPFAR funding in focus countries (country teams) to adopt evidence-based and country-level approaches to fighting HIV/AIDS<sup>8</sup> as called for in OGAC's 5-year strategy.<sup>9</sup> Challenges cited by country teams included, for example, budgeting for abstinence-related

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<sup>4</sup>The act outlines the duties of the HIV/AIDS Coordinator as including, among others, auditing, monitoring, and evaluating all PEPFAR programs; directly approving all PEPFAR activities, including funding; and establishing criteria needed to assess the measurable outcomes of PEPFAR activities. (Pub. L. No. 108-25, § 102(a)(2).)

<sup>5</sup>This provision was included as a sense of Congress in the Leadership Act. OGAC has followed this provision in its allocation of PEPFAR appropriations.

<sup>6</sup>The Leadership Act endorses the "ABC model" (Abstain, Be faithful, correct and consistent use of Condoms) to prevent the sexual transmission of HIV (Pub. L. No. 108-25, § 301(a)(2)). Since January 2004, OGAC has defined abstinence-until-marriage programs as comprising both activities promoting abstinence (A) and activities promoting fidelity (B).

<sup>7</sup>In this report, "allocating PEPFAR funds" refers to the distribution, across and within the country teams, of funds that have been appropriated for PEPFAR.

<sup>8</sup>Our 2006 report recommended that the Global AIDS Coordinator collect and report information regarding the effect of the abstinence-until-marriage spending requirement on country teams' sexual prevention programming. See GAO, *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief*, [GAO-06-395](#) (Washington, D.C.: April 2006).

<sup>9</sup>OGAC's 5-year strategy calls for evidence-based policy decisions and programs that respond to local needs and social and cultural patterns.

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activities separately from other prevention activities and difficulty delivering appropriate prevention messages to populations at high-risk of HIV/AIDS.<sup>10</sup> In addition, a congressionally mandated study by the Institute of Medicine's (IOM) Committee for the Evaluation of PEPFAR Implementation, published in March 2007, found that the Leadership Act's spending directives hinder program implementation.<sup>11</sup> While acknowledging PEPFAR's accomplishments, the IOM study recommends that Congress replace the spending directives with mechanisms that ensure country teams' accountability for results and link spending directly to overall and country-level PEPFAR targets. The IOM study does not specify the form that such mechanisms should take.

We were asked to identify potential approaches that respond to the IOM's recommendation to replace the spending directives with an alternative approach. This report describes (1) views of leading HIV/AIDS experts regarding the Leadership Act's spending directives and the current process of allocating PEPFAR funds under these directives; (2) absent the spending directives, an alternative approach to allocating PEPFAR funds, based in part on the experts' views; and (3) potential challenges related to implementing this alternative approach, as identified by PEPFAR country team officials.

To address these objectives, we conducted semi-structured interviews with 22 HIV/AIDS experts<sup>12</sup> and, based on our analysis of information from these interviews, outlined an alternative approach to allocating PEPFAR funds. In addition, we conducted initial and follow-up surveys of PEPFAR country team members. (Survey questions, results, and number of respondents per question are presented in an electronic supplement to this

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<sup>10</sup>OGAC permits country teams to apply for exemptions from the 33 percent abstinence-until-marriage requirement. For example, OGAC guidance states that it would be appropriate for a country team in a country with a concentrated epidemic—in which HIV has infected at least 5 percent of individuals in defined subpopulation but is not well-established in the general population—to seek an exemption from this requirement.

<sup>11</sup>Institute of Medicine, *PEPFAR Implementation: Progress and Promise* (Washington, D.C.: National Academies, 2007).

<sup>12</sup>These experts included individuals affiliated with the U.S. government, the faith-based community, academia, and multilateral organizations such as the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Health Organization (WHO). We selected these experts on the basis of several criteria, including educational background in public health and medicine, experience working with major HIV/AIDS organizations, and leadership experience in addressing HIV/AIDS. (See app. II for more information on these experts.)

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report, available at our Web site.<sup>13</sup>) We also interviewed government officials from four PEPFAR focus countries as well as officials at OGAC and the U.S. Agency for International Development (USAID) in Washington, D.C., and we held meetings with officials at the World Health Organization (WHO); the Joint United Nations Programme on HIV/AIDS (UNAIDS); and the Global Fund to Fight AIDS, Tuberculosis, and Malaria in Geneva, Switzerland. In addition, we reviewed PEPFAR documents, such as the President's Emergency Plan for AIDS Relief Fiscal Year 2008 Country Operational Plan (COP) Guidance. (See app. I for a more detailed description of our scope and methodology.) We conducted this performance audit from May 2007 to March 2008 in accordance with generally accepted government auditing standards.

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## Results in Brief

HIV/AIDS prevention and treatment experts whom we interviewed recognized that the Leadership Act's spending directives had some benefits, but many experts expressed concerns about the effect of the AB and ARV directives on country-based and evidence-based programming. More than half of the experts stated that the prevention directive helped protect funding for prevention, and a number of the experts said that the treatment directive helped expand access to HIV/AIDS treatment in the 15 focus countries. However, 13 of 22 experts expressed concern that the AB directive posed obstacles to the development of country-based and evidence-based programming. In addition, the same number of experts explicitly stated that PEPFAR's AB directive hindered the development of integrated prevention programs that appropriately balanced AB prevention activities with other prevention activities. Further, 12 experts stated that the ARV directive does not reflect the varying cost of ARV drugs. Overall, the experts advocated revising PEPFAR's current allocation process, which is based on the spending directives, with a more country-based approach. Several experts also advocated a leadership role for OGAC in providing guidance and technical assistance to country teams.

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<sup>13</sup>GAO, *Global HIV/AIDS: Survey of PEPFAR Country Teams*, GAO-08-534SP (Washington, D.C.: April 2008), available at <http://www.gao.gov>. The survey, which included a primary survey and a short follow-up, requested information on issues such as setting targets, selecting interventions, and using cost information. The country team members surveyed included Centers for Disease Control and Prevention (CDC) Chiefs of Party, U.S. Agency for International Development (USAID) health team leaders, and PEPFAR coordinators in the 15 PEPFAR focus countries. Survey percentages reported do not include nonresponses to each question in our survey.

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A more country-based approach to the current process of allocating PEPFAR funds could strengthen country teams' ability to develop programs that respond to local needs. Building on the IOM recommendation to eliminate the spending directives, the proposed alternative approach in this report includes changes to three elements of the current allocation process—setting targets, selecting interventions, and considering costs—but gives country teams more responsibility for planning PEPFAR programs, subject to OGAC's continued review.<sup>14</sup> Under the proposed approach, teams would draw on country-level data to propose targets, including annual and multiyear targets, that respond to each country's conditions; OGAC would work with teams to ensure that the proposed targets are aimed at meeting the global PEPFAR targets. In contrast, teams currently set annual targets to meet 5-year country-level targets established by OGAC. Country teams would also select interventions to meet their proposed targets, unconstrained by the spending directives, subject to OGAC's review. Currently, teams select interventions within the constraints of the spending directives. In addition, teams would consider country-level cost information according to a consistent, OGAC-defined methodology; teams currently identify and analyze costs in varying ways. Although OGAC bases its country-level allocations in part on the proposed budgets in the teams' plans, OGAC has not provided the teams formal guidance or a methodology for identifying and analyzing cost information. In contrast, federal standards state that agencies should use consistent costing methodologies in their planning to provide reliable and timely information to federal managers and Congress.<sup>15</sup> To ensure country teams' accountability for results under the proposed approach, OGAC would retain its leadership role, including approving country plans and leading efforts to monitor allocation of funds and progress toward targets.

Most PEPFAR country team officials whom we surveyed reported that the proposed alternative approach to allocating PEPFAR funds would be feasible. However, some of the officials cited several key challenges that they might face in implementing the approach. With regard to proposing all country-level targets, most PEPFAR country team officials stated that it

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<sup>14</sup>The proposed alternative approach is based on our analysis of the views and comments of the 22 experts, the PEPFAR country teams, and OGAC officials. For more information about our methodology, see appendix I.

<sup>15</sup>See Statement of Federal Financial Accounting Standards No. 4, *Managerial Cost Accounting Standards and Concepts* (Washington, D.C.: 2007).

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would not be difficult for country teams to do so. However, some country team officials identified reaching consensus on targets, both internally and with external participants—such as host country officials and implementing partners—as potential challenges. With regard to selecting interventions, officials noted a range of ongoing challenges—including measurement and evaluation difficulties, limited data, and lack of host country capacity—that would likely continue under the alternative approach. With regard to using cost-related data in their planning and budgeting, many officials said it would not be difficult for country teams to do so, but they cited a lack of complete and appropriate data and wide variations in costs as current obstacles that are also likely under the alternative approach.

If Congress decides to remove the spending requirements as IOM recommended, we suggest that Congress encourage OGAC to adopt a more country-based approach to allocating funding, with OGAC providing overall leadership and guidance for setting country-specific targets, selecting interventions, and considering costs, as discussed in this report. In addition, to help ensure that PEPFAR country teams are better able to provide consistent and accurate cost estimates to OGAC, we recommend that the Secretary of State direct OGAC to provide appropriate guidance to PEPFAR country teams on identifying and using cost-related information in their planning and budgeting of PEPFAR programs.

OGAC provided written comments regarding a draft of this report, which we have reprinted in appendix IV, as well as technical comments that we incorporated as appropriate. OGAC agreed with our recommendation to improve its guidance to country teams on how to identify and use cost information for planning and budgeting. In its written comments, OGAC emphasized that PEPFAR policies and procedures are intended to ensure country ownership consistent with applicable law. Our report's central finding—based on input we received from noted HIV/AIDS experts—that a more country-based approach could improve allocation of funds does not suggest that country-teams play no role in PEPFAR programming. However, a number of experts we interviewed observed that congressional spending directives and targets set by OGAC have constrained country-level programming. OGAC's written comments also suggested that our report demonstrated some misunderstanding of PEPFAR operations. In response, we added to our report more information about OGAC's annual allocation process. OGAC further challenged our presentation of expert concerns regarding the impact of the 33 percent AB spending directive. In response, we added a footnote detailing some of the experts' comments regarding the AB spending

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directive. In addition, OGAC stated its concern that the report does not address the potential consequences of eliminating the current 10 percent spending directive for programs serving orphans and vulnerable children (OVC). Although our work focused on the prevention and treatment spending directives, a number of individuals whom we interviewed noted that this directive helped protect programs for OVC. We also recognize that Congress may view the OVC directive as necessary to protect this vulnerable group.

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## Background

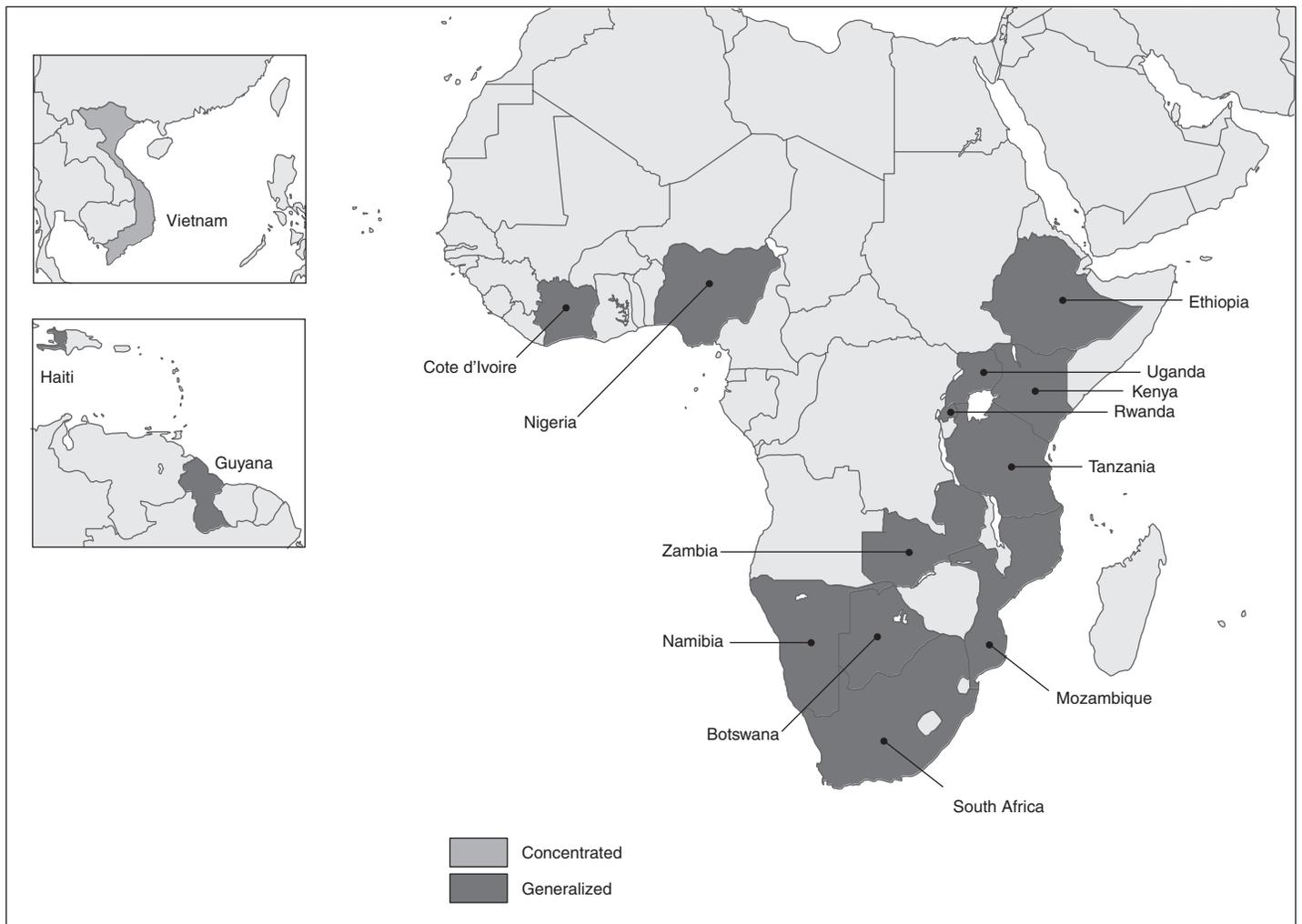
More than 20 million people have died from AIDS since 1981. In 2007, an estimated 2.1 million died from AIDS and about 2.5 million people were newly infected with HIV. Data for 2007 from UNAIDS indicate that about 33.2 million people worldwide are living with HIV/AIDS. More than two-thirds of these people live in sub-Saharan Africa, where adult HIV prevalence in 2007 was estimated by UNAIDS at 5 percent.

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## HIV/AIDS Epidemic in PEPFAR countries

The nature of the AIDS epidemic varies among the 15 PEPFAR focus countries, 12 of which are in sub-Saharan Africa (see fig. 1). Although the epidemic in some focus countries is concentrated in certain populations, in other focus countries it has spread among the general population. In addition, the groups most vulnerable to HIV infection vary among the focus countries. For example, while girls and young women are most vulnerable in some countries, populations typically considered high-risk groups, such as intravenous drug-users or commercial sex workers, are most vulnerable in others.

**Figure 1: Stage of the HIV/AIDS Epidemic in PEPFAR Focus Countries, December 2007**



Source: UNAIDS data.

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

## Leadership Act's Spending Directives and Guidance

The Leadership Act specifies the percentages of PEPFAR funds to be allocated for HIV/AIDS prevention, treatment, and care activities for fiscal years 2006-2008. The act endorses the "ABC model" (Abstain, Be faithful, correct and consistent use of Condoms) for sexual prevention of

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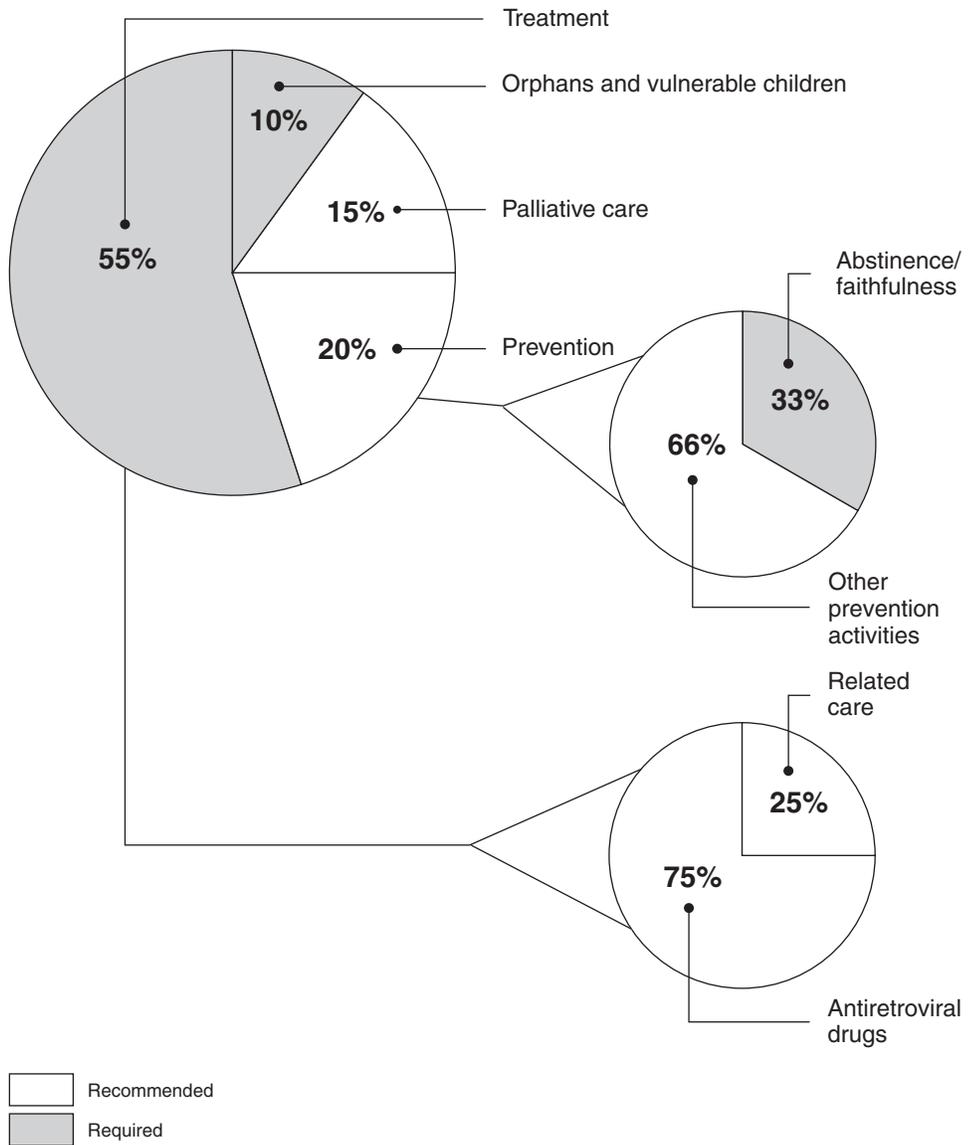
HIV/AIDS.<sup>16</sup> The act also requires that at least 10 percent of PEPFAR funds be devoted to care for orphans and vulnerable children.<sup>17</sup> (See fig. 2.)

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<sup>16</sup>Pub. L. No. 108-25, § 301(a)(2). The ABC model is based, in part, on the experience of Uganda, which implemented an integrated and comprehensive ABC campaign in the 1980s and observed a decline in HIV/AIDS prevalence by 2001. Many researchers who have studied the Ugandan experience emphasize the importance of all three components of ABC and have concluded that all three aspects of the model contributed to Uganda's decline in HIV prevalence. Although substantial debate exists about the extent to which each component of the model is responsible for reducing HIV prevalence in Uganda and other countries, there is consensus in the public health community that using an integrated, comprehensive ABC model can have a positive impact in fighting HIV/AIDS (W. Cates, M. M. Cassell, H. D. Gayle, E. C. Green, D. T. Halperin, N. Hearst, D. Kirby, and M. J. Steiner, "The Time Has Come for Common Ground on Preventing Sexual Transmission of HIV," *Lancet*, vol. 364 (2004).

<sup>17</sup>Pub. L. No. 108-25, § 403.

**Figure 2: Spending Directives and Guidance from the Leadership Act for Fiscal Years 2006-2008**



Source: GAO analysis of 2003 Leadership Act.

Note: The percentage shown for other prevention activities represents PEPFAR prevention funds remaining after the required allocation for abstinence/faithfulness activities.

**PEPFAR Funding**

In fiscal year 2007, Congress appropriated about \$4.52 billion for global HIV/AIDS efforts. Of this amount, approximately \$4.48 billion was appropriated to four accounts: (1) the Global HIV/AIDS Initiative (GHAI),

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(2) the Child Survival and Health account, (3) the National Institutes of Health (NIH) budget account, and (4) the Centers for Disease Control and Prevention (CDC) Global AIDS Program.<sup>18</sup> In this report, “PEPFAR funding” refers to funds appropriated to these four accounts.<sup>19</sup>

In fiscal year 2007, planned PEPFAR allocations for prevention, treatment, and care activities in the 15 focus countries totaled about \$2.35 billion.<sup>20</sup> Of that sum, about \$488 million (21 percent) was allocated for prevention; approximately \$703 million (30 percent) was allocated for care, which includes assistance for orphans and vulnerable children; and about \$1.16 billion (49 percent) was allocated for treatment (see fig. 3).

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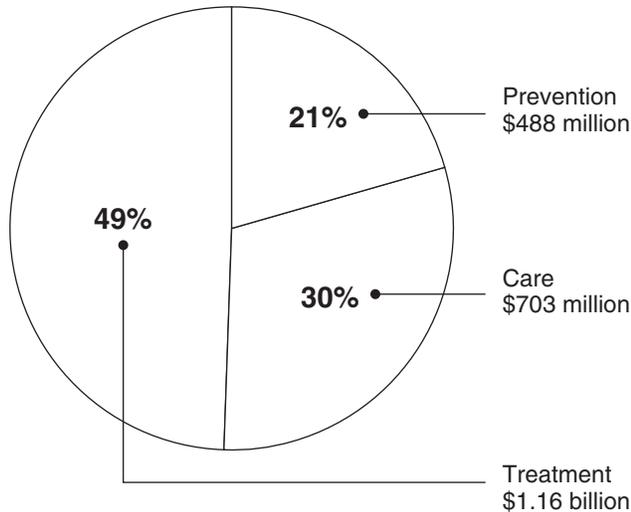
<sup>18</sup>The remaining \$37 million in global HIV/AIDS funding was appropriated to other accounts to support global HIV/AIDS efforts. These accounts include the Economic Support Fund, which is intended to advance U.S. strategic goals through economic assistance, and Foreign Military Financing, which provides support to foreign militaries.

<sup>19</sup>For fiscal year 2004, Congress appropriated funds to NIH for global HIV/AIDS, but those funds supported international HIV/AIDS research rather than efforts in the PEPFAR focus countries. Therefore, funds for NIH for fiscal year 2004 are not included in our calculations of PEPFAR funding for that year. In addition, in fiscal year 2004, Congress appropriated funds to the Prevention of Mother to Child Transmission (PMTCT) account; this account expired at the end of fiscal year 2004, but some country teams carried over PMTCT funds to fiscal year 2005. Therefore, for fiscal year 2004 and 2005, this report includes funding to the PMTCT account. Although the PMTCT account expired, OGAC continues to fund PMTCT activities through the remaining accounts.

<sup>20</sup>We report planned allocations rather than obligations or expenditures because our report focuses on the PEPFAR allocation process (see app. I for more information on the scope and methodology of our report). The total allocation of \$2.35 billion for prevention, treatment, and care differs from the \$4.48 billion appropriated because the remaining \$2.13 billion was not allocated to prevention, treatment, and care activities in the focus countries: about \$754 million was allocated to international partners, such as the Global Fund; approximately \$368 million was allocated to HIV/AIDS programs in nonfocus countries in which PEPFAR operates; about \$362 million was allocated for National Institutes of Health HIV/AIDS research; about \$81 million was allocated to tuberculosis efforts; approximately \$40 million was allocated to microbicides; about \$29 million was allocated to the International AIDS Vaccine Initiative; and about \$497 million was allocated for other costs, which include strategic information and management and staffing. The total planned allocation for fiscal year 2007 differs from data that OGAC reported to Congress for that year, because OGAC’s reported funding included these other costs, which were not reported as program area funds until fiscal year 2006. To be consistent with our prior work, we do not include these costs in our calculations of PEPFAR funding.

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**Figure 3: PEPFAR's Planned Allocations for Prevention, Treatment, and Care, Fiscal Year 2007**



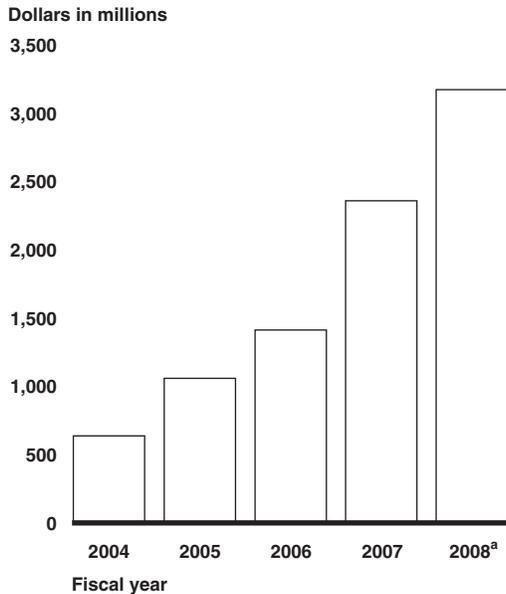
Source: GAO analysis of budget data provided by OGAC.

PEPFAR's annual planned allocations have increased significantly since the program received its first appropriation in January 2004. In fiscal year 2004, planned allocations to the 15 focus countries for prevention, treatment, and care activities totaled approximately \$629 million. Planned allocations to the focus countries for these activities were approximately \$1.05 billion in fiscal year 2005, \$1.4 billion in fiscal year 2006, and \$2.35 billion in fiscal year 2007. For fiscal year 2008, planned allocations to the focus countries for prevention, treatment, and care total about \$3.16 billion.<sup>21</sup> Figure 4 shows total planned PEPFAR funding allocations for fiscal years 2004-2008.

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<sup>21</sup>As of March 31, 2008, planned allocations for fiscal year 2008 had not yet been approved by OGAC. The total allocation amount was obtained from OGAC's Country Operational Plan and Reporting System (COPRS) on February 6, 2008, and may be subject to revision.

**Figure 4: Total Planned PEPFAR Funding Allocations for 15 Focus Countries, Fiscal Years 2004-2008**



Source: GAO analysis of fiscal years 2004-2006 budget data provided by OGAC; GAO analysis of fiscal years 2007-2008 budget data from OGAC's Country Operational Plan and Reporting System database.

Note: As of March 31, 2008, OGAC had not yet approved fiscal year 2008 planned allocations.

## PEPFAR Program Areas

PEPFAR guidance establishes several program areas that comprise activities undertaken for prevention, treatment, and care. For prevention, the guidance defines five program areas—abstinence/faithfulness (AB); “other prevention,” which includes condom activities (“C”), management of sexually transmitted infections, and reduction of injection drug use; prevention of mother-to-child transmission (PMTCT); blood safety; and safe medical injections. These areas are divided into two groups: (1) activities aimed at preventing sexual transmission—AB and “other prevention,” and (2) activities aimed at preventing nonsexual transmission—prevention of mother to child transmission, blood safety, and safe medical injections.<sup>22</sup>

<sup>22</sup>To meet the AB spending directive, OGAC mandated in its ABC guidance that PEPFAR country teams spend at least half of prevention funds on sexual transmission prevention and two-thirds of those funds on AB activities.

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In addition, PEPFAR guidance specifies three program areas for treatment: ARV drugs, which encompasses the cost of ARV drugs as well as logistical and supply chain support; ARV services, which includes training clinicians and other health care providers on ARV-related issues; and laboratory infrastructure. The guidance defines four program areas for care: basic health care and support; tuberculosis (TB) prevention and treatment; care of orphans and other vulnerable children affected by HIV/AIDS, including basic education and health care; and counseling and testing.

Within each program area, OGAC has developed a number of indicators that it uses to measure progress. For example, two indicators under the PMTCT program area are the number of facilities providing the minimum package of PMTCT services and the number of pregnant women who received HIV counseling and testing for PMTCT and who received their test results.

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## Office of the Global AIDS Coordinator

Established in January 2004, OGAC is responsible for developing a global HIV/AIDS strategy and administering PEPFAR. The Leadership Act authorizes the Global AIDS Coordinator to carry out international prevention, treatment, and care and other HIV/AIDS-related activities through nongovernmental organizations (NGO) and U.S. executive branch agencies.<sup>23</sup> The act also charges the coordinator with primary responsibility for overseeing and coordinating PEPFAR activities. These duties include, among others, auditing, monitoring, and evaluating all PEPFAR programs; directly approving all PEPFAR activities, including funding; and establishing criteria needed to assess the measurable outcomes of PEPFAR activities.<sup>24</sup>

In the countries where PEPFAR operates, PEPFAR programs are managed by country teams, each consisting of staff from PEPFAR's implementing agencies and led, respectively, by the U.S. Ambassador for that country. Some focus country teams include a PEPFAR coordinator, who is responsible for coordinating with implementing agencies and the host

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<sup>23</sup>Pub. L. No. 108-25, § 102(a)(2). The agencies primarily responsible for implementing PEPFAR are USAID, the Department of Health and Human Services' Centers for Disease Control and Prevention (CDC), and the Department of State. Other agencies involved in PEPFAR are the Peace Corps and the Departments of Defense, Labor, and Commerce.

<sup>24</sup>Pub. L. No. 108-25, § 102(a)(2).

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country government, and for facilitating the development of that country's PEPFAR program.

OGAC also monitors and evaluates PEPFAR funding and program results. For instance, OGAC requires country teams to submit semiannual and annual progress reports for each fiscal year; these reports describe program results and identifying obligations for the past fiscal year. OGAC uses this information to monitor country teams' progress toward the PEPFAR global targets.

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## Current Process for Allocating PEPFAR Funding

The current process for allocating PEPFAR funding within the framework of the spending directives is a multistage annual process. These stages include, among others, OGAC's provision of an initial budget to each country team; each team's submission of an annual strategy, known as a country operational plan (COP); and OGAC's assessment of each team's opportunities, challenges, and progress in the previous year. Based on OGAC's assessment, PEPFAR's interagency headquarters leadership provides a new annual allocation for each country team.

- OGAC provides each country team an initial planning budget, subject to annual appropriations, as well as COP technical guidance. In setting the initial planning budget for each country, OGAC takes several factors into account, including the country team's progress toward achieving the previous year's annual country-level targets; national coverage rates for individuals eligible for PEPFAR prevention, treatment, and care services; and financial obligation rates. For fiscal year 2007, OGAC provided each focus country team with an initial planning budget in June 2006.
- On the basis of these budgets and guidance, the country teams develop their COPs—including annual country-level targets, selected interventions and the organizations that will implement them (implementing partners),<sup>25</sup> and estimated costs of interventions—and submit them in late September. For fiscal year 2007, country teams submitted COPs by September 30, 2006.
- The interagency headquarters team—comprising staff from OGAC and the agencies that implement PEPFAR—then conducts technical and programmatic reviews of the proposed programs, consulting with country

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<sup>25</sup>Implementing partners carry out interventions, such as administering ARV drugs or providing HIV testing.

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teams to clarify and discuss issues related to the COPs. After these reviews are complete, the PEPFAR principals, which include the Global AIDS Coordinator and senior management from the PEPFAR implementing agencies, review the COPs and make recommendations to the Global AIDS Coordinator regarding their approval.

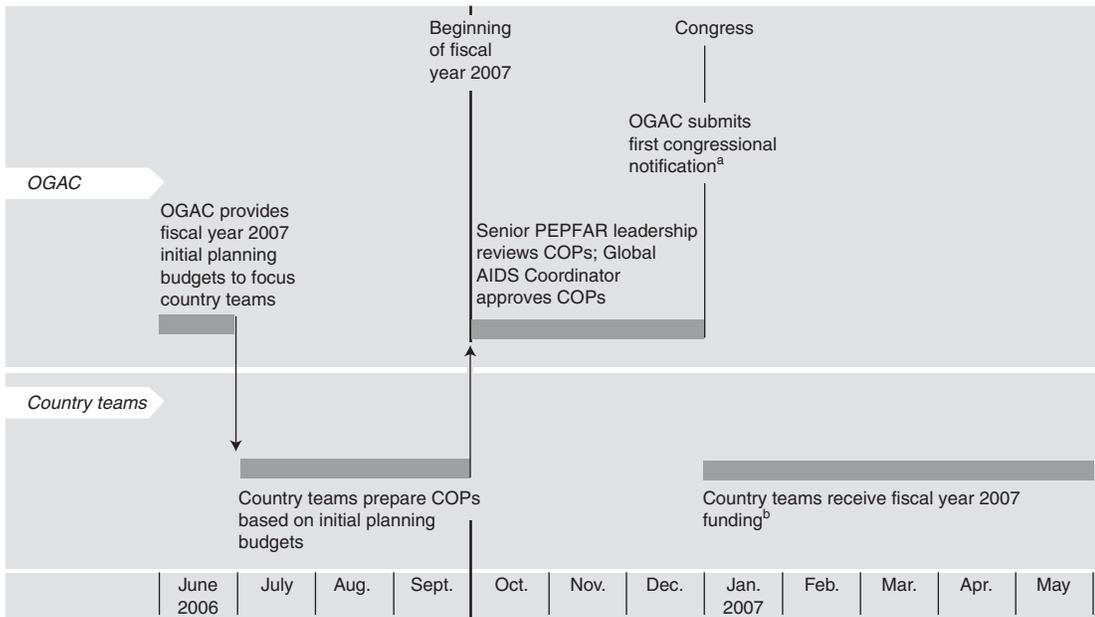
- OGAC provides a series of notifications to Congress of the activities and budget functions it plans to implement under PEPFAR in the current fiscal year. For fiscal year 2007, OGAC submitted four congressional notifications, beginning in December 2006.
- Funds are eventually released to the PEPFAR implementing agencies and country teams, which then allocate their funding to implementing partners according to their COP strategies. The process for transferring and obligating funds and the time required to complete this process vary by agency, but all implementing agencies are instructed to obligate their funds within the current fiscal year, with a few exceptions.<sup>26</sup>
- During each annual budget cycle, OGAC reassesses each country team's opportunities and challenges and review its progress in the previous year. Based on this assessment, PEPFAR's interagency headquarters leadership provides a new annual allocation for each country team.

Country teams received fiscal year 2007 funding from January to May 2007. Figure 5 shows the timeline for PEPFAR's planning and allocation process for fiscal year 2007.

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<sup>26</sup>All unobligated funds undergo a carryover approval process during the first quarter of the following fiscal year.

**Figure 5: Timeline of PEPFAR’s Planning and Allocation Process**



COPs Country Operational Plans  
 OGAC Office of the U.S. Global AIDS Coordinator  
 Source: GAO analysis of OGAC data.

<sup>a</sup>OGAC submitted four congressional notifications for fiscal year 2007.

<sup>b</sup>The process for transferring and obligating funds and the time required to complete this process vary by agency. The timeline depicts the general time frame during which country teams received USAID and CDC funds for fiscal year 2007.

The development of country teams’ COPs includes three elements: setting targets, selecting interventions, and considering costs.

- **Setting targets.** OGAC set initial 5-year country-level targets for prevention, treatment, and care for each focus country that, when summed across countries, total PEPFAR’s global targets.<sup>27</sup> To achieve these 5-year

<sup>27</sup>According to OGAC, the global targets were developed from the 5-year country-level targets. OGAC identified 50 percent of the need for prevention, treatment, and care in each country and used those figures to set the 5-year country-level targets. These targets were then added together across countries to produce the global targets. OGAC set the 5-year country-level targets in 2004, and the targets are fixed. The 5-year country-level targets include the accomplishments of PEPFAR’s own programs, as well as the results of host governments’ and other donors’ programs that receive U.S. government support. Country teams are to achieve the 5-year country-level care and treatment targets by September 30, 2009; they are to meet the prevention target by September 30, 2010.

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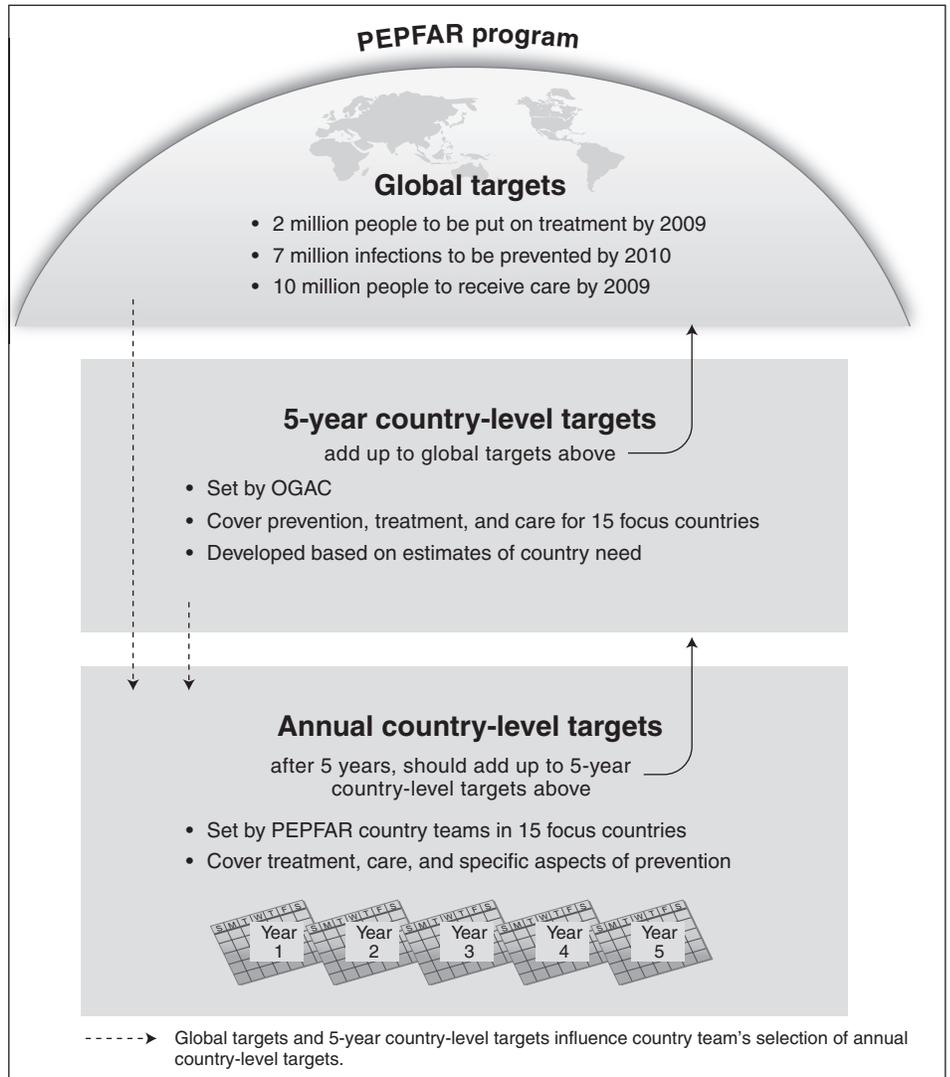
country-level targets, each country team sets annual targets for prevention, treatment, and care.<sup>28</sup> (See fig. 6.) For instance, each team sets annual targets for the number of individuals to receive HIV-related palliative care and the number of orphans and vulnerable children to be assisted that over 5 years should strive to achieve or exceed OGAC's 5-year country-level target for care. OGAC guidance urges country teams to do everything possible to meet the 5-year country-level targets.<sup>29</sup> Although OGAC does not require that country teams' annual targets sum to the 5-year targets, it considers PEPFAR's global targets to be "hard" targets that it is committed to achieving.

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<sup>28</sup> Owing to the difficulty in estimating the number of infections prevented, country teams are not required to provide annual country-level targets for infections averted. Country teams set annual country-level prevention targets only for PMTCT activities, such as providing HIV counseling and testing to pregnant women. Thus, for prevention, country teams' annual country-level targets are not intended to sum to the 5-year country-level targets.

<sup>29</sup> OGAC guidance states that if the 5-year country-level targets are unrealistic, annual targets should not be set to show that the 5-year targets will be met.

**Figure 6: Relationship between PEPFAR Global Targets, 5-Year Country-Level Targets, and Annual Country-Level Targets**



Sources: GAO analysis of PEPFAR data; Map Resources (map); and Nova Development (clip art).

- **Selecting interventions.** Each country team selects interventions to meet its annual targets, within the constraints of the spending directives and the context of the country's epidemic. OGAC provides guidance to country teams on selecting interventions. For example, OGAC guidance addresses developing and implementing prevention programs that use the ABC approach.

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- **Considering costs.** Each country team estimates costs when setting targets, selecting interventions, and developing budgets. Country teams obtain as-needed technical assistance for conducting cost analyses from PEPFAR implementing agencies. OGAC bases its country-level allocations in part on the proposed budgets in country teams' annual COPs and each country's efficiency in achieving its targets.

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## IOM's 2007 Recommendations

In its report,<sup>30</sup> the IOM Committee for the Evaluation of PEPFAR Implementation concluded that, although the spending directives may have been initially helpful in ensuring that PEPFAR had a balance of activities for prevention, treatment, care, and orphans and vulnerable children, they have limited PEPFAR's ability to tailor its programs to the specific epidemic in each country. The committee recommended that Congress remove the spending directives and replace them with more appropriate mechanisms to ensure that PEPFAR country teams are held accountable to OGAC and Congress for achieving results and that spending is linked directly to overall and country-level PEPFAR targets.

The report made several other recommendations. For instance, it called for PEPFAR to emphasize long-term strategic planning and capacity building to help build a sustainable response to the HIV/AIDS epidemic. The report also recommended that PEPFAR work to accumulate better data to determine the most appropriate prevention interventions for each country, empower women and girls by focusing on the factors that put them at greater risk for HIV/AIDS, and build workforce capacity by increasing support for educating new health care workers.

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## Experts Generally Called for a More Country-Based Approach to Allocating PEPFAR Funds

Although more than half of the 22 experts we interviewed acknowledged benefits of PEPFAR's overall prevention spending directive, the same number of experts expressed concern about the AB directive's effect on country-based and evidence-based programming. Many of the experts stated that the prevention and treatment directives have, respectively, protected funding for prevention and helped expand access to HIV/AIDS treatment. However, 13 of 22 experts expressed concern that the AB directive has posed obstacles to country-based programming, and 13 experts said it has hindered development of integrated prevention programs. In general, the experts advocated replacing the current

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<sup>30</sup>The IOM report is available at <http://www.iom.edu/CMS/3783/24770/41804.aspx>.

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allocation process with a more country-based approach for allocating PEPFAR funds.<sup>31</sup> In addition, several experts advocated a leadership role for OGAC in providing guidance and technical assistance.

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### Experts Acknowledged Some Positive Impact of Spending Directives for Prevention and Treatment

Consistent with the IOM 2007 study, experts we consulted generally agreed that PEPFAR has expanded HIV/AIDS prevention and treatment programs, supporting significant progress in combating the HIV/AIDS epidemic in the focus countries.<sup>32</sup> Many of the experts acknowledged that the prevention and treatment spending directives had a positive impact during PEPFAR's first 5 years.

- Thirteen experts noted benefits from the Leadership Act's directive to spend 20 percent of PEPFAR funding on prevention. In general, these experts said that the prevention directive ensured that PEPFAR continued to fund prevention in the face of an increasing focus on expanding access to treatment. For example, one commented that the prevention spending directive secured protection of prevention funding despite the call for a massive expansion of ARV treatment. Another expert observed that securing funding for prevention is extremely important because the AIDS epidemic will never be ended through treatment alone.
- Nine experts agreed that PEPFAR's directive to spend 55 percent of funding on HIV/AIDS treatment helped expand access to ARV treatment in the focus countries. This result is consistent with IOM's conclusion that a primary accomplishment of PEPFAR has been to demonstrate that treatment can be rapidly scaled up in resource-constrained environments. For example, one expert stated that the treatment directive's strength was in securing a large amount of money to expand ARV therapy although it was considered very expensive at the time. However, another expert, qualifying his support for the directive, said that during the first phase, PEPFAR was disproportionately skewed toward treatment and that, although the treatment directive may have been useful to initiate the massive scale up of ARV treatment, it should be reconsidered for the next 5-year period.

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<sup>31</sup>All results from our expert interviews come from our standardized structured instrument (see app. III).

<sup>32</sup>In this report, we narrowed our scope to include prevention and treatment and did not specifically ask the experts questions about care and orphans and children spending directives.

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## Experts Expressed Concerns about AB and ARV Directives and Called for a More Country-Based Approach to Allocations

A number of experts questioned the effect of the AB and ARV spending directives on country teams' ability to develop integrated, country-based programs. For example:

- Thirteen of 22 experts expressed concern that the AB directive posed obstacles to the development of country-based and evidence-based programming.<sup>33</sup> In addition, 13 experts explicitly stated that the AB directive hindered the development of integrated prevention programs that appropriately balanced abstinence-until-marriage prevention activities with other prevention activities.<sup>34</sup> Experts also noted that the AB directive inhibits the integration of prevention, treatment, and care programs.<sup>35</sup> In contrast, two experts highlighted the benefits of the directive, emphasizing the importance of programs promoting fidelity for sexually active adults in countries with generalized epidemics.
- Twelve experts stated that the ARV directive does not reflect the changing price of ARV drugs. For example, seven experts noted that the cost of ARV drugs has decreased over the past 5 years.<sup>36</sup>

Several experts observed that it is important to set targets and select interventions that reflect country-level data and to base funding allocations on the needs and costs in each country. For example, 9 experts suggested that it is important that PEPFAR targets be based on country-specific data, and 10 experts observed that such data are important for the selection of interventions. Other experts recommended determining funding levels based on the characteristics of each country's epidemic. In

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<sup>33</sup>Thirteen of the 22 experts stated that the AB directive posed obstacles to developing evidence-based programs, and 6 of the 13 stated that the directive negatively affected country-based programming. One of the 13 experts stated that AB programs are being implemented with no measure of effectiveness, and another noted that AB programs are too restrictive. Three of the 22 experts generally supported the spending directives. The remaining six experts did not comment on the directive's impact on evidence-based or country-based programming.

<sup>34</sup>Consistent with this argument, in April 2006, we reported that 8 of 15 PEPFAR country teams indicated that segregating AB from "other prevention" funding compromised the integration of their prevention efforts. See [GAO-06-395](#), p. 35.

<sup>35</sup>Five of six host country officials whom we interviewed also noted that the AB directive does not reflect their country-level needs and conditions.

<sup>36</sup>First-line drugs are initial ARV regimens. In some cases, patients are switched to more expensive regimens because of occurrence of side effects and/or drug resistance.

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addition, several experts noted that to set appropriate targets, OGAC and country teams need to know the costs of interventions in each country.

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### Experts Advocated That OGAC Provide Guidance and Technical Assistance

A number of the experts we interviewed said that OGAC should provide guidance and technical assistance to country teams during the next phase of PEPFAR.<sup>37</sup>

- Six experts stated that OGAC should provide guidance to country teams. Of these six, one expert pointed out that OGAC should provide guidance that lays out how PEPFAR country teams need to communicate with host country authorities. Another of these experts noted that currently OGAC provides limited guidance on how country teams should conduct outcome evaluations to determine whether programs are having an impact or how they can be more effective. This expert also suggested that it would be useful if OGAC provided more information to country teams about what is and is not working. According to one expert who did not support delegating key decisions to the country teams, in the absence of spending directives, OGAC should provide guidance for allocating funding for both generalized and concentrated epidemics.
- Four experts suggested that OGAC should provide technical assistance to the country teams. For example, according to one of these experts, a key role for OGAC would be to provide advice on the effectiveness of given interventions.

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### Alternative Approach to Allocating Funding Could Strengthen Country-Based Programming

A more country-based approach to the current process of allocating PEPFAR funds could strengthen country teams' ability to develop programs that respond to local needs. Building on the IOM recommendation to eliminate the spending directives, the proposed alternative approach includes changes to three basic elements of the current allocation process—setting targets, selecting interventions, and considering cost—but gives country teams greater responsibility for planning their country's PEPFAR programs, subject to OGAC's continued review (see fig. 7). Under the proposed approach, country teams would propose targets, including annual and multiyear targets, that respond primarily to the country's conditions; OGAC would work with the country teams collaboratively and iteratively to ensure that the proposed targets

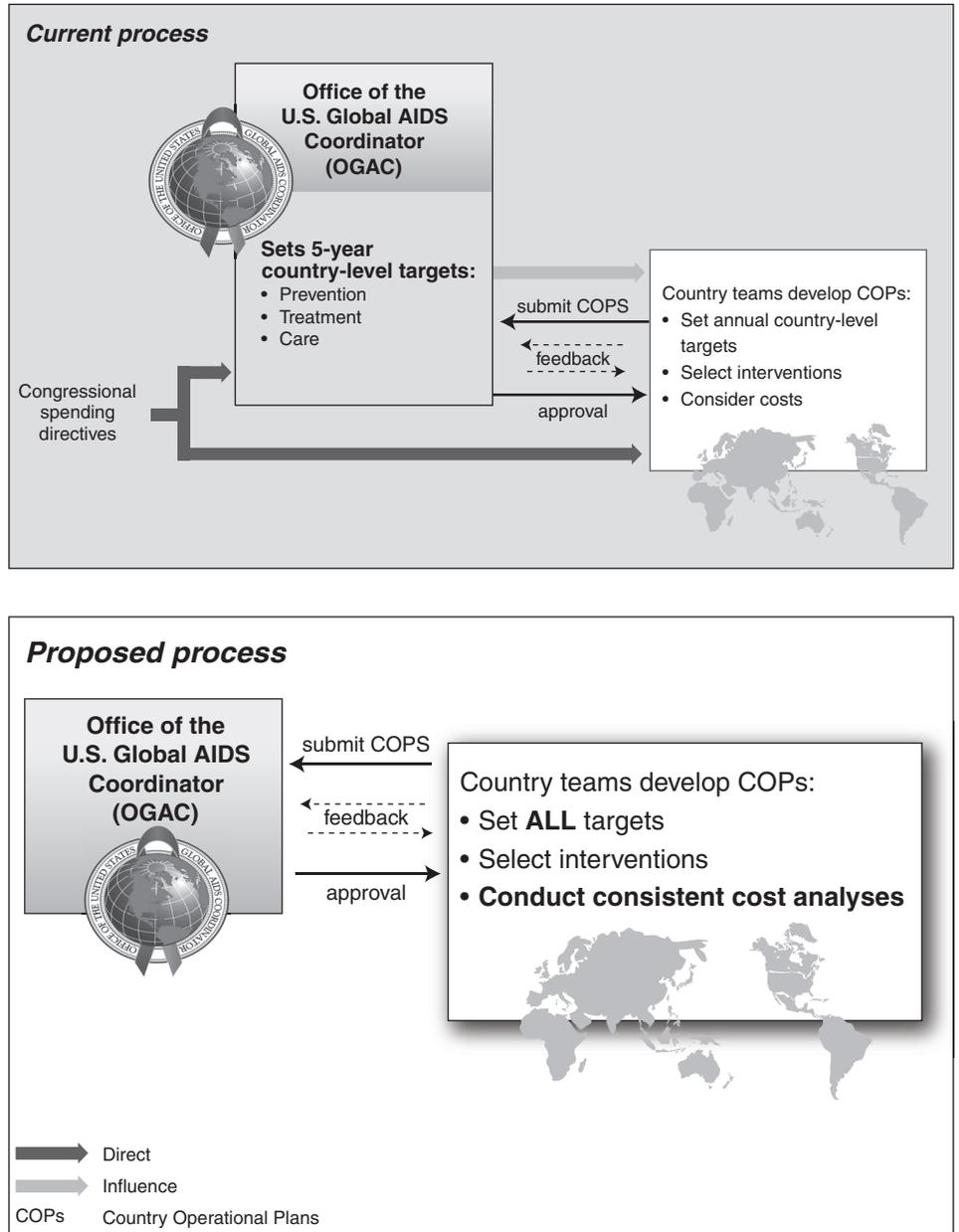
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<sup>37</sup>Although our structured interview did not include a question regarding OGAC's role, some experts chose to comment on this topic.

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are aimed at meeting the global PEPFAR targets. The country teams would also select interventions to meet their proposed targets, unconstrained by the spending directives, subject to OGAC's review and with OGAC's guidance and technical assistance. In addition, the teams would consider country-level cost information according to a consistent, OGAC-defined methodology; currently, countries use costs in varying ways, with OGAC providing as-needed technical assistance but no formal guidance. OGAC would retain its leadership role under the alternative approach, including reviewing and approving COPS and monitoring country teams' progress toward global targets.

**Figure 7: Current Allocation Process Compared with Alternative Approach to Allocating PEPFAR Funds**



Sources: GAO analysis of OGAC data; GAO analysis.

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## Country Teams Would Propose Country-Level Targets to Reflect Country Conditions and Data, Subject to OGAC Review

Under the proposed approach, country teams would draw on local epidemiological information and cost data to propose targets, which could include annual and multiyear targets, that respond primarily to the country's conditions. OGAC would review the countries' proposed targets and, in a collaborative, iterative process, work with the countries to modify the proposed targets to reflect both PEPFAR's global targets and changing local conditions, such as trends in HIV/AIDS infection rates among vulnerable populations. According to an OGAC official, in the absence of OGAC's 5-year country-level targets, OGAC would determine whether country teams' proposed country-level targets are on track to meet the global targets.

- Twenty-eight of 38 country team officials responding to our first survey reported that allowing country teams to propose all targets would have a very positive or positive effect on prevention programs. Similarly, 23 of the 38 responding country team officials reported that allowing country teams to propose all targets would have a very positive or positive effect on treatment programs.
- When asked to provide information on the effect of allowing teams to propose all country-level targets, nine country team officials said that this would make their programs responsive to local needs and conditions. In addition, six officials reported that proposing country level targets would enhance country teams' ability to consider country-specific information and team knowledge.

Under the current approach, country teams' target setting reflects the combined influence of OGAC's 5-year country-level targets and country-level information, according to country team officials we surveyed.

- Most country team officials reported that OGAC's 5-year country-level targets greatly affect their process for setting annual country-level targets. Thirty-two of 38 survey respondents indicated that the 5-year country-level targets were extremely or very important in their process of setting annual country-level targets, and several country team officials reported challenges related to the 5-year country-level targets. For example, one noted that the targets set by OGAC did not correspond with the host country government's own goals. Another respondent stated that OGAC's 5-year country-level targets for care did not appropriately address orphans and vulnerable children or home-based care.
- Most country team officials reported that other sources of information were also influential in their process of setting annual country-level targets. For example, 27 of 38 survey respondents indicated that

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information from the host country's national strategy and targets was extremely or very important, while 32 of 38 respondents reported that the PEPFAR country team's own analysis of country data was extremely or very important to setting annual targets.

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### Alternative Approach Would Allow Country Teams to Select Interventions without Constraints of Spending Directives

Under the alternative approach, the country teams would select interventions based on country-level epidemiological and other evidence, without the constraint of the spending directives. OGAC would continue to review the selected interventions as part of the COP process and would provide guidance and technical assistance on proposed interventions.

Under the current approach, country team officials we surveyed reported that three factors—the Leadership Act's spending directives, country-specific information, and input from other partners—influence their selection of interventions. About half said that the spending directives constrained the selection process. A number of country team officials also noted that guidance provided by OGAC influenced their selection of interventions.

- Country team officials generally said that they considered data on effectiveness of interventions and past program performance as well as country-level information as major factors in their selection of interventions. For example, 37 of 38 respondents indicated that the effectiveness of interventions is an extremely or very important factor in their determination of which interventions to use. Also, 35 of 38 country team officials reported that information about the past performance of ongoing programs is extremely or very important in determining which interventions to implement. In addition, almost all country team officials reported that they considered the following to be extremely or very important when selecting interventions: country capacity, country-level epidemiological data, cultural acceptability, and professional and technical expertise of in-country PEPFAR staff.
- About half of the country team officials reported that the current spending directives constrained their selection of interventions. In response to our follow-up survey, 15 of 32 officials reported that the spending directives presented challenges to selecting interventions, with most respondents focusing on challenges posed by the prevention directives. For example, one respondent stated that the national universal access treatment target

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had not been met because the country team had to follow the spending directives.<sup>38</sup>

- Most country team officials reported collaborating with implementing partners, host country representatives, and major donor representatives in selecting interventions. Respondents most frequently characterized implementing partners as being heavily involved in determining which interventions to carry out: 35 of 38 respondents reported that implementing partners were extremely or very involved in selecting interventions. In addition, 34 of 38 respondents noted that host country technical working groups—groups organized by the host country government that are usually comprised of representatives from major donors as well as host government officials—were extremely or very important. In addition, 26 of 36 officials who responded to a question about country officials’ participation in the selection of interventions reported that host country authorities were extremely or very involved in this process.
- A majority of country team officials (23 of 38) reported that formal guidance provided by OGAC influenced their selection of interventions.

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## Country Teams Would Consider Costs Using OGAC-defined Methodology

Under the alternative approach, each country team would analyze, in a manner consistent across all teams, country-level cost data to determine the funding needed for the interventions they select. In doing so, the country teams would use a consistent methodology defined by OGAC. In contrast, under the current approach, although most country teams reported using cost data in planning and budgeting, the teams reported using varying methodologies to identify and analyze this data. Although OGAC provides the country teams as-needed assistance and guidance in using cost data for budgeting and planning, it has not provided formal guidance or established a consistent methodology for conducting cost analyses, in accordance with federal accounting standards.

Almost all country team officials who responded to our survey reported using cost information in their planning and budgeting. Specifically, 35 of 38 respondents said that they use cost information when planning and

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<sup>38</sup>The results in this subsection were based on responses to three open-ended questions related to selecting interventions for prevention, treatment, and care: “What challenges, if any, have you encountered while selecting interventions to meet country-level targets for prevention/treatment/care?”

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budgeting PEPFAR programs, with about half of this group using the information to a great or very great extent and the other half using it to a moderate extent or to some extent.<sup>39</sup> However, country team officials reported using varying methods to identify and analyze cost information to plan and budget PEPFAR programs. Some respondents reported calculating cost per unit for interventions or services, while others stated that they compare costs across implementing partners. For instance, 11 of 32 respondents said that they use information about the actual unit cost of specific interventions to a great or very great extent when planning and budgeting. Other reported methods for identifying and analyzing cost information include using cost data to discuss cost-effectiveness and to identify and complement other funding sources.

- An official from one country team explained its attempts to estimate cost per intervention. The official provided an example related to a care intervention, noting that the country team first determines the level of funding available for care interventions and then identifies the most effective interventions for care—in this case, co-trimoxazole, an antibiotic that can be used to treat most of the opportunistic infections associated with HIV/AIDS—and the number of beneficiaries it hopes to serve. The country team then determines the cost of an average dose of the drug by using information from implementing partners, interagency technical working groups, and supply chain partners. Finally, the team calculates the cost of providing the drug to the identified beneficiaries.
- Officials from another country team reported that the country team calculates rough costs for each implementing partner. For example, to estimate the cost per patient treated, the officials reported that they divide each partner's proposed budget by the number of patients the partner planned to treat with ARVs. The country team then compares the cost per patient across implementing partners to identify partners whose costs are much higher or lower than average. The country team then holds discussions with those implementing partners to determine the reasons for the variation.
- Five country team officials also reported using cost information in other ways. For instance, in response to an open-ended question, 3 of 35

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<sup>39</sup>To obtain cost-related information, officials reported drawing on a wide variety of sources, including implementing partners, their own PEPFAR country team, and their own U.S. government agency. Overall, most officials found these sources to be useful—for example, 29 out of 37 officials found information from implementing partners to be very useful.

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respondents reported that they use cost data in discussions about cost-effectiveness of implementing partners or new interventions. Two of 35 respondents said they use cost information to help them identify and complement other funding sources, such as the host country government or other donors.<sup>40</sup> For example, one of these respondents noted that cost information is used to help the country team determine how to complement other funding sources, such as the Global Fund and the Clinton Foundation, for interventions such as ARVs.

Although OGAC bases its country-level allocations in part on the proposed budgets in country teams' annual COPs, OGAC has not provided the teams formal guidance on identifying and analyzing cost information, nor has OGAC developed a methodology that the teams could apply to identify and use cost information. Federal financial accounting standards state that agencies should use consistent costing methodologies in their planning to determine the full cost of resources that contribute to the production of outputs in order to provide reliable and timely information to federal managers and Congress.<sup>41</sup> In 2006, OGAC conducted a high-level exercise to determine the cost of averting an infection, using several cost models that examine prevention program cost effectiveness.<sup>42</sup> According to an OGAC official, although several country teams have used these models to plan their own prevention programs, other teams found that the model was too high level and not country specific enough to be useful. Instead of providing formal guidance, OGAC offers country teams assistance and guidance on an as-needed basis. For example, OGAC officials noted that staff from OGAC's Strategic Information unit provide informal technical

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<sup>40</sup>The open-ended question was: "How do you use information on the costs to PEPFAR of specific interventions in your planning and budgeting process?"

<sup>41</sup>Federal standards further state that reliable information on the costs of federal programs and activities is crucial for effective management of government operations. This information should be used by program managers to improve operating economy and efficiency. In addition, this information can be used by Congress and federal executives in making decisions about allocating federal resources, authorizing and modifying programs, and evaluating program performance. See Statement of Federal Financial Accounting Standards No. 4, *Managerial Cost Accounting Standards and Concepts* (Washington, D.C.: 2007).

<sup>42</sup>One such model used by OGAC in this exercise was the Futures Group's GOALS model, which enhances planning by linking program goals and resource allocation levels.

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assistance to country teams on performing cost analyses.<sup>43</sup> In addition, from time to time OGAC distributes studies on the costs of interventions to the country teams to assist them in planning and budgeting their programs. Several PEPFAR country team officials indicated the need for guidance from OGAC on how or to what extent they should conduct cost analysis in planning or budgeting programs. These country team officials noted that it would be useful to receive more detailed guidance on (1) how much to spend on specific aspects of programs, such as human resources; (2) what methodology to use to determine and analyze costs; (3) the best methods to obtain cost-related data; and (4) how to conduct costing studies.

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### OGAC Would Retain Leadership Role in Allocation Process

Under the alternative approach to allocating PEPFAR funds, OGAC would maintain its current leadership role. For example, in addition to collaborating with the country teams in setting targets, selecting interventions, and considering costs, OGAC would

- provide initial budgets to the country teams to facilitate the planning and development of COPs,
- review and approve the COPs,
- monitor and report on funds allocated to assure that programs are balanced and integrated, and
- monitor progress toward targets.

To assure country teams' accountability for results, OGAC would continue to review country teams' annual progress reports and gather and analyze strategic information to monitor and evaluate PEPFAR programs.

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<sup>43</sup>The Strategic Information staff at OGAC, among other things, measure progress toward the global targets; support international agencies and host country government for program management and reporting systems; and use surveillance, survey, and program data to help improve programs' design and focus.

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## Most Country Team Officials Found Alternative Approach Feasible but Identified Potential Challenges

Most PEPFAR country team officials whom we surveyed reported that the proposed alternative approach to allocating PEPFAR funds would be feasible.<sup>44</sup> However, some officials identified several key challenges that they might face in implementing the approach. With regard to proposing all country-level targets, most officials said that country teams could easily do so, although some county team officials identified reaching consensus on targets, both internally and with external participants, as potential challenges. With regard to selecting interventions, officials noted a range of challenges—such as measurement and evaluation difficulties, limited data, and lack of host country capacity—that they currently face and which, according to our analysis, they would likely encounter under the alternative approach.<sup>45</sup> With regard to using cost-related data, many officials cited a lack of complete and appropriate data and wide variations in costs as current obstacles that are also likely to continue under the alternative approach.

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## Proposing Targets Would Be Feasible, but Reaching Consensus Could Be a Challenge for Some Country Teams

Most of the PEPFAR country team officials we surveyed stated that proposing all country-level targets would not be difficult, although some officials cited potential challenges. Twenty-nine of the 32 country team officials who responded to our follow-up survey said it would be easy or very easy for country teams to propose all country-level targets, which could include multiyear targets; 3 said it would be difficult to do so.<sup>46</sup> When asked to explain their response, 10 of 23 who predicted an easy or very easy process mentioned country team experience as a key reason.<sup>47</sup>

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<sup>44</sup>Survey questions, results, and number of respondents per question are presented in an electronic supplement to this report, which may be accessed at our e-supplement ([GAO-08-534SP](#)). Survey percentages reported do not include nonresponses to each question in our survey.

<sup>45</sup>While we did not specifically ask about the feasibility of selecting interventions under the new approach, the main challenges cited by respondents to selecting interventions were related to the constraints posed by the directives.

<sup>46</sup>Three CDC officials predicted that it would be difficult for country teams to set all country-level targets because it would require host country involvement and prioritization by country teams, the targets set by host country governments are problematic, and some targets are hard to quantify. Each of these responses was selected by one official, with some officials selecting more than one response. No respondent said that it would be very difficult for country teams to propose all country-level targets.

<sup>47</sup>Country team officials were asked to provide an open-ended response to the close-ended question “Why would it be easy or difficult (to set all targets at the country level)?” We do not know, therefore, how many of the remaining respondents would have had similar or different views on the issue of data availability.

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Twelve of these 23 officials also noted the existence of good data, including epidemiological data, data on partner contributions, and direct feedback from providers and consumers, as a key reason that proposing targets would be easy or very easy. In addition, 11 of these 23 officials reported that they currently work closely with their implementing partners and host country government to develop annual country-level targets. These country team officials cited, among other things, strong collaboration mechanisms such as joint working groups and good access to government decision-makers.

When asked to identify potential challenges related to proposing all targets, some country team officials said that reaching external and internal consensus about the targets could be difficult.<sup>48</sup>

- **Reaching external consensus.** About a third of 36 officials who responded to a question in our original survey about developing targets identified reaching external consensus on country-level targets with the host country government, implementing partners, or both, as a potential challenge. For example, one official stated that the process of reaching consensus with the national authorities regarding program priorities might be more challenging without the requirements imposed by OGAC. Another official in this group suggested that the host country government might in some cases push for its own health priorities such as investment in infrastructure. In contrast, all six host country officials we interviewed praised the strong collaboration between their governments and PEPFAR country teams and stated that it would not be difficult to reach agreement with country teams on country-level targets.
- **Reaching internal consensus.** Some country team officials also reported that it could be difficult for the country team to reach internal consensus regarding the level of the targets. Specifically, 10 of 36 officials who responded to a question in our original survey about developing targets noted that reaching consensus within the country team might be a challenge if the country teams were to propose all country-level targets. For example, one official cited different levels of technical expertise and understanding within the country team might make it difficult to reach consensus. Another official expressed concern that agencies would want to focus on targets in their particular area of expertise. However, two

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<sup>48</sup>The open-ended question asked was: "What would be the potential challenges in your country if all PEPFAR country-level targets were set by the country team rather than by OGAC?"

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officials also noted that the process of shared analysis and planning involved in developing consensus with both external partners and within the country team could strengthen both interagency relations and the program itself. Another official acknowledged that such negotiations are a difficult but necessary part of the planning process.

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### Some Current Challenges Could Continue to Affect Selection of Interventions

Challenges that country team officials associated with their current process for selecting interventions included measurement and evaluation difficulties, limited data, and lack of country capacity.<sup>49</sup> According to our analysis, these challenges would likely continue under the alternative approach.

- **Measurement and evaluation difficulties.** A number of country team officials cited concerns related to considering interventions' effectiveness. Thirty-seven of the 38 officials who responded to a question in our original survey about selecting interventions indicated that interventions' effectiveness is an extremely or very important consideration. However, 9 of 31 officials who responded to a question in our follow-up survey on selecting interventions noted that they had encountered challenges related to measurement and evaluation when selecting interventions to meet country-level targets for prevention, and one official reported such challenges when attempting to select interventions to meet country-level care targets. For example, several officials observed that it was difficult to measure the actual outcomes of prevention interventions, such as mass media activities. Another official cited the difficulties associated with measuring the success of a program designed to increase the likelihood of a nonevent such as preventing an infection. These difficulties in measuring the impact of interventions can make it harder for country teams to select interventions, because the links between the interventions and their ultimate effects may not be clear.
- **Limited data.** Six of 31 officials who responded to a question in our follow-up survey about selecting interventions indicated that limited data on areas such as epidemiology and demography have challenged their ability to select interventions to meet PEPFAR's targets for prevention, treatment, and care. For example, one official noted that because data on the demography of high-risk groups are inadequate for designing prevention interventions to reach these groups, the country team instead

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<sup>49</sup>We asked three open-ended questions related to selecting interventions for prevention, treatment, and care: "What challenges, if any, have you encountered while selecting interventions to meet country-level targets for prevention/treatment/care?"

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selects interventions that reach the general population. As a result, according to the official, the interventions are weak and unfocused.

- **Lack of country capacity.** Six of 31 country team officials who responded to a question in our follow-up survey about selecting interventions stated that a lack of human resources and infrastructure and weak absorptive capacity in their host country challenged their selection of interventions to meet PEPFAR targets. These shortfalls in country capacity make it more difficult for these country teams to select interventions that are likely to be effective. For example, one official mentioned that the lack of available human resources at the institutional and community levels made it difficult to track adherence to treatment. Another official noted that although home care needs continued to increase, fulfilling these needs is difficult owing to the “massive exodus” of trained physicians and nurses.

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### Considering Costs Would Be Feasible, but Data Problems Could Pose Challenges

Twenty-three of 32 country team officials who responded to a question in our follow-up survey about considering costs said it would not be difficult for country teams to use information on the cost of specific interventions as part of their planning and budgeting.<sup>50</sup> However, country team officials noted several challenges—including data gaps and wide variations in cost—that have made obtaining accurate data difficult.<sup>51</sup> According to our analysis, these challenges would continue if the alternative approach were implemented.

- **Data gaps.** Country team officials noted a lack of country-specific data as an obstacle to using cost data in planning and budgeting.<sup>52</sup> For example, in a follow-up interview, an official from one country team stated that she did not know what the costs for treatment and care services should be in her host country, owing in part to the lack of any HIV/AIDS-related cost study by the host country government. An official from another country team

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<sup>50</sup>Country team officials were asked, “How easy or difficult would it be for country teams to use information on the costs of specific interventions as part of their planning and budgeting?”

<sup>51</sup>Other challenges that officials frequently cited as extremely or very significant included concerns about data reliability (28 of 37 respondents) and data not being available (26 of 36 respondents). Respondents were asked to select from a list of potential challenges; figures indicate the total number of respondents who responded to each individual challenge.

<sup>52</sup>This challenge was cited as extremely or very significant by 21 out of 37 survey respondents who responded to a closed-ended question on the extent to which a lack of country-specific data posed a challenge to obtaining using cost information.

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cited the lack of country-specific cost data and reported that her country team had to look outside the host country for data on the costs of using a certain drug to treat opportunistic infections. In addition, 11 of 16 officials who reported using cost information to a great or very great extent in their planning and budgeting cited the challenge of data not covering all populations within the host country as significant or very significant.<sup>53</sup>

- **Cost variations.** Country officials also cited varying costs as an obstacle to using cost information in their planning and budgeting. In response to an open-ended question,<sup>54</sup> 10 of 38 country team officials who responded to a question in our original survey about considering costs noted that varying costs for programs, interventions, and persons served limited their ability to use cost data for planning PEPFAR programs. For example, one official observed that costs could vary depending on geographical differences. Another noted that costs of interventions can vary depending on whether an intervention is being implemented in a rural or an urban area or in a clinic or community setting.

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## Conclusions

PEPFAR's contribution to expanding access to antiretroviral treatment and expanding prevention and care programs during its first 5-year phase has been widely recognized. Over the next 5 years, the U.S. bilateral contribution will likely remain the largest single source of funding to combat the global HIV/AIDS pandemic. Absent the current directives for allocating U.S. funds, a country-based approach, such as the alternative approach we describe, would increase the use of local evidence and country priorities and conditions in planning and implementing programs. This could enhance country teams' ability to address local needs and enable OGAC and country teams to meet the IOM criteria of assuring accountability for results and linking funding to achieving targets.

Shifting some planning responsibilities from OGAC to country teams would support the more country-based approach suggested by the HIV/AIDS experts we consulted, while preserving OGAC's key leadership role. Country team officials generally found such an approach to be feasible, but some also identified continuing challenges, including

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<sup>53</sup>In contrast, among the 18 officials who used costing information to a moderate or some extent, only 5 individuals found the lack of data covering all populations within the host country to be a significant or very significant challenge.

<sup>54</sup>These additional challenges resulted from an open-ended follow-up to our close-ended question on challenges asking for any other challenges officials have experienced.

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reaching consensus and obtaining data on the cost of interventions in each country. Under both the current and the proposed approach, cost analysis is of key importance to planning and to ensuring accountability at the country level. Lacking formal guidance, country teams have relied on ad hoc approaches to obtain and analyze cost information and reported varying uses of cost analysis in budgeting and planning. Until OGAC develops clear guidance on how to identify and use cost information in planning and budgeting, country teams will likely remain unable to provide consistent or accurate cost estimates to OGAC. The lack of reliable data cited by country team officials also limits their ability to develop accurate cost estimates. As a result, OGAC may be limited in its ability to ensure accountable use of resources, and OGAC managers and Congress may lack full and accurate cost information when making decisions about resource allocation.

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## Matter for Congressional Consideration

If Congress decides to remove the spending directives as IOM recommended, we suggest that Congress encourage OGAC to adopt a more country-based and evidence-based approach to allocating funding, with OGAC providing overall leadership and guidance for setting country-specific targets, selecting interventions, and considering costs, as discussed in this report.

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## Recommendation for Executive Action

To help ensure that PEPFAR country teams are better able to provide consistent and accurate cost estimates to OGAC, we recommend that the Secretary of State direct OGAC to provide appropriate guidance to PEPFAR country teams for identifying and using cost-related information in planning and budgeting PEPFAR programs.

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## Agency Comments and Our Evaluation

OGAC provided written comments about a draft of this report, which we have reprinted in appendix IV. OGAC also provided technical comments separately, which we have incorporated as appropriate. OGAC agreed with our recommendation to help provide consistent and accurate cost estimates to the field by strengthening guidance for identifying and using cost information for planning and budgeting.

In its written comments, OGAC emphasized that PEPFAR policies and procedures are intended to ensure country ownership consistent with applicable law. Our report's central finding—based on the observations of noted HIV/AIDS experts—that a more country-based approach could improve allocation of funds does not suggest that country-teams play no

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role in PEPFAR programming. For example, our report describes country team involvement in developing country operational plans and the role of these teams in selecting interventions within the constraints of the spending directives. However, consistent with the Institute of Medicine's 2007 report and our 2006 report, a number of experts we interviewed observed that the congressional spending directives and targets set by OGAC have constrained country-level programming, particularly as a result of country teams' efforts to comply with the AB spending directive.

OGAC's written comments suggested that our report demonstrated some misunderstanding about PEPFAR operations and that several aspects of the proposed alternative approach have been part of PEPFAR from its start. As our report states, the proposed approach includes changes to three basic elements of the current allocation process—setting targets, selecting interventions, and considering cost—but gives country teams greater responsibility for planning their country's PEPFAR's programs, subject to OGAC's continued review. In response to OGAC's comment, we added text to our report to clarify that OGAC's annual budget process includes a reassessment of each country team's opportunities and challenges and a review of its progress in the previous year, which guide new funding allocations for the recipient countries. (See page 16.) OGAC's technical comments did not challenge our overall description of its processes, and we addressed these technical comments with changes to the background section of our report.

OGAC also challenged our presentation of experts' concerns regarding the impact of the AB spending directive. In response, we added a footnote further detailing the experts' comments regarding the AB spending directive (see page 22). In the footnote, we note that 13 experts observed that the AB directive posed obstacles to developing evidence based programs and that 6 of these 13 stated that the directive negatively affected country-based programming. Additionally, 1 of the 13 experts stated that AB programs are being implemented with no measure of effectiveness, and another noted that AB programs are too restrictive. Three of the 22 experts generally supported the spending directives. The remaining 6 experts did not comment on the directive's impact on evidence-based or country-based programming.

OGAC further commented that our report does not address the potential consequences of eliminating the current statutory 10 percent allocation for programs serving orphans and vulnerable children (OVC). Because our work focused on the prevention and treatment spending directives, we did not specifically discuss the OVC spending directive with experts, host

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country officials, or PEPFAR officials. However, a number of those whom we interviewed noted that this directive helped protect programs for OVC. We recognize that Congress may view the OVC directive as necessary to protect this vulnerable group, although it may constrain a more country-based approach to allocating funds.

Finally, OGAC described some steps it takes to allow a country-based approach within applicable law, including new guidance for fiscal year 2008 that requires only countries with generalized epidemics (those with national prevalence rates exceeding one percent in the general population) to meet the AB spending directive; no AB justification is required for countries with only concentrated epidemics. OGAC also elaborated on three specific challenges and ongoing efforts to allocate PEPFAR funding using country-based and evidence-based approaches.

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Unless you release its contents earlier, we plan no further distribution of this report until 30 days after this date. At that time, we will send copies of this report to the Department of State, appropriate congressional committees, and other interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>. If you or your staff have any questions regarding this report, please contact me at (202) 512-3149 or [gootnickd@gao.gov](mailto:gootnickd@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made significant contributions to this report are listed in appendix V.



David Gootnick, Director  
International Affairs and Trade

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# Appendix I: Scope and Methodology

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In March 2007, the Institute of Medicine (IOM) recommended that Congress remove the current spending directives for the President's Emergency Plan for AIDS Relief (PEPFAR) and replace them with alternative mechanisms that ensure accountability and link spending to performance targets. However, the IOM did not specify the form that such mechanisms should take. At the request of Congress, we identified a potential approach that responded to the IOM's recommendation.

To obtain background information on PEPFAR's current approach to allocating funds under the Leadership Act's spending directives, we reviewed the 2003 Leadership Act; documentation from the Office of the U.S. Global AIDS Coordinator (OGAC), including the President's Emergency Plan for AIDS Relief FY08 Country Operational Plan (COP) Guidance and PEPFAR's Five-Year Global HIV/AIDS Strategy; and information from prior GAO reports.<sup>1</sup> We also reviewed information from OGAC's Country Operational Plan and Reporting System (COPRS), a central U.S. government data system developed to support the collection and analysis of data related to PEPFAR planning and reporting requirements. We conducted interviews with officials from OGAC and the U.S. Agency for International Development (USAID) in Washington, D.C., to obtain information about the current approach to funding allocation. In addition, we met with officials at the World Health Organization (WHO); Joint United Nations Programme on HIV/AIDS (UNAIDS); and the Global Fund to Fight AIDS, Tuberculosis, and Malaria in Geneva, Switzerland. To understand processes used by PEPFAR field staff, we examined data from two surveys that we conducted from October to November 2007 (see below for more information).

To determine HIV/AIDS experts' views of the Leadership Act's spending directives and identify their suggestions for an alternative approach to funding allocation, we conducted semi-structured interviews with 22 leading experts in the field of HIV/AIDS from June 2007 to January 2008.

Our structured interview tool included questions related to the current PEPFAR targets and spending requirements, and alternative approaches to

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<sup>1</sup>GAO, *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief*, [GAO-06-395](#) (Washington, D.C.: Apr. 4, 2006); *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief*, [GAO-06-1089T](#) (Washington, D.C.: Sept. 6, 2006).

allocating funding.<sup>2</sup> To develop questions to use in our semi-structured interviews, we reviewed IOM's report, *PEPFAR Implementation: Progress and Promise*. We also reviewed prior GAO work on PEPFAR.<sup>3</sup>

We identified and selected experts to interview by using a nonprobability selection methodology.<sup>4</sup> First, to determine a population of experts, we started with a small group of core experts selected from those that participated in the IOM's evaluation of PEPFAR, and we asked these experts for suggestions of other experts to interview. Most of the experts we selected to interview were suggested by more than one other expert; in some cases, we included experts not suggested by more than one expert to obtain coverage across all of our selection criteria. We selected experts to interview based on numerous criteria, such as (1) educational background in medicine, public health, or both; (2) professional experience in working with HIV/AIDS organizations; and (3) leadership experience in addressing HIV/AIDS issues. With a few exceptions, all of the experts we selected fulfilled these three criteria. In addition, our selection criteria helped ensure that we obtained a wide range of viewpoints, including those supported by the faith-based community.<sup>5</sup> We also selected experts who possessed expertise in prevention, treatment, and both prevention and treatment.<sup>6</sup> We interviewed 22 HIV/AIDS experts in 17 interviews. (For a list of experts interviewed, see appendix II.) In addition to interviewing the experts who participated in our semi-structured interviews, we also held general discussions about PEPFAR with four other experts from UNAIDS, WHO, OGAC, and Harvard Medical School and School of Public Health. These experts are also listed in appendix II.

To summarize experts' responses to our semi-structured interviews and develop categories for our analysis, we conducted a comprehensive

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<sup>2</sup>See appendix III for our structured interview questions.

<sup>3</sup>See [GAO-06-395](#) and [GAO-06-1089T](#).

<sup>4</sup>Because we used a nonprobability selection methodology, our overall list of potential interviewees is not a complete list of all HIV/AIDS experts or all experts on PEPFAR. Our findings cannot be generalized to all HIV/AIDS experts or all individuals with expertise on PEPFAR.

<sup>5</sup>We modified our selection criteria to include experts supported by the faith-based community in response to congressional interest. We determined that including these criteria was appropriate for our design and objectives.

<sup>6</sup>Given our limited scope and time frames, we chose to select experts with experience in prevention and/or treatment.

content analysis of all responses. We first grouped open-ended qualitative interview responses into a set of overarching issue areas, separating comments related to the Leadership Act's current spending directives and those related to an alternative approach to PEPFAR funding allocation. To categorize and summarize these responses, we performed a systematic content analysis of each set of the open-ended responses. Three GAO analysts and two methodologists reviewed the responses and independently proposed categories; to ensure the validity and reliability of our analysis, they met and reconciled any differences. A similar process was used to create subcategories. An analyst placed each of the experts' responses into one or more resulting categories, a second analyst reviewed the placement, and a methodologist reviewed the entire analysis and resolved any disagreements about the placement of text into categories. After coding the experts' suggestions on an alternative approach to allocating PEPFAR funding, we determined that the experts' suggestions generally fell into three areas. Based on our analysis of these three areas, we outlined an alternative approach that provides PEPFAR country teams greater authority to set country-based targets, choose interventions to achieve these targets and conduct rigorous costing analyses to support their planning and budgeting.<sup>7</sup>

To identify challenges to implementing the alternative approach to allocating PEPFAR funds, we conducted an e-mail survey of PEPFAR field staff from October to November 2007. We surveyed the Centers for Disease Control and Prevention (CDC) Chief of Party, the USAID health team leader, and the PEPFAR coordinator in each of the 15 focus countries. Four of these officials held both the PEPFAR coordinator position and the USAID health team leader positions; as a result, 41 officials received our survey. Our survey included questions on setting country-based targets, selecting appropriate interventions, and using cost information to plan and budget PEPFAR programs. We pretested our survey with CDC and USAID staff that work on HIV/AIDS issues and had recently returned from the field. We achieved a response rate of 93 percent (38 of 41). In collecting and analyzing the survey data, we took steps to minimize errors that might occur during these stages. Survey questions, results, and number of respondents per question are presented in an electronic-supplement, which may be accessed at [GAO-08-534SP](#).

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<sup>7</sup>We consulted OGAC officials regarding this approach, and they agreed that the current funding allocation process includes the three parts noted above.

To obtain additional information on country teams' experiences with setting targets, selecting interventions, and using cost information, we conducted a follow-up e-mail survey with respondents to our first survey. We obtained a response rate of 84 percent (32 of 38). In collecting and analyzing the survey data, we took steps to minimize errors that might occur during these stages.

To analyze responses to open-ended questions in both of our surveys, we followed the same content analysis methodology described above for analyzing experts' comments.

To obtain the perspectives of host country government officials from English-speaking PEPFAR focus countries with varying socioeconomic conditions, we conducted structured interviews in January 2008 with five government officials and one former official government official in the health ministries or national governmental HIV/AIDS organizations in four countries—Namibia, Nigeria, Uganda, and Zambia. We selected these officials based primarily on availability. With the assistance of two methodologists, we developed a structured interview tool. We pretested this tool with three individuals who had previous experience working in the governments of countries that receive PEPFAR funding. Information from the six interviews are used anecdotally in the report and are not representative of the views of all officials in these countries or the views of officials from countries not interviewed. Because of the limited use of these data in the report, we determined that the data from these interviews were sufficiently valid and reliable for our auditing purposes.

We conducted this performance audit from May 2007 to March 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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# Appendix II: List of Experts

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To address our first two objectives, we conducted 17 structured interviews with 22 HIV/AIDS experts from June 2007 to January 2008. At some of these interviews, we spoke with more than one expert; we have identified group interviews below. In addition, we conducted interviews with four other experts to obtain their general views on PEPFAR.

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## List of Experts Participants in Semi- structured Interviews

Dr. Stefano Bertozzi, Director of Health Economics and Policy, School of Public Health of Mexico, National Institute of Public Health

Dr. James Curran, Professor of Epidemiology and Dean, Rollins School of Public Health, Emory University

Dr. Kevin de Cock, Director, Department of HIV/AIDS, World Health Organization

Dr. Helene Gayle, President and Chief Executive Officer, CARE

Dr. Eric Goosby, Chief Executive Officer and Chief Medical Officer, Pangea Global AIDS Foundation

Dr. Edward C. Green, Director, AIDS Prevention Research Project, Harvard Center for Population and Development Studies

Dr. Norman Hearst, Professor, Family Medicine and Epidemiology, University of California, San Francisco

Dr. Michel Kazatchkine, Executive Director, Global Fund to Fight AIDS, Tuberculosis, and Malaria

Dr. Peter Lamptey, President, Public Health Programs, Family Health International

Dr. Richard Marlink, Executive Director, Harvard AIDS Initiative, Harvard School of Public Health, Harvard University; Scientific Director, Care and Treatment, Elizabeth Glaser Pediatric AIDS Foundation

Dr. Anne Peterson, Director, Center for Global Health, World Vision International

Dr. Peter Piot, Executive Director, Joint United Nations Programme on HIV/AIDS; Under Secretary-General, United Nations

Dr. James Sherry, Professor and Chair, Department of Global Health, School of Public Health and Health Services, George Washington University

Mr. John Stover, President, The Futures Institute

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Centers for Disease Control and Prevention

Dr. Deborah Birx, Division Director, Global AIDS Program, Centers for Disease Control and Prevention

Dr. Elizabeth Marum, Team Leader, Counseling and HIV Testing, HIV Prevention Branch, Global AIDS Program, Centers for Disease Control and Prevention

Dr. Lawrence Marum, Team Leader, Medical Transmission, HIV Prevention Branch, Global AIDS Program, Centers for Disease Control and Prevention

Dr. Dorothy Mbori-Ngacha, Chief, Prevention of Mother-to-Child Transmission Section, Global AIDS Program—Nairobi, Kenya, Centers for Disease Control and Prevention

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Partners in Health

Dr. Paul Farmer, Founding Director, Partners in Health; Professor of Medical Anthropology, Department of Social Medicine, Harvard Medical School, Harvard University; Associate Chief, Division of Social Medicine and Health Inequalities, Brigham and Women's Hospital

Dr. Joia Mukherjee, Medical Director, Partners in Health

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United Nations Children's Fund

Dr. Chewe Luo, Senior Program Advisor, HIV/AIDS, United Nations Children's Fund

Dr. Doreen Mulenga, Acting Chief, HIV/AIDS, United Nations Children's Fund

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Other Experts Interviewed

Dr. Paul Delay, Director, Evidence, Monitoring, and Evaluation, Joint United Nations Programme on HIV/AIDS

Ambassador Mark Dybul, U.S. Global AIDS Coordinator, Office of the U.S. Global AIDS Coordinator

Dr. Charles Gilks, Director Coordinator of Antiretroviral Therapy and HIV Care Team, HIV Department, World Health Organization

Dr. Jim Kim, Professor of Health and Human Rights, Harvard School of Public Health; Professor of Medicine and Social Medicine, Harvard Medical School; Chief, Division of Social Medicine and Health Inequalities, Brigham and Women's Hospital; Director, François Xavier Bagnoud Center for Health and Human Rights; Chair, Department of Social Medicine, Harvard Medical School.

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# Appendix III: Data-Gathering Tools Used

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To address our objectives, we used several data-gathering tools. To obtain experts' views of the Leadership Act's spending directives and identify their suggestions for an alternative approach to funding allocation, we used a structured interview tool. To gather information on challenges to implementing the alternative approach to allocating PEPFAR funds, we conducted an e-mail survey and a follow-up e-mail survey.

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## Expert Interviews: Structured Interview Tool

We asked the following questions in the semi-structured interviews we conducted with 22 experts.

### Background

1. What **do you consider** your primary area of expertise related to HIV/AIDS? (e.g., epidemiology, HIV/AIDS research; treatment; evaluation; program management, etc.)
- Would you say that your **experience** is primarily in prevention, treatment, or a combination of the two? Can you describe your experience in this area?
2. Have you had any first-hand experience with programs that received PEPFAR funding?
3. Did you participate in the 2007 IOM study? If yes, what were your roles and responsibilities in the IOM study?

### Prevention

4. Regarding the first-phase target of preventing 7 million HIV infections, do you think this target should be modified for PEPFAR's second phase or remain the same?
5. As you know, the Leadership Act requires that 20 percent of total PEPFAR funding be directed to prevention activities and 33 percent of this amount be used for abstinence-until-marriage programs.
- What are the strengths and limitations of the overall 20 percent prevention requirement?
- What are the strengths and limitations of the 33 percent requirement for abstinence-until-marriage programs?

6. The IOM report recommends doing away with these spending requirements and adopting alternative mechanisms that (1) are based on adaptive, evidence-based programming; (2) ensure accountability; and (3) are linked to and commensurate with efforts to achieve overall and country targets.

- a. Should the spending requirements be replaced with different spending requirements, or with a different approach?
- b. What ideas or suggestions do you have for alternatives to these spending mechanisms for prevention?

Criteria:

- a. How is this mechanism based on adaptive, evidence-based programming?
- b. How does this mechanism promote accountability?
- c. How is the mechanism linked to overall and country prevention targets?
- d. How would the mechanism help the program to meet its targets?

Feasibility:

- e. What suggestions do you have for determining the feasibility of this mechanism?
  - With regard to our field survey of PEPFAR implementers—what topics or questions do you suggest we address with PEPFAR implementers?
  - Do you know of anyone we should talk to with experience applying similar mechanisms to the one you have suggested?
- h. How does the mechanism you've outlined as an alternative to the current PEPFAR approach contrast with other alternatives or approaches that other experts are considering at this point in time?
- i. Are these mechanisms specific to prevention-related activities, or could they be applied to treatment activities as well?

**Treatment**

7. Regarding the first-phase target of providing ARVs to 2 million people, do you think this target should be modified for PEPFAR's second phase or remain the same?

8. As you know, the Leadership Act requires that 55 percent of total PEPFAR funding be directed to treatment activities. Also, 75 percent of this amount is to be used for the purchase and distribution of ARVs.

- What are the strengths and limitations of the overall 55 percent treatment requirement?
- What are the strengths and limitations of the 75 percent ARV purchase and distribution requirements?

9. The IOM report recommends doing away with these spending requirements and adopting alternative mechanisms that (1) are based on adaptive, evidence-based programming; (2) ensure accountability; and (3) are linked to and commensurate with efforts to achieve overall and country targets.

a. Should the spending requirements be replaced with different spending requirements, or with a different approach?

b. What ideas or suggestions do you have for alternatives to these spending mechanisms for prevention?

Criteria:

c. How is this mechanism based on adaptive, evidence-based programming?

d. How does this mechanism promote accountability?

e. How is the mechanism linked to overall and country prevention targets?

f. How would the mechanism help the program to meet its targets?

Feasibility:

g. What suggestions do you have for determining the feasibility of this mechanism?

- With regard to our field survey of PEPFAR implementers—what topics or questions do you suggest we address with PEPFAR implementers?
- Do you know of anyone we should talk to with experience applying similar mechanisms to the one you have suggested?

h. How does the mechanism you've outlined as an alternative to the current PEPFAR approach contrast with other alternatives or approaches that other experts are considering at this point in time?

i. Are these mechanisms specific to treatment-related activities, or could they be applied to prevention activities as well?

**Other:**

10. Are there any other issues regarding PEPFAR reauthorization that you would like to discuss?

- a. Areas of the report that warrant further GAO focus?
- b. Issues IOM left out of the report that warrant further study?

**Survey of PEPFAR Country Team Officials**

The questions, results, and number of respondents per question from our first survey of PEPFAR country team officials are provided in the electronic supplement to this report [GAO, *Global HIV/AIDS: Survey of PEPFAR Country Team Officials*, [GAO-08-534SP](#) (Washington, D.C.: April 2008)], available at <http://www.gao.gov>.

**Follow-up Survey of PEPFAR Country Team Officials**

The following questions were sent as a follow-up to the 38 PEPFAR country team officials who responded to our initial country team survey.

1 a. How easy or difficult would it be for country teams to set all country-level targets?

Select one:

very easy

easy

neither easy nor difficult

difficult

very difficult

1 b. Why would it be easy or difficult?

2 a. What challenges, if any, have you encountered while selecting interventions to meet country-level targets for prevention?

2 b. What challenges, if any, have you encountered while selecting interventions to meet country-level targets for treatment?

2 c. What challenges, if any, have you encountered while selecting interventions to meet country-level targets for care?

3. To what extent do you use information about the actual unit cost of specific interventions in your country when planning and budgeting? (For example, the cost per person of PMTCT services in a given region):

Select one:

very great extent

great extent

moderate extent

some extent

little or no extent

Please explain your answer:

4 a. How easy or difficult would it be for country teams to use information on the costs of specific interventions as part of their planning and budgeting?

Select one:

very easy

easy

neither easy nor difficult

difficult

very difficult

4 b. Why would it be easy or difficult?

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# Appendix IV: Comments from the Office of the U.S. Global AIDS Coordinator

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



**United States Department of State**

*Assistant Secretary for Resource Management  
and Chief Financial Officer*

Washington, D.C. 20520

MAR 25 2008

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

Dear Ms. Williams-Bridgers:

We appreciate the opportunity to review your draft report, "GLOBAL HIV/AIDS: A More Country-Based Approach Could Improve Allocation of PEPFAR Funding," GAO Job Code 320504.

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

If you have any questions concerning this response, please contact Clint Fenning, Foreign Affairs Officer, Office of the US Global AIDS Coordinator, at (202) 663-2420.

Sincerely,

A handwritten signature in black ink, appearing to read "Bradford R. Higgins".

Bradford R. Higgins

cc: GAO – Audrey Solis  
S/GAC – Mark Dybul  
State/OIG – Mark Duda

Department of State Comments on GAO Draft Report

GLOBAL HIV/AIDS: A More Country-Based Approach Could  
Improve Allocation of PEPFAR Funding  
(GAO-08-480, GAO Code 320504)

On behalf of the U.S. Department of State (DOS), the Office of the U.S. Global AIDS Coordinator (OGAC) appreciates the opportunity to comment on the draft report from the Government Accountability Office (GAO) entitled, "*Global HIV/AIDS: A More Country-Based Approach Could Improve Allocation of PEPFAR Funding*" (GAO-08-480). We appreciate the report's emphasis on country ownership because that is one of the fundamental principles of the President's vision for development.

The President's Emergency Plan for AIDS Relief (PEPFAR) has been on the cutting edge of implementing the President's vision for development. This vision is based in the power of partnerships, representing a new era in development based in the intrinsic dignity, equality and worth of every human life. Because PEPFAR is a partnership between equals, PEPFAR strives to implement the principles of the Monterrey Consensus, beginning with the key aspects of country ownership and results-driven development. PEPFAR was one of the original co-sponsors of the UNAIDS' Three Ones approach that is also based in country ownership. Since its inception, PEPFAR has put policies and practices in place to ensure country ownership. A key aspect of this approach is the administration of resources in-country – a fundamental characteristic of PEPFAR.

As the Institute of Medicine said, PEPFAR is a "learning organization," and it pursues new opportunities to improve all aspects of the program – including its country-ownership and results-based focus. As such, OGAC appreciates the review and insights provided by GAO. However, there seemed to be some fundamental misunderstandings about how PEPFAR operates. In fact, several of the aspects of the new approach that were recommended have been part of PEPFAR from the earliest days of the initiative.

As part of the results-based approach, each country was provided with five-year prevention, treatment, and care goals in 2004. The initial country allocations for Fiscal Year (FY) 2004 were based on these goals and other

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parameters, including country capacity. With each annual budget cycle, there is a re-assessment of country opportunities and challenges, and a review of progress in the previous year/s. Based on this assessment, PEPFAR's interagency headquarters leadership provides a new annual allocation for each country. As can be seen below, several countries have already exceeded their initial goals for treatment and care. However, if there are opportunities for expanded services in the coming year, additional resources will be provided.

Treatment <sup>1</sup> : FY2007 Progress Toward Emergency Plan Target of 2 Million Individuals Receiving Treatment			
Country	Emergency Plan 5 Year Target	Total number of individuals reached	Percentage of 5 Year target met
Botswana <sup>2</sup>	33,000	90,500	274%
Cote d'Ivoire	77,000	46,000	60%
Ethiopia	210,000	81,800	39%
Guyana	2,000	2,100	105%
Haiti	25,000	12,900	52%
Kenya	250,000	166,400	67%
Mozambique	110,000	78,200	71%
Namibia	23,000	43,700	190%
Nigeria	350,000	126,400	36%
Rwanda	50,000	44,400	89%
South Africa	500,000	329,000	66%
Tanzania	150,000	96,700	64%
Uganda	60,000	106,000	177%
Vietnam	22,000	11,700	53%
Zambia	120,000	122,700	102%
<b>All countries</b>	<b>2,000,000</b>	<b>1,358,500</b>	<b>68%</b>

Note:  
Numbers may be adjusted as attribution criteria and reporting systems are refined.  
Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.  
Total includes the number of individuals reached through upstream contributions to national, regional and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, or protocol and curriculum development, as well as those receiving services at USG-funded service delivery sites.

Footnotes:  
<sup>1</sup> Treatment includes the provision of antiretroviral drugs and clinical monitoring of ART among those with advanced HIV infection.  
<sup>2</sup> Botswana results are attributed to the National HIV Program. Beginning FY2005, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator. This decision mostly affected reporting in the areas of care and treatment.

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<b>Care<sup>1</sup>: FY2007 Progress Toward Emergency Plan Target of 10 Million Individuals Receiving Care</b>			
<b>Country</b>	<b>Emergency Plan 5 Year Target</b>	<b>Total number receiving care services</b>	<b>Percentage of 5 Year Target Met</b>
Botswana <sup>2</sup>	165,000	224,300	136%
Cote d'Ivoire	385,000	115,500	30%
Ethiopia	1,050,000	726,600	69%
Guyana	9,000	5,300	59%
Haiti	125,000	113,100	90%
Kenya	1,250,000	743,600	59%
Mozambique	550,000	669,000	122%
Namibia	115,000	163,900	143%
Nigeria	1,750,000	282,000	16%
Rwanda	250,000	102,700	41%
South Africa	2,500,000	1,349,500	54%
Tanzania	750,000	745,400	99%
Uganda	300,000	722,300	241%
Vietnam	110,000	47,400	43%
Zambia	600,000	627,000	105%
<b>All countries</b>	<b>10,000,000</b>	<b>6,637,600</b>	<b>66%</b>

**Note:**  
Numbers may be adjusted as attribution criteria and reporting systems are refined.  
Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.  
Total number receiving care includes individuals reached through upstream contributions to national, regional and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, or protocol and curriculum development, as well as those receiving services at USG-funded service delivery sites.

**Footnotes:**  
<sup>1</sup> Care includes the areas of Orphans and Vulnerable Children and Care & Support (including TB/HIV).  
<sup>2</sup> Botswana results are attributed to the National HIV Program. Beginning FY2005, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator. This decision mostly affected reporting in the areas of care and treatment.

Under PEPFAR guidance, each country team is provided an overall funding level in the late spring/early summer of the year preceding the fiscal year to use in planning an appropriate country response. For example, an FY 2008 planning level was provided in May-June 2007, along with planning guidance. These planning levels are subject to the annual appropriation of resources.

Upon receiving the country planning level, each PEPFAR country team works to design a program tailored to the country epidemic; this program is reflected in the team's submission of the Country Operational Plan (COP) in September along with targets for each program set by the country team through an iterative process with stakeholders. See attached guidance on target-setting as provided to teams in the FY 2008 COP guidance.

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Country teams do operate within the context of congressionally mandated budgetary directives. However, the COP guidance states that “If meeting any of the mandatory requirements is not reasonable from a programmatic perspective, please submit a justification with the COP.” See attached FY 2008 COP guidance.

The guidance further states, “For other bilateral country programs, however, only those with generalized epidemics (i.e. national prevalence rates exceeding 1% in the general population) are expected to meet AB budgetary requirements. New for FY 2008 is that no AB justification is required for countries that have concentrated epidemics, with national prevalence below 1%.”

As these documents make clear, PEPFAR agrees that a country-based approach to planning investments is critical—that is why PEPFAR has specifically been designed to allow a country-driven approach consistent with applicable law. PEPFAR has been implemented accordingly throughout the past five years.

Regarding the directive for abstinence and faithfulness programs, the report notes that 12 of 22 of the experts consulted – one more than half -- expressed concern about its impact. The report then presents data on the treatment directive and concludes that “Overall, the experts recommended revising PEPFAR’s current allocation process...” (page 4) – a key basis for the report’s recommendation. The two directives are very different in their purposes and impact to date, so the reference to an “overall” expert view may create confusion. We are concerned that some may misread the report as a whole to imply a broader consensus against the abstinence and faithfulness directive than the data suggest, and to accord much more weight to the views of one group of 12 experts than another group of 10 experts. More effort throughout the report to convey the diversity of views on the abstinence and faithfulness directive could help to prevent such misunderstanding.

Also of concern is the report’s lack of discussion of the consequences of elimination of the current statutory allocation of 10 percent for programs serving orphans and vulnerable children (OVCs). During 2007, in light of the urgent need for additional programs in this area, PEPFAR asked country teams to submit proposals for additional funding for OVC programs – but proposals fell far short of available resources. This experience suggests that

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the directive plays an important role in ensuring at least minimal funding for OVC programs, and provides an important counterpoint to other views on funding allocations – a counterpoint from which the report would have benefited.

PEPFAR will continue and strengthen the country-based, country-led approach with a Partnership Compact model under a second five-year authorization. OGAC also agrees with the report's recommendation to strengthen guidance on the costing of HIV/AIDS interventions.

In the paragraphs below, we elaborate on three specific challenges and ongoing efforts to allocate PEPFAR funding utilizing country-based and evidence based approaches.

**1. Country setting of prevention targets.** OGAC recognizes the difficulty of setting outcome level targets for prevention interventions, such as mass media activities, as well as the near impossibility of routine direct measurement of the impact of programs designed to prevent HIV infections (page 35). For this reason, in the area of behavioral prevention, country teams are only asked to set output targets (i.e., number of people reached with behavior messages). The current and ongoing Next Generation of Indicators project, through PEPFAR agency and community consultation, is intended to provide an improved set of program monitoring output indicators. Routine monitoring of outcomes such as behavior change, however, will not be possible due to the difficulty of measurement. Therefore, for this information we will continue to require special studies (i.e., Public Health Evaluations, behavioral surveys) or population-based evaluations (i.e., Demographic and Health Surveys, or AIDS Indicator Surveys).

As a result of the above-mentioned difficulties and the fact that incidence testing technologies currently under development are not yet ready for extensive use, measuring the impact of HIV prevention programs on incidence and infections averted requires statistical modeling. PEPFAR currently uses a population-based model to estimate the number of infections averted as a result of all activity in country. While the statistical models are formed at headquarters, they are reviewed and approved by the USG country teams before they are finalized.

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Unfortunately, this population-based model will not provide specific program intervention information. The gaps in the body of scientific knowledge around effectiveness or cost-effectiveness of prevention interventions make it difficult to model impact at a program level with any degree of certainty. However, we continue to work with program impact models. As the body of knowledge around prevention interventions grows, these types of models will become increasingly useful.

**2. Producing cost guidance.** PEPFAR does have a number of models ranging from John Blandford's study, "Cost of Comprehensive HIV Treatment in Emergency Plan Focus Countries"—an intensive multi-country study conducted in Nigeria, Uganda, Ethiopia, Botswana and Vietnam—to country-driven estimation of treatment costs. The data gathered from the multi-country study, which allow disaggregation by cost component, programmatic activity and source of support, are being utilized in the development of a cost-projection model for use by PEPFAR country teams to estimate resource needs for treatment. A user-friendly model has also been piloted to allow PEPFAR country teams and country partners to project resource needs to support the purchase of antiretroviral medications and associated buffer stock. Similar to PEPFAR's work in partner portfolio monitoring, OGAC can start to distribute guidance that sets minimum standards for cost analyses, e.g., outlier analysis, determination of unit costs, and also provide options for more intensive studies by fiscal year 2010.

**3. Evaluating country-set targets.** To be consistent with the Three Ones, it is important that PEPFAR and its other multilateral partners (Global Fund, UNAIDS, World Health Organization, and the World Bank) have common indicator, target setting, and reporting guidance to improve the quality of targets and results reporting and to avoid duplicative efforts. OGAC's Strategic Information unit, in coordination with its interagency partners, has worked for two years through the UNAIDS Monitoring and Evaluation Reference Group (MERG) to harmonize indicator guidance. This guidance document is being released during the first quarter of this year. PEPFAR will use this harmonized work as the basis for the Next Generation of indicators.

As the report notes, country-set targets are not always realistic and/or rooted in current data. PEPFAR expects that the annual review and reconciliation of data at the country level will improve with the availability of data and the collaborative target setting process. Since 2005, PEPFAR has met with the multilateral agency headquarters (WHO, UNAIDS,

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UNICEF, and Global Fund) to review and harmonize data reported from multiple sources on the number of patients receiving antiretroviral treatment (ART). The goals of this activity have been 1) to identify and reconcile discrepancies in reported data; and 2) for all multilateral organization publications to report one reconciled national number of individuals on treatment. In February 2008, this exercise was extended to five of the PEPFAR country-level indicators (ART, ARV prophylaxis, counseling and testing, OVC, and tuberculosis treatment) during the 2007 UNGASS data reconciliation meeting in Geneva, Switzerland.

While the practice of data reconciliation among the multilateral agencies and PEPFAR has helped to improve the quality and consistency of data reported in publications at the international level, it is widely recognized that in order to best support the “Third One,” one national reporting system, this process would be most effective taking place at the national level. This new practice would allow national programs to begin to ascertain the underlying reasons for systematic discrepancies and begin taking steps to rectify those discrepancies.

PEPFAR country teams are strongly encouraged to organize or attend data reconciliation meetings with appropriate stakeholders in country prior to the submission of semi-annual progress reports to review country-level indicators. At a minimum, participants at this in-country data reconciliation meeting should include the Global Fund, the UNAIDS monitoring and evaluation officer, and the appropriate host country government representative. This data reconciliation meeting should be scheduled in advance of the Semi-Annual Program Results submission in order to give sufficient time for maximum stakeholder participation in the process. Implementing each of these steps noted also will enhance the abilities of national and USG teams to improve the setting of realistic targets.

In conclusion, the current PEPFAR funding allocation process is country-based and consistent with the authorizing legislation. PEPFAR has specifically been designed to allow a country-driven approach, which has given the host countries the flexibility to implement effective HIV/AIDS programming. PEPFAR is a learning organization that will continue to adjust and adapt its guidance to strengthen its ability to meet the challenges in fighting HIV/AIDS around the world.

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We appreciate GAO's examination of these important issues and their recommendations. We look forward to working with Congress to further develop our processes that ensure country-owned and results-based programs.

**Attachment 1: Guidance on Mandatory Budget Requirements**

For FY 2008, as in prior years, there are three mandatory budgetary requirements for all focus countries: (Abstinence and Be Faithful (AB), Orphans and Vulnerable Children (OVC) and Treatment). For Other Bilateral countries, only the AB requirement applies. There have been some minor modifications in both the OVC and AB guidance for the FY 2008 COP.

- Track 1.0 central budgets (from headquarters) will be attributed to these mandatory requirements (see further explanation below).
- If meeting any of the mandatory requirements is not reasonable from a programmatic perspective, please submit a justification with the COP (see the COP Planning section on the Extranet for the format of the justifications). You should engage your Core Team Leader in discussions of any necessary justifications.
- Integrated programs should be distributed, as appropriate, across program areas. For more information, please see the guide to allocating activities across program areas on page 59.

**PREVENTION: ABSTINENCE AND BE FAITHFUL**

Note: Special instructions for Other Bilateral Countries at the end of this section.

ABC – Abstinence, Being faithful, and the correct and consistent use of Condoms for people engaged in high-risk behaviors – is the most effective, evidence-based approach to the prevention of sexual transmission of HIV (as described in PEPFAR’s ABC Guidance). In each of the focus countries except Vietnam, the primary mode of HIV transmission is sexual contact; therefore, a significant proportion of prevention funding should be dedicated to ABC activities to prevent sexual transmission of HIV.

In FY 2008, each country should strive to dedicate 50% of total prevention funds to sexual transmission, and within sexual transmission funds, to dedicate 66% to AB. If a country does not meet these expectations, a written justification is required.

However, failure to meet the 50% requirement for sexual transmission within all prevention programs would not justify failure to reach the 66%

requirement within sexual transmission prevention funds for AB activities. In some countries, based on epidemiology, it may not make programmatic sense to devote 66% of sexual prevention funds to AB, and in such cases, a written justification would be appropriate.

An example of when a justification would be appropriate is if the country is experiencing a concentrated epidemic, in which case a higher proportion of sexual transmission funds would likely be directed to correct and consistent condom use among people engaged in high-risk behaviors, within the context of the ABC approach.

$$\frac{\text{AB Funding} + \text{Condoms and Other Prevention Funding}}{\text{Prevention Funding}} = \% \text{ Sexual Prevention}$$

Note: Prevention Funding = PMTCT Funding + AB Funding + Injection Safety + Blood Safety + Condoms and Other Prevention Funding

$$\frac{\text{AB Funding}}{\text{Sexual Prevention Funding}} = \% \text{ AB}$$

Please note: in a generalized epidemic, a very strong justification will be required if a country does not meet the 66% AB or 50% sexual prevention requirement. Again, please inform your Core Team Leader as soon as possible if you think these budgetary requirements will present a problem, and consider requesting technical assistance from the Prevention TWG.

Generally speaking, the percentage of sexual prevention funds dedicated to AB programming in the country should not decrease between FY 2007 and FY 2008. However, if new evidence or priorities warrant decreasing the percentage of sexual transmission funds dedicated to AB programming, then please provide an explanation for the proposed decrease in the justification narrative.

**SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:**

For other bilateral country programs, however, only those with generalized epidemics (i.e. national prevalence rates exceeding 1% in the general population) are expected to meet AB budgetary requirements. New for FY 2008 is that no AB justification is required for countries that have concentrated epidemics, with national prevalence below 1%.

**ORPHANS AND VULNERABLE CHILDREN (OVC)**

All focus countries must allocate 10% of total prevention, care, and treatment resources towards OVC programs. Given the maturity of the PEPFAR program and the magnitude of the problem, there is an expectation that countries are bringing OVC programs to scale. New for FY 2008, pediatric treatment will not be counted towards the 10%. This is in no way intended to lessen the focus on Pediatric treatment, which is also highly important; however, pediatric treatment funds should be attributed only to the treatment budgetary requirement, not to OVC.

Please submit a justification if your FY 2008 COP does not meet the 10% OVC requirement.

**TREATMENT**

To reach the goal of 2 million, and to meet the Congressional directives that the Emergency Plan allocate 55% of its program resources to antiretroviral treatment (ART), in FY 2008 the 55% budgetary requirement for treatment will continue to apply to all focus countries. Please submit a justification if your FY 2008 COP does not meet the 55% treatment requirement.

$$\frac{\text{ARV Drugs Funding} + \text{ARV Services Funding} + \text{Lab Funding}}{\text{Prevention Funding} + \text{Treatment Funding} + \text{Care Funding}} = \% \text{ Treatment}$$

**Attachment 2: Guidance on Target Setting**

The information below is to provide countries some information on how to set targets. This is not meant to be a formula or template to follow in setting your targets, but simply to give you a better idea of what roles different individuals play in target-setting, what documents would be useful in setting your targets and key concepts that relate to target setting.

**What is target-setting in the context of PEPFAR?**

Target-setting is an iterative, group process integral to program planning and program management. Targets are set at the partner-level, program-level, country-level and international level using standardized indicators to outline measurable future achievements for PEPFAR.

**Who does target-setting?**

Target setting is a collaborative *group process* that is best conducted with the active participation of program managers/project officers (e.g. cognizant technical officers or CTOs), budgetary staff, implementing partners, strategic information staff (HQ SI advisors, in-country SI liaisons and other SI technical area personnel), core team staff (HQ and in-country) and technical work group members, who each have roles and responsibilities in the group process. All USG agencies in country should agree to and follow the same target-setting processes to arrive at consistent partner-, program- and country-level targets.

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The following are our comments regarding the March 25, 2008, letter from the Office of the U.S. Global AIDS Coordinator.

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## GAO Comments

1. Our report's central finding—based on the observations of noted HIV/AIDS experts—that a more country-based approach could improve allocation of funds does not suggest that country-teams play no role in PEPFAR programming. For example, our report describes country team involvement in developing country operational plans and the role of these teams in selecting interventions within the constraints of the spending directives.
2. We added text to our report, in response to OGAC's written comments, to clarify that OGAC's annual budget process includes a reassessment of each country team's opportunities and challenges and a review of its progress in the previous year, which guide new funding allocations for the recipient countries (see p. 16). OGAC's technical comments did not challenge our overall description of its processes, and we addressed these technical comments with minor changes to the background section of our report.
3. We added a footnote in our report stating that 13 of 22 experts observed that the AB directive posed obstacles to developing evidence-based programs and 6 of these 13 experts said that the directive negatively affected country-based programming (see p. 22). One of the 13 experts stated that AB programs are being implemented with no measure of effectiveness; another noted that AB programs are too restrictive. Three of the 22 experts generally supported the spending directives. The remaining six experts did not comment on the directive's impact on evidence-based or country-based programming.
4. Because our work focused on the prevention and treatment spending directives, we did not specifically discuss the 10 percent spending directive for OVC with experts, host country officials, or PEPFAR officials. However, a number of those whom we interviewed noted that this spending directive helped protect programs for OVC. We recognize that Congress may view the OVC directive as necessary to protect this vulnerable group, although it may constrain a more country-based approach to allocating funds.

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# Appendix V: GAO Contact and Staff Acknowledgments

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## GAO Contact

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## Acknowledgments

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# Related GAO Products

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*Global Health: Global Fund to Fight AIDS, TB and Malaria Has Improved Its Documentation of Funding Decisions but Needs Standardized Oversight Expectations and Assessments.* [GAO-07-627](#). Washington, D.C.: May 2007.

*Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief.* [GAO-06-395](#). Washington, D.C.: April 2006.

*Global Health: The Global Fund to Fight AIDS, TB and Malaria Is Responding to Challenges but Needs Better Information and Documentation for Performance-Based Funding.* [GAO-05-639](#). Washington, D.C.: June 2005.

*Global Health: U.S. AIDS Coordinator Addressing Some Key Challenges to Expanding Treatment, but Others Remain.* [GAO-04-784](#). Washington, D.C.: June 2004.

*Global Health: Global Fund to Fight AIDS, TB and Malaria Has Advanced in Key Areas, but Difficult Challenges Remain.* [GAO-03-601](#). Washington, D.C.: May 2003.

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