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The Blind Hydra
USAID Policy Fails to Control Malaria

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Summary

Although several papers in academic journals have discussed the efficacy of individual malaria programs, and other publications have analyzed the functioning of the United States Agency for International Development, this is the first comprehensive analysis of the Agency's overall approach to malaria control. USAID is found wanting: its lack of transparency makes detailed economic assessments of performance impossible; its organizational structure and methods of information management hinder opportunities for collaboration with other donors and prevent necessary assessments of ongoing programs; it avoids accountability for program performance by deflecting responsibility onto contractors; it fails to condition funding for these contractors on relevant outcome measurements; it has influenced the construction of a system wherein the vast majority of funding for malaria either never leaves the United States or funds the employment of US citizens; it ensures continued Congressional support by maintaining key beltway contractors who lobby for increased funding; it spends less than five percent of its malaria budget purchasing actual life-saving interventions; and lastly, it bases its choice of malaria interventions on extraneous political consideration, not on best practice, unnecessarily costing lives.

USAID should take several positive steps to improve overall performance. It should increase its transparency. Such a move will instigate necessary upgrades in organization and data management, improve the Agency's capacity to work with other donors and allow external experts to contribute useful suggestions for performance improvements. It should ensure that programs have the necessary funding and scope to achieve success—a sustainable reduction in the malaria burden—and measure their progress with appropriate interim results. At present, USAID spreads its funds too thinly to run such robust programs. By focusing on fewer countries, USAID could provide tangible results, lowering criticism of its performance and establish best practice models for other countries to follow, saving more lives. Where its comparative advantage lies in providing technical assistance, it must coordinate with other agencies that provide actual medical interventions (bed nets, insecticides, drugs) in order to ensure a robust effort. Lastly, it must not inhibit countries from using interventions that its staff opposes for reasons other than effectiveness in combating malaria.

If USAID cannot do this, Congress should distribute USAID's malaria budget to another agency.

I. INTRODUCTION

In 1997, the United States Agency for International Development (USAID) joined several major international development organizations, including the World Bank and the World Health Organization (WHO), to form the Africa Initiative for Malaria Control (AIM) (Brundtland 2002). At the time, malaria mortality rates in Southern and Eastern Africa had doubled from their 1980s levels, and concern was growing over the disease's increasing human and economic toll (WHO 2003). AIM intended to counter that rise by morphing itself into a global initiative known as Roll Back Malaria (RBM). RBM's goal of halving malaria mortality by 2010 marked an ambitious new effort to fight the disease, and the over 90 public and private agencies that subsequently joined the fight were optimistic about the prospects for alleviating the disease burden (Brundtland 2002).

Fast forward to 2005, and the hope for progress has not been realized. Instead of moving towards a fifty percent reduction, deaths due to malaria have further increased, possibly by as much as 10 percent (Attaran 2004). Put simply, so far Roll Back Malaria has failed (*Lancet* 2005).

RBM's failure should be an embarrassment to its core members, WHO, UNICEF, and USAID among others. It has left a massive public health problem, one that claims over one million lives a year, unsolved. Although well intentioned international aid organizations have attempted to put a positive spin on RBM's lack of progress, donors are nevertheless faced with a vexing problem. Should they continue investing resources in a losing battle? Commit even further now that the problem has worsened? Change tactics and maybe do more with current resources?

This paper analyzes the dilemma from the perspective of the US government, with particular emphasis on the role of USAID in efforts to battle malaria. There have been serious discussions in Washington about increasing malaria funding over and above the nearly five-fold increase from just under $14 million in 1998 to $80 million in 2004 (USAID 2004). It is, therefore, absolutely crucial that those funds be allocated correctly. As America's foreign aid agency and the prime administrator of US global health funding, USAID would be the obvious recipient of any future increases in the anti-malaria campaign. But is it the best choice?

To determine how the US should continue its efforts against malaria, and the role USAID should have in those efforts, this paper analyzes the Agency's past performance against the disease. Based on that assessment, as well as a close look at its current orientation, we forecast how well it will spend future, possibly increased, malaria funds. We then make a series of recommendations for how the Agency, and the US Government as a whole should proceed in its laudable efforts to fight malaria.

Though the focus here is USAID's malaria programs, many of the weaknesses highlighted apply to other aspects of the agency. Failures in the fight against malaria are a microcosm of more general Agency shortcomings. Thus, the conclusions drawn by the evidence from malaria programs should interest anyone concerned with American foreign aid.

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II. UNDER THE FEVER TREE

The Scope of the Problem

Describing the enormity of the worldwide malaria problem requires no hyperbole. According to the most recent estimates (Snow et. al. 2005), approximately 2.2 billion people are currently at risk of contracting the disease. Malaria causes at least one million deaths annually, and approximately 515 million cases of acute illness.

The malaria burden falls heaviest on Africa, where over ninety percent of the world's malaria deaths occur (WHO 2003). However, current research suggests that previous WHO estimates significantly underestimated malaria incidence outside of Africa, and that perhaps a quarter of all malaria cases occur in other regions (Korenromp 2005; Snow et. al. 2005).

Malaria preys most heavily upon pregnant women and young children. In Africa alone it kills a young child every thirty seconds, and often leaves survivors with significant brain damage and cognitive impairments. The disease debilitates those malaria sufferers that escape death and long term impairment for at least a week, and sometimes longer.

Malaria, through its harm to labor productivity and educational development, carries a high economic cost as well A recent paper in the *American Journal Of Tropical Medicine* estimated that malaria independently hindered economic growth in endemic countries by 1.3% per person per year, whereas no such correlation was observed for other tropical diseases (Sachs and Gallup 2001). The total annual cost of the disease in Africa could be as much as $12 billion. Furthermore, within endemic countries, the poor suffer at disproportionately high rates. A survey in Tanzania revealed that under-five mortality from malaria was 39% higher for the poorest citizens than the wealthiest, and a similar study in Zambia estimated higher prevalence rates among the most destitute (WHO 2003).

Though malaria currently affects predominantly tropical areas, which are also less developed economically, its reach has not always been so limited. Many temperate regions, including the United States contain the mosquito vectors capable of carrying malaria. Increased international trade and travel make these areas vulnerable to a recurrence. Though miniscule by comparison to malarious countries, the US has seen a steady increase in localized malaria outbreaks, due mainly to tourists returning and immigrants arriving from endemic areas.[1]

Despite its devastating toll, malaria remains a thoroughly preventable and curable disease. Spraying tiny amounts of insecticide on the inside walls of dwellings—known as indoor residual spraying (IRS)—is highly effective at repelling and killing the mosquitoes that transmit the disease. Insecticide treated bednets (ITNs) similarly provide a barrier between potential victims and mosquitoes during the night, which is the vector's most active period. If one does become infected, several drugs can cure the disease. Most effective, and least susceptible to resistant strains, are artemisinin-based

[1] For a detailed chronicle of malaria incidence in the US, see Roberts et al (forthcoming).

combination therapies (ACTs), which are derived from an ancient Chinese herbal remedy.

The Battle

Malaria is caused by the *Plasmodium* parasite and transmitted by female mosquitoes of the genus *Anopheles*. The connection between mosquitoes and malaria was not always known, however, and many believed that the disease was caused by the moisture loving *Acacia Xanthophloea* (dubbed the "Fever Tree") or by bad swamp air (Van Wyck 1984; Harrison 1978). Once the role of the mosquito was discovered in 1898, malaria control efforts focused on habitat reduction, known as environmental vector control. Chemical control methods, involving the use of available insecticides and larvicides, were also employed. Though advances in vector control and treatment with quinine yielded moderate success in some places, post-World War Two efforts that utilized the newly synthesized insecticide known as DDT affected the most dramatic reductions in malaria yet witnessed.

DDT was first used in 1939 as an agricultural insecticide in Switzerland, but its public health applications quickly became known after the Allies used it to control typhus epidemics during the war. Its subsequent employment in malaria control brought astounding success. Through massive DDT spraying programs, Sri Lanka (then called Ceylon) reduced its malaria cases from three million annually to 29 in less than twenty years (Harrison 1978). Complete eradication was quickly achieved in many areas, including most of Brazil, Southern Europe, and the United States. India and parts of Southern Africa also experienced dramatic reductions. The prevailing strategy , which relied primarily on the use of DDT spraying to combat malaria, required careful planning, a highly organized and well trained staff of sprayers, and constant vigilance against signs of recurrence.

Buoyed by the successful application of DDT to malaria control, in 1955 the WHO launched its Global Malaria Eradication Campaign. Supported by $1.2 billion in US bilateral assistance (a large amount of money today and a truly vast sum then), given from 1950-72, the WHO's campaign was a decisive endorsement of the unilateral 'vertical' approach to malaria control advocated most strongly by American epidemiologists like Fred Soper (Tren and Bate 2000).

But by the latter part of the 1960s, malaria began to creep back in countries that had used the vertical approach to affect dramatic reductions. Many countries, notably India, were simply unable to maintain the perpetual commitment to a highly organized spray program required for success (Harrison 1978). In addition, many parts of Africa, where poor infrastructure made it unsuitable for massive spraying campaigns, were so severely malarious that the region was deemed too daunting a task for eradication, and bypassed altogether (Nchinda 1998).

By 1969, after a formal reexamination of the malaria eradication strategy, the WHO endorsed a series of recommendations that would eventually lead to the phasing out of the vertical eradication approach (WHO 1969). The new strategy, which came to dominate the major global health agencies, emerged due to growing concern that a strictly one-dimensional approach (massive spraying with DDT) was inadequate to tackle

the malaria problem. It therefore emphasized the importance of strengthening basic health services, dealing with each region's unique socioeconomic and cultural situations, and focusing on malaria treatment, as opposed to strictly prevention. Known as the 'horizontal' approach, the new paradigm stressed control and containment of malaria, as opposed to complete eradication.

Despite the beginnings of this strategic reorientation, and growing concern over resistance to DDT and possible harmful effects from its use, as described in Rachel Carson's influential *Silent Spring*, vector control programs would remain an integral component of malaria campaigns for the next decade. Expert testimony at WHO meetings warned that no evidence of DDT's toxicity had ever been established and that "limiting the availability or use of DDT for the control of malaria and other vector-borne diseases in developing countries could lead to a public health disaster" (WHO 1970). A WHO technical report issued in 1971 similarly recognized DDT as the "major single factor that made the concept of time-limited eradication possible" and recommended the continued availability of insecticides, "particularly DDT" (WHO 1971). Even the US delegate, responding to concerns that the country's impending ban on DDT would harm developing nations' malaria control efforts, pledged not to limit its availability for public health purposes (WHO 1971, 386).

In practice, however, DDT and vector control methods, as well as the goal of eradication, would eventually lose out to the horizontal control and treatment approach. A dwindling supply of DDT had precipitated a steep price increase, prompting both the Nepalese and Indonesian delegates at the WHO to request purchasing assistance from wealthy nations on behalf of all developing countries (WHO 1975). No such assistance was forthcoming. In reality, the die had already been cast against vector control methods, and 1978 simply ushered in the formal reorientation of global malaria control to a horizontal approach. Despite subsequent protests from the Burmese and Comoros delegation that the WHO should not lose focus on vector control (WHO 1980), and the Mexican and Spanish delegations' insistence that eradication remain the goal of malaria control (WHO 1978, 491), the WHO and its key supporters (foremost among them USAID) disowned the methodologies that had been used to eradicate malaria in the developed world during the post-war era.

The WHO's actions echoed far beyond Geneva, as the new horizontal programmatic approach would form the basis of nearly every bilateral and multilateral malaria program. Vector control began to disappear from the vocabulary of public health officials. Dr. Jose Najera, Director of the Malaria Action Program, explained the new tactics best: "[Malaria control goals] would be accomplished mainly by the use of drugs for chemotherapy" (WHO 1983). Significantly, with the integration of malaria control into the primary health system established as the new paradigm, the disease nearly dropped from the radar of international health altogether. Indeed, with malaria safely eliminated from donor nations, Western countries seemed less interested in funding malaria specific activities, and both bilateral and multilateral interest funding for parasitic diseases dropped off during the seventies (WHO 1978, 488).

Renewed international interest in malaria did not materialize until the nineties[2]. An international treaty intent on banning persistent organic pollutants (POPs)[3] sparked heated debate among those concerned that it would sound the final death knell of the use of vector control in malaria control. Despite initially fierce opposition from environmental groups, health officials opposed to the proposed DDT ban were able to include an exemption for public health applications. Yet aside from slight alterations in rhetoric, donor agencies like USAID continued largely on the same horizontally integrated course with regards to malaria, and continued to deemphasize vector control and DDT.

Aside from the attention generated by the POPs treaty, the launch of the international Roll Back Malaria campaign in 1998 marked a revived international concern over the persistence of the malaria burden. Unable to ignore the rising malaria mortality rates battering developing countries, due in large part to increased chloroquine resistance, the WHO, UNICEF, and USAID, among others, spearheaded this new, ambitious effort to marshal resources and halve the global malaria burden by 2010. Though it offered a new organizational framework to deal with the malaria problem, RBM offered little innovation in strategy. Key objectives remained treatment oriented, with the significant addition of prevention through ITNs. ITNs, which were much more palatable to influential environmental groups and had a proven, if somewhat limited, effectiveness, had become increasingly popular during the 1990s among donors looking for a practical malaria control solution that could be integrated into a horizontal approach and would not generate the same controversy as vector control. Setting the goal that 60 percent of those at risk for malaria across the globe would be covered with these nets by 2010, RBM's architects—including USAID—hoped that significant ITN usage would be both realistic to implement and a major contributor to saving lives.

In addition to setting a new priority on malaria, RBM offered a formal confirmation of the consensus approach used by Western donors to coordinate and dominate international health strategies. As a partnership initiative, however, RBM merely cemented a strategy that key bilateral donors, such as USAID, had been espousing for years: community-based malaria programs integrated into the more general concerns of strengthening primary health care systems, building capacity, and developing sound management and drug policies. The latter had become especially crucial, as the drug of choice for the last half century, chloroquine, had become nearly useless due to high resistance, and the development of ACTs offered new hope for effective drug treatments.

Since its launch, RBM's progress in the fight against malaria has been disappointing. Deaths continue to rise, and a doubling of international resource commitment to the problem has proven ineffectual. Prospects for meeting the RBM goals and objectives by 2010 are dim at best. However, malaria remains a thoroughly preventable and treatable disease, and the means to make significant strides in eliminating its burden are available

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[2] WHO Resolutions in 1989 and 1993 regarding malaria served mainly to reaffirm the malaria control strategy agreed upon in the late 1970s.

[3] The Stockholm Convention of May 23rd 2001 An agreement on persistent organic pollutants was first adopted by the UNEP Governing Council in May 1995 and endorsed by the WHO in 1997. It was finally signed by 91 countries and the European Commission on May 23rd 2001. See www.pops.int for the treaty's full text.

today. The establishment in 2002 of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), a grant-making organization that serves as an international clearinghouse for direct disbursements of donated funds, offers a hopeful avenue for progress if monies are allocated better then in the recent past. In addition, bilateral organizations like USAID have similarly increased their resource commitments to battling the disease. In the next section of the paper, we will provide background on what USAID is, and how it has spent these funds.

III. USAID

Overview

In 1961, Congress passed the Foreign Assistance Act, thereby creating a single agency, known as the United States Agency for International Development (USAID), to serve multiple development functions previously under the domain of separate organizations. The orientation of the new agency would be, as President Kennedy put it, "To prevent the social injustice and economic chaos upon which subversion and revolt feed".[4] The US thus hoped to conflate development aid and national security interests and use USAID as a 'soft' weapon in the Cold War.

A good deal of literature has chronicled the evolution of USAID through the Vietnam War, the humanitarian minded reforms of the 1970s and the reassertions of Cold War primacy characteristic of the Reagan era (Lebovic 1988; Ruttan 1996.). Despite attempts to divorce the Agency from national security considerations during the Carter administration, USAID remained more or less a tool to achieve US political objectives abroad throughout this time period (Ruttan 1996).

Delivery mechanisms of foreign aid did undergo some changes during the Cold War. The reforms of 1973, which established a "basic human needs" criterion in USAID's development mission, also marked a shift towards direct budgetary assistance to developing country governments. Interestingly, despite rhetoric suggesting a move away from such promotion of the public sector, the Reagan administration did little to change this model (Eberstadt 1988; Berrios 2000). Instead, it deemphasized the 'human needs' portion of USAID's mission—with the important exception of health care activities, which grew under Reagan—and reemphasized security related issues (Berrios 2000).

With the end of the Cold War arriving at the beginning of George H.W. Bush's first term, USAID faced a transitional period that led to major changes in how it implemented foreign aid. Since USAID's existence was largely predicated on the crucial role of foreign development assistance in winning the Cold War and protecting US security interests, many in Congress saw little further need for the Agency. Foreign aid spending during the 1990s steadily declined, and conservative Congressmen, foremost among them being Senator Jesse Helms (chairman of the Foreign Relations Committee) called for USAID's complete elimination. Helms, who famously described foreign aid as "throwing money down foreign rat holes", and his colleagues accepted a compromise: make USAID smaller, hold it accountable to the State Department and introduce private sector reforms (Berrios 2000).

The subsequent reforms enacted at USAID during the Clinton administration had the most immediate impact on the Agency's current malaria program, and indeed, on most of its development assistance. As part of the initiative to streamline government through privatization, and make the Agency acceptable to Congress, USAID became largely a contracting organization during the early part of the 1990s. Accordingly, USAID closed 29 missions between 1994 and 1998 and began the now dominant practice of targeting

[4] Remarks at the Eighth National Conference on International Economic and Social Development. June 16, 1961, Shoreham Hotel, Washington DC. http://www.jfklink.com/speeches/jfk/publicpapers/1961/jfk244_61.html

private US commercial firms and NGOs to carry out development work (Berrios 2000). From a political economy perspective, USAID supplanted its bygone national security constituency with an influential interest group of commercial supporters in order to ensure its continued existence. Unable to lobby for funds in Congress itself, the Agency actively beseeches its 'partners' to push for greater funding.

The Contracting Dilemma

Though USAID is not unique among government agencies in achieving its objectives primarily through contracting, it has drawn a great deal of criticism for its particular way of doing business. One major criticism is the Agency's preference for large, US based organizations with which it has long relationships. An analysis by Ruben Berrios in 2000 found that the contracting market structure was segmented and largely uncompetitive. Since a significant part of the supposed advantage of contracting lies in the competition for contracts, drawing from only a small pool of organizations seriously hampers the Agency and increases the possibility of rent-seeking. Berrios found that for-profit firms receive the most money from USAID, the geographic distribution of all contractors skews heavily towards the Washington DC area, and that some of the firms rely exclusively on USAID contracts to stay in business.

In line with criticisms that the USAID contracting process is tilted in favor of insiders, observers have noted that employees of USAID tend to move between agency and contracting jobs with great frequency (Stavrakis 1996; Berrios 2000; Dobbs 2001). The Research Triangle Institute, Chemonics and the Academy for Education Development are but a few of many examples of contractors actively courting former USAID employees (Stavrakis 1996; Dobbs 2001). Inside knowledge of the Agency is clearly valuable for procurement purposes. Indeed, a quick search of any international development job board shows that previous experience procuring USAID funding is a high demand skill.

U.S. Preference

Many other criticisms of the agency persist. Berg (1997) points out that consulting work typically performed by contractors, often disguised in the preferred euphemism of 'technical assistance', undermines the very local institutions and capacity that the aid is trying to build. Berrios (2000) notes that contractors are paid at US rates for work local organizations can do much more cheaply. Indeed, for years, USAID justified its own existence by stressing that foreign aid money benefited domestic economic interests through contracts to US organizations and commodity import programs for US products.

Although exact figures are unclear, USAID spends a significant percentage of international development funds on domestic goods and services. Data from USAID's Buy American Report, the best available assessment, indicates that over the last decade, between 70 and 80 percent of funding appropriations were directed to US sources (Tarnoff and Nowels 2004).[5] In gross terms, the Business Alliance for International

[5] It is unclear what allocations are included in this calculation, and even the Agency's budget office admits that data are incomplete. According to a senior budget officer at USAID, the Agency has ceased to even actively gather data on procurement of US and non-US sourced goods and services in recent years. He explains that gathering the data is difficult, and because the numbers have remained steady for the last decade (between 70 and 80 percent of procurement is for US-sourced goods and services), there is little desire to continually measure this statistic.

Economic Development estimated in 1996 that foreign aid sustained 200,000 domestic jobs.

USAID is not solely responsible for choosing mainly US based organizations to carry out development work. Under the act that created USAID in 1961, Congress included special guidelines to ensure that Agency funds financed goods and services of American origin.[6] The inclusion of these 'Buy American' provisions remains a source of contention for many aid specialists associated with USAID. However, the Agency relies on these provisions both to ensure that its constituency of USAID-dependent contractors continues to lobby for increased funding from Congress, and to appease Agency opponents in Congress with domestic interest arguments. As a result of the benefits USAID accrues by complying these provisions, USAID has refrained from advocating for changes to the Buy American guidelines, nor has it aggressively utilized the exceptions to these rules provided by law.[7]

Reluctance to challenge the status quo on use of American goods and services is typified by the behavior of former USAID Administrator Brian Atwood. After leaving the Agency, Atwood told the *Washington Post* that the Buy American procurement laws were "the biggest headache I had to deal with" at the Agency (Dobbs 2001). Yet during Atwood's tenure, in all of his appearances before Congress and statements to the press concerning his initiative to reform USAID (including its procurement policies), he made no mention of his Buy American migraine. In fact, in 1995 he boasted to a Senate subcommittee that he "introduced reforms to open up USAID's procurement to the best expertise in America", but omitted any reference to non-American sources.[8] During that same testimony, he blatantly endorsed the Buy-American policy, stating, "Foreign assistance is far from charity, it is an investment in American jobs, American business."[9]

Atwood's actions are unsurprising. The political capital bought with USAID's approval of the Buy American rules continues to override concerns over the tying of aid to US interests. Unlike President's Emergency Plan for AIDS Relief (PEPFAR) head Randall

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[6] These special guidelines served as extensions to the Buy American Act, a piece of legislation originally enacted in 1933 with the intent to give domestic producers preference in government purchases. The specific requirements of the Act have been updated periodically (Luckey 2003).

[7] There are three general conditions under which USAID contracting officers may bypass the Buy American restrictions on procurement of goods and services: 1)) If the required article is unavailable; 2) If unforeseen circumstances, such as emergency situations, necessitate non-US procurement; 3) If "it is necessary to promote efficiency in the use of United States foreign assistance resources, including to avoid impairment of foreign assistance objectives";
In addition, procurement may be opened to 'less developed countries' (geographic code 941) under these criteria: 1) when cost from the US is fifty percent more or higher 2) an "acute shortage" for the commodity exists in the US but not elsewhere 3) Persuasive political considerations 4) Procurement in the 'cooperating country' (i.e. the place where the good or service is used) would best promote the foreign assistance objectives 5) Other circumstances critical to projects success.
Finally, federal rules prohibit USAID from procuring goods and services from "foreign policy restricted countries". As of April 1, 2004, these include Cuba, Iran, Iraq, Laos, Libya, North Korea and Syria (China was removed in 2002).
(U.S Government. 2002[last revised]. "Chapter II: Agency for International Development" *Code of Federal Regulations*, Title 22, Volume 1, Parts 1 to 299)

[8] Senate Foreign Relations Subcommittee on International Relations, *Reorganization of US Foreign Affairs Agencies*, 104th Cong., 1st sess., 1995.

[9] Senate Foreign Relations Subcomittee, *Reorganization.*

Tobias, who bluntly announced before Congress his intention to waive Buy American requirements for anti-retroviral treatment[10], no USAID official has similarly conveyed to Congress its desire to sidestep these rules.

Transparency and Criticism

A final, but significant, criticism of USAID contracting policy concerns the transparency of the process. USAID policy forbids the disclosure of "proprietary" information related to its contracts, which keeps the financial details of the bidding process—including the identity of non-winning bidders, specific subcontracting arrangements, and even general budget documents—hidden from public view. Furthermore, USAID's has not updated its online database of contracts—known as the yellowbook—since 2001 (USAID 2003). In addition to such proprietary information, general facts about Agency policies and procedures are likewise off-limits to the general public. In response to a request for information regarding evaluation procedures, a USAID-Kenya employee explained the rules: "I'm unable to respond to your queries due to strict Agency policy of sharing USAID information with people or sources we are NOT familiar with".[11]

In addition to its internal informational controls, USAID disapproves of contractors who disagree with or criticize the Agency. Stavrakis (1996) notes that the Health Enterprise Institute (HEI), which depended solely on USAID for funding, ceased operations because "HEI bumped heads with AID and went out of business." For fear of losing future contracts, few employees of organizations receiving funding from USAID were willing to go on the record with their criticisms when interviewed by the authors. The same is true for USAID employees, who have been known to have career paths derailed after publicly criticizing their employer.[12] Thus, it continues to be extremely difficult for outsiders to know what USAID does, let alone offer suggestions for improvement.

The importance of USAID in Global Health Policy

Before examining how USAID uses its malaria funding, it is important to briefly note why the significance of its actions exceed the annual sum that Congress earmarks for malaria activities. The 'multiplier effect' of USAID policy and programming decisions can often be more substantial than the Agency's direct action.

Like many American agencies, USAID is a trendsetter. Though its leadership role is more subtle than in the days when US funding and expertise dominated the WHO's malaria eradication campaign, American contributions still constitute a quarter of the organization's budget (U.S. Dept of State 2003). Even more importantly, as the world's most powerful nation, US input continues to be the single most important unilateral influence on global health policy (Kickbusch 2002). Former WHO employee and current

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[10] Senate Appropriations Subcommittee on Foreign Operations, *HIV-AIDS*, 108th Cong, 2nd sess., May 18, 2004.

[11] Personal correspondence, Tuesday, April 5, 2004.

[12] A recent example involves former Chief of Travel and Transportation Shirl Hendley, who raised the alarm in 2002 that USAID travel practices violated federal rules. After being ignored by top USAID officials, who benefited from the rules violations, she refused to stay quiet. She was subsequently reassigned because, according to her reassignment letter, "you have chosen to do what you believe is correct, even if it contradicts the instructions you have been given." An investigation spearheaded by Senator Charles Grassley (R-IA) vindicated Hendley and strongly rebuked top AID officials, including Administrator Andrew Natsios and now-retired Inspector General Everett Mosley.

head of the Division of Global Health at Yale University, Ilona Kickbusch, claims that US support for global health initiatives is so crucial that "many international documents read as if they have been written for members of the U.S. Congress rather than for the broader global health community" (134). As the development arm of the US government, whose financial and political support is crucial for global health programs, USAID thus has considerable input in designing policies and strategies for such initiatives.[13] In malaria policy, USAID was a key player in the design of the present RBM initiative and continues to exert its influence in policy formulation. Thus, strategic and operational improvements undertaken at USAID will upgrade the whole RBM movement.

In addition to its impact on global health agencies, USAID acts as a role model for private lending. Private donors to international causes—whose giving triples official US government assistance—look to USAID as the arbiter of what programs and interventions are acceptable to fund. Corporations, who value the good publicity generated from their charitable contributions, are wary of crossing swords with official US development policy. ExxonMobil, for instance, explicitly endorses RBM and funnels its $1.5 million contribution to the battle against malaria through USAID-affiliated ITN programs. Thus, the path that USAID chooses in its efforts to combat malaria has far greater consequences than its Congressional earmark.[14]

[13] Fear that the US will withdraw support for international health efforts over policy disagreements are grounded in reality. The US pulled $34 million from the UN Population Fund and redirected it to USAID after a dispute over proposed spending restrictions for abortions and abortion rights (Kickbusch 2002).

[14] See Congressional testimony by Roger Bate for more detail on this issue (http://wwwc.house.gov/international_relations/108/bat091404.htm)

IV. SAVING LIVES, ONE CONSULTANT AT A TIME

The following section describes the organization, composition and results of USAID's malaria funding. It first bears noting that obtaining this information proved extremely challenging. Part of the difficulty stems from the Agency's ignorance of its fractured and disorganized malaria programs. The biggest obstacle, however, is USAID's unwillingness to share information with outsiders. The Agency's transparency deficiency is evident not only in its refusal to release details of the contracts it uses to allocate its $80 million malaria endowment, but also in the vague and ambiguous information it does provide. USAID's secretive behavior over information unrelated to national security leaves a strong impression that opacity is its intention.

A further complication attendant in researching USAID uses of funding is the Agency's well deserved reputation for skirting established regulatory guidelines and exploiting exemptions to Federal Acquisition Regulation (FAR) guidelines to its advantage. A veteran Department of Defense employee who came to work at USAID confided that he was "shocked" by the manner in which Agency employees used the FAR's emergency exceptions to avoid proper procedure in cases that clearly did not warrant special treatment. The lack of continuity between government policy and Agency practice is troublesome and difficult to elucidate in an atmosphere where employees do not feel comfortable openly criticizing the organization's actions.

Finally, some of the information gathered here came as a result of Congressional pressure on USAID to explain where its malaria money is being spent. The pressure began in February 2004 when Senators Judd Gregg and Russ Feingold, reacting to articles in the British medical journal *Lancet*[15] and the Wall Street Journal[16], called for an investigation into USAID's malaria funding upon learning that the Agency bucked its own policies by declining to back effectual drugs (i.e ACTs). In October, two Congressional hearings later, now retired assistant Administrator Anne Peterson was embarrassed by Senator Sam Brownback when she proved unable to account for how USAID spent the $80 million it received for malaria in 2004.[17]

Since Anne Peterson first spoke to a Congressional subcommittee about USAID's malaria program in September of 2004, not a single program report, evaluation or other document concerning the Agency's malaria activities has been published on the Agency's publicly available database (the Development Experience Clearinghouse)[18]. But as a result of the efforts of independent scientists and organizations, and the subsequent interest demonstrated by Congress, in December of 2004 USAID distributed, to those who had made inquiries, the most comprehensive breakdown to date of its malaria allocations.[19] The report, titled "USAID Malaria Programs 2004", offers only short,

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[15] Attaran et al, 2004. "Viewpoint: WHO, the Global Fund, and medical malpractice in malaria treatment", *The Lancet*, January 17, 363(9404):237.

[16] 2004. "Review and Outlook: WHO's Bad Medicine," *Wall Street Journal*, January 21.

[17] Testimony from that hearing can be found at http://foreign.senate.gov/hearings/2004/hrg041006p.html

[18] Based on latest (May 23, 2005) search of the Development Experience Clearinghouse database for keyword "malaria."

[19] The report in question has not been made public, nor is it likely to be publicized any time soon.

vague descriptions of line item activities, and does not identify the 'partners' (contractors and grantees) responsible for implementing enumerated programs. It also contains numerous errors and omissions. Most disturbingly, funding breakdowns contain mathematical errors. The stated subtotals do not sum to the total figure given for malaria spending.

A Blind Hydra: The Organization and Process of USAID Funding

The fractured and confusing organization of USAID's malaria efforts constitutes a key obstacle to focused and effective programming. USAID manages resource constraints by diffusing funds thinly across numerous countries, which hampers efforts to make significant strides in any one place. In addition, program structures skew heavily towards the near exclusive involvement of large US based NGOs and contractors, which leaves little hope for the sustainable outcomes and the building of local capacity that USAID claims to support. Finally, USAID sustains and compounds problems of disorganization by its lack of transparency.

How USAID Receives and Distributes Funds Internally

Each year, Congress earmarks a specific sum for USAID to spend on malaria. Reflecting greater concern with rising malaria mortality rates, that sum has increased from nearly $14 million in 1998 to $80 million in 2004, and now represents approximately six percent of the Agency's total 2004 budget request for Child Survival and Health (CSH) Programs[20].

Table 1

USAID Malaria Program Funding 2004 (in thousand $US) [21]

Region	**Funding**	**Average Per Country/Regional office**
Africa	40,710	1,800
Asia Near East	5550	925
Europe and Eurasia	1,000	1,000
Latin America and Caribbean	4,120	687
Total	**51,380**	**1,500**
Bureau of Global Health	**Funding**	
Global Leadership	5,874	n/a
Support to Field	13,707	n/a
Research	10,577	n/a
Total	**30,160**	n/a
Agency Total	**(*SIC*) 79,530**	n/a

1All numbers are reproduced directly from "USAID Malaria Programs 2004". Arithmatic mistakes are preserved from the original, hence column sums do not equal Agency Total.

[20] It is unclear whether USAID accounts for all its malaria funds in the CSH category

[21] The source of this information is "USAID Malaria Programs 2004". The report's mistakes in tabulation, inconsistencies in accounting methodology and vague descriptions made it impossible for us to calculate exact figures. Indeed, stated country and regional totals do not sum to corresponding subtotals, and neither method of calculation (summing stated country and regional totals or summing stated subtotals) yields a total figure equal to the stated $79,530,000. In addition to basic arithmetic weaknesses, the report omitted a monetary value for the procurement of bednets and medicine in Uganda and failed to specify which anti-malarial medication was purchased in Uganda and the DRC. Thus, numbers stated here are best approximations from flawed data.

USAID officials allocate funds to the central office and individual country and regional bureaus (see table 1 for funding breakdowns). Funds diverted to the central office in Washington, known as the global bureau, are ostensibly for activities beyond the scope of specific countries and for which individual bureaus have no incentive to invest. These include research, such as the $7,260,000 spent on malaria vaccine development in 2004, transnational policy reform, such as working on continental barriers to pharmaceutical imports, and provision of Washington-based 'backstoppers' in support of field programs.

The distribution of funding by country breaks up rather evenly. In Africa, where malaria money is divided between 20 countries and 3 regional offices, funding for both averages $1.8 million.[22] For all the individual country and regional offices across the globe, the average allotment is an even smaller $1.5 million. Such a thin-but-wide disbursement strategy is highly dubious. It limits program options within each country and prevents large investments in successful programs. Diffuse funding does however support a large number of missions, and their well compensated staff, and gives a superficial indication of USAID's global pervasiveness with regard to malaria control.

Methods of Funding

After securing its annual funding, each mission (i.e. USAID country field office) must then budget its malaria monies. One option is to buy into existing contracts managed by the central USAID office. These contracts, known as Indefinite Quantity Contracts (IQCs), obligate the contractor to perform a specific scope of work for the global bureau in Washington, but also include a mechanism for individual country offices to purchase services.[23]

Missions may also negotiate directly with eligible agencies. Such direct bilateral mechanisms are becoming increasingly popular with USAID missions that prefer the flexibility to set their own guidelines. Due to high management costs and personnel shortages at many missions, missions generally reserve bilateral contracts for projects with longer life spans, and buy-ins used for short term needs.

When a country, regional or global bureau negotiates funding with an outside agency, it must follow reasonably standard guidelines. Three types of funding agreements for these transactions exist: grants, contracts, and cooperative agreements (CAs).[24] These three vary according to their level of specificity. Grants are made to an organization for a specific purpose and activity. They are the least prevalent funding mechanism, but can

[22] For the 23 African country and regional offices, mean=$1,791,739, Standard Deviation=$877,820, and median=$1,800,000.

[23] The initial contract specifies a minimum sum that USAID will purchase from the partner, a best guess of how much 'incremental funding' missions are expected to add, and a ceiling for such funding additions. Since buy-ins may potentially double or triple the value of a contract, these mechanisms are major incentives for contractors. From the perspective of missions, buying into IQCs carries the advantage of reducing the transaction and management costs associated with negotiating and overseeing new contracts. Because USAID does not release contracting details, it's impossible to determine exactly what percentage of these contracts are composed of country buy-ins. USAID staffers consulted for this article estimated figures ranging from 25 to 75 percent, though all note substantial heterogeneity.

[24] Acronyms at USAID can be quite confusing. The abbreviation 'CA' can refer either to a Cooperative Agreement, or to the partner in such a contract, known as a Cooperative Agency.

be utilized by USAID to skirt the more stringent competition and bidding requirements of other mechanisms. Contracts are more popular than grants and are generally also used for specific activities. These may be procurement related—as in a deal to buy a certain number of condoms from a producer—but are more often for a particular service, such as consulting with a local health ministry on a particular drug policy issue. Finally, the most pervasive type of agreement, CAs—which are often referred to as grants due to similarities in the procurement rules for each—are employed when USAID has specified a general area of work needed in a particular location(s), but not the intricacies of how the work will be undertaken.[25]

The types of health programs funded under these three mechanisms can be further divided into two broad, permeable categories[26]: 1) direct Private Voluntary Organization (PVO) programs and 2) global technical projects[27]. The first consists of grants and contracts awarded to PVOs—non-profit organizations based almost exclusively in the US[28]—for various field projects. These are usually funded through specific contracts or grants, often with a specific mission. PVO programs, however, comprised only 24% of total USAID spending in 2003 (USAID 2005a).[29] USAID funnels much of the PVO award money to a few large agencies, such as AED and MSH.

The other general type of programming–global technical projects—usually involves more generalized work centered on cooperation with national and district level governments and government agencies. These programs aim to improve policies related to malaria control activities and strengthen health and health management systems. Funded by either contracts or CAs—usually the latter—such programs typically consist of sending

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[25] Adding to the confusion are the means by which these agreements are procured. In one scenario, the relevant bureau issues a Request for Proposal (RFP), in which it specifies precisely what work it wants accomplished—and usually how it should be done—and judges the subsequent proposal submission according to several criteria. The winner of the competition generally receives a contract to provide what it promised in the proposal.
Alternatively, a bureau might issue a Request for Assistance (RFA) in which a particular problem or challenge is posed, and competing organizations propose a program that will provide a potential solution. Winners of RFAs can receive contracts or CAs, depending on the nature of the problem and solution. Finally, some funding agreements arise from unsolicited proposals. These proposals generally arise as a response to areas of need emphasized in each bureau's annual program statement and are not subject to the same rules of competition.
In addition, to these details, each contracting agreement must conform to a specific type and structure specified by the FAR. See Berrios (2000) for a comprehensive overview of cost structures, contract types and negotiation and competition rules used by USAID.
[26] Research activities, which consume 10.5 million—or 13 percent—of USAID's malaria budget are not included in this analysis.
[27] The categories 'Global Technical Project'—which refer to projects primarily involving consultations with national health bureaus—and 'Direct PVO programs'—which are generally field operations implemented directly by a PVO—are general categories. USAID does not officially classify its programs according to these criteria, and does not keep official statistics on funding levels for either. Assertions made in this paper concerning relative funding levels for each category are based on consultations with USAID employees and reasonable inference from line item descriptions in "USAID Malaria Program 2004."
[28] As of February, 2005, USAID had 516 registered US PVOs, and 58 international PVOs. For most grant competitions, only US PVOs are eligible. However, international PVOs may be eligible as sub-grantees on a particular project.
[29] By law, USAID must fund PVOs at least the equivalent of 1995 levels, which constituted 15 percent of the agency's budget (GAO 2002: 7)

US consultants to advise health ministries on ways to implement better drug policies, improve human resources, increase efficiency through better management. Occasionally consultants oversee specific health projects and train selected workers. Depending on the activity, PVOs may execute global technical projects, as well.

Organizational Problems: Data and Monitoring

Data on USAID development contracts and projects is scant. According to a US General Accountability Office (2002) report, the Agency simply does not bother gathering such information: "USAID does not collect financial data that would allow a detailed funding analysis for any specific type of nongovernmental organizations except PVOs" (7). In addition, the report found more general accounting problems contributing to the information lapse: "The Agency's data on its use of PVOs and NGOs were not complete due to the disparate accounting systems and limitations in its data-coding procedures" (7). Existing information is "plagued by data entry flaws, and organizations are frequently categorized incorrectly" (7).

USAID's data shortfalls are widespread. According to the Agency's website, the number of evaluations submitted to its document repository for all projects has declined from 529 in 1994 to 135 in 2003 (USAID 2005b). The decline in evaluations stems primarily from an Agency rule change enacted during the reforms of the Clinton Administration that eliminated reporting obligations from recipients of USAID money (Weber 2004). Whereas previously USAID mandated that every program must generate a midterm and final report, the rule change allowed program managers the flexibility to negotiate the monitoring and evaluation components of each programs with funding recipients on a case by case basis. Originally intended to save needless paperwork and give program staff more flexibility, the relaxation of requirements has simply resulted in less information on program performance.

According to an internal review of USAID's evaluation experience by Janice Weber (2004), past recommendations for improving the evaluation system have been ignored by the Agency, and current evaluation practice is rife with impropriety. The report notes that the quality of current evaluations has deteriorated substantially due to "a system that only rewards success (thus, the overwhelming majority of self-graded, fully successful SOs [strategic objectives]), rather than rewarding an honest assessment" (14; parentheses preserved from source). Other critics have noted similar weaknesses. Clements' (1999) investigation of USAID program reports found favorable portrayals of failed projects, use of measurement criteria unrelated to program impacts, and whitewashing of legitimate concerns. Positive bias in evaluations and assessment is particularly problematic when reviews are conducted by, or with considerable input from, the partner carrying out the particular project.

Further, according to Weber, Missions (USAID's field offices) have been known to deny country clearance to Global bureau evaluators in order to cover up program deficiencies or other problems. She also suggests that program officers or evaluators will even insert proprietary information into evaluations, or deceptively categorize them as 'assessments', in order to avoid submitting these documents to the public domain. Weber stresses that her key recommendations (requiring submission of evaluations, withholding payment to partners/Missions who do not submit evaluations to the public domain, regularly using

external evaluators, reemphasizing exchange of information with other agencies) are not new ideas, but ones that Senior Management has ignored for the past decade.

USAID's informational shortfalls are particularly disturbing considering the Agency's disparate structure. Without good centralized information sources, effective cooperation between USAID's many heads is nearly impossible. Multiple funding mechanisms increase the confusion and decrease the ability of well-intentioned employees and partners to make a comprehensive review of Agency efforts. As documented by the US General Accountability Office (GAO) report, USAID's lack of data on the types of organizations it funds and the funding mechanism it employs makes it impossible for the agency to effectively evaluate what works best (GAO 2002:10, 20). The inability—as well as the unwillingness—to evaluate one's own performance seriously impairs the process of designing effective programs for the future. It also casts grave doubts on the Agency's ability to make effective use of additional funds.

In addition to undermining USAID's potential for effectively evaluating its use of funds, the combination of an unnecessarily complex organizational structure and inadequate information on internal activities hinders cooperation amongst USAID contracting partners and other development agencies. Without a centralized source of reasonably detailed information on existing activities, there is little hope that other organizations might fill in gaps left by USAID activities. This point is especially salient with regard to malaria, for which USAID takes a narrow approach to programming.

Pathways to Unsustainable Outcomes

Another problematic element of USAID's organizational structure concerns the nearly exclusive employment of US based organizations for its development work.[30] Utilizing primarily US and Western NGOs to carry out development work usually has a deleterious effect on prospects for sustainable capacity building.[31] When local organizations do not have stewardship over health projects, there is little chance that they will continue after the implementing NGO leaves. That's not surprising, considering that the incentive structure inherent in USAID's contracting model promotes dependence on outside institutions. Few organizations—both for profit and non-profit—can be expected to legitimately work towards creating an environment that no longer requires their existence. Yet so many USAID projects, like the recently minted $250 million grant given to North Carolina's Intrahealth and eight other US-based subcontractors for work on building health care capacity in developing countries[32], ask partner organizations to attain goals that would render these outfits obsolete. Especially in malaria programming, where USAID's stated strategy consists of "reducing the burden of malaria by helping countries develop the *capacity* to more effectively prevent and appropriately treat

[30] See the Section 3 for more detail on the reasons behind USAID's procurement preferences.

[31] The potential for foreign aid to undermine local capacity has been noted by several economists, most notably P.T Bauer, see Reality and Rhetoric: Studies in the Economics of Development, Harvard University Press, 1984. Also, see The Elusive Quest for Growth, by William Easterly. Most recently, in a speech delivered at the World Bank, Francis Fukuyama criticized development aid that employed foreign agencies to spearhead delivery as undermining local capacity building.

[32] USAID has not yet officially announced the awarding of this grant, even though the Agency finalized the deal on September 30, 2004. As of April 2005, information on the project, including verification that it exists, is not posted anywhere on USAID's official website.

malaria", the nearly exclusive use of US organizations is a recipe for failure (USAID 2005).

USAID has made some rhetorical commitments to integrating local institutions in its development work. Most notably, Vice President Al Gore's New Partnership Initiative (NPI), launched in 1995, suggested "enhancing the impact of the Mission's active involvement with local stakeholders (USAID 1997). However, as evidenced most clearly in the unchanged level of funding dedicated to US organizations (approximately 75 percent since 1995), application of that principle has been lacking. Snook (1999) quotes a USAID contractor and a USAID mission employee in Tanzania describing how NPI worked in the field:

> [According to the contractor], the effort to bring beneficiaries [i.e. locals] in as stakeholders and partners was not working because the 'partners' don't have time for all the endless meetings. Decisions were still made in advance. The 'partners' are invited in to rubber stamp the decision, to demonstrate "partnership"…[According to an official at the Tanzanian USAID mission,] 'The Tanzanians are brought in at the end to stand there and nod yes'. (97).

Such behavior can hardly be construed as strengthening local capacity.

Another indication that NPI is more rhetoric than action is the continued priority given to big contractors like Population Services International (PSI), Management Sciences for Health (MSH) and AED. Theses organizations typically have little connection to local civic groups within the community, and do not emphasize developing such relationships. Yet programs like the Child Survival and Health Grants Program (CSHGP), which funds NGOs who do work with local groups, have not seen funding increases despite the significant rise in USAID's health budget.

Reforming the near-exclusive use of large US and Western organizations will be difficult so long as the Agency's current funding structure remains in place. Further, the imperiled status of USAID during the 1990s seems to have made the Agency unhealthily fearful of juicy press accounts detailing how a local organization embezzled US aid dollars. As Hyden and Mease (1999: 222) describe, "USAID has been caught squarely in the accountability trap", meaning that the Agency would rather allocate its monies to US organizations likely to waste a good portion of it but steal none, rather than local institutions that are in a better position to effectively use resources but are more vulnerable to instances of fraud and embezzlement (Bate and Schwab 2005).

Despite these obstacles, recent developments offer hope for much needed change. With unprecedented fervor, the current administration has supported foreign aid projects, such as the $15 billion PEPFAR initiative, without appealing to arguments based on the benefits that will accrue to domestic interests. Further, threats from terrorism, and concerns over a tarnished American image abroad, have spurned a renewed interest in humanitarian projects abroad. Thus, the present political climate appears amenable to altering the practice of excluding local groups.

Summary of Organizational Issues

The complex layers of internal bureaucracy and varied types of funding mechanisms have engendered an incoherent and ineffective framework for operating a successful malaria program. Currently, the manner in which malaria funds are used by USAID suffers from weaknesses in both organization and process. The fractured geographical distribution of resources prevents USAID from accomplishing substantial work in any one country.

Scattered resource allocation likewise promotes diffuse accountability. Disseminating funding across wide breadths of countries and through multiple avenues of contracting agreements relieves individual USAID officials operating in various missions of the responsibility for general failures. Similarly, the Washington based malaria team, with little actual control over funding decisions, avoids overall culpability. No matter how well intentioned and talented these officials are, success rarely results from such an arrangement.

The combination of USAID's diffuse structure and inability to develop a comprehensive internal information network limits effective cooperation and hinders efficient program development. Informational deficiencies at the Agency are severe. Data regarding its own projects and financial commitments are grossly inadequate both for designing effective projects based on past experiences and managing existing ones. In addition, no one branch of USAID has full knowledge of activities occurring in other branches, which severely limits the potential for effective coordination with other aid agencies .

Finally, the predominance of US based organizations contracted as project implementers undermines the Agency's capacity building approach to health problems, particularly malaria. Sustainable results are difficult, if not impossible, to obtain when foreign organizations maintain primary stewardship of development projects. Thus far, scant evidence exists to suggest that USAID's rhetoric espousing the increased involvement of local institutions is being applied.

V. *MONEY FOR MALARIA: HOW IS IT BEING USED?*

Thus far we've examined the historical arc of malaria control activities, the institutional history of USAID and its current structural organization. The recurrent themes of organizational weakness, lack of coordination, informational deficiencies, ineffective programming, unsustainable outcomes, poor leadership and slow, overly cautious and incomprehensible decision making overtly manifest themselves in USAID's malaria control program.

Words, Not Butter (Medicine, Insecticides or Bednets)
With regards to malaria control, the strategy USAID has adopted can best be described as an extreme capacity approach. According to the official USAID malaria website, the Agency is committed to fighting malaria by helping countries "build the capacity" to prevent and treat the disease (USAID 2005d). The phrasing is no accident; for the most part, USAID does not use its funds to help countries directly fight malaria.

Thanks to the recently issued "USAID Malaria Programs 2004",[33] for the first time it is now possible to determine how this capacity approach manifests itself in funding decisions. The results are striking. Of the $80 million Congress allocated to USAID to fight malaria in 2004, USAID used only approximately $4 million to purchase life saving interventions.[34] That's an estimated 5% of total malaria funding spent on the mechanisms proven to prevent and treat malaria: IRS chemicals and equipment, medicines and ITNs, with most going towards the latter. USAID did not spend any money on insecticides or ACTs.

Determining how USAID used the rest of the money is much more difficult. Besides the $10.5 million dedicated to researching and testing a malaria vaccine and new malaria drugs, USAID utilized the remaining funds mainly for activities such as "technical assistance", "strengthening capacity", "policy revision" and "social marketing of ITNs". Details of these funding allocations are absent since the report declines to provide adequate descriptions, or even the names of each activity's 'implementing partner'(i.e. contractor or grantee).

According to USAID officials consulted for this paper, phrases like "technical assistance" and "capacity building" refer mainly to hiring consultants, based predominately in the US, to advise government ministries on relevant policy and management issues. Sometimes, training of local staff plays an integral role in these activities.

Reports of spending in Ghana reflect typical allocation patterns. In that country, USAID allocated $200,000 for "direct technical assistance to [sic] Government of Ghana supporting transition of ACTs", including training local drug regulators. That sum was also used to "build capacity of local private sector drug manufacturers and strengthen

[33] USAID produced this report after members or Congress and others pressured it for better accounting on malaria activities . USAID has distributed it only to those who have requested information on the agency's malaria funding; it is not available to the public. The working title appears to be "USAID Malaria Program 2004," and the report does not give an author, whether a person, department, or bureau.
[34] As described in the previous section (footnote?), arithmetic errors and omissions of data prevent precise reporting of figures. Numbers here are best approximations from flawed data supplied by USAID.

drug quality monitoring." An additional $200,000 line item is allocated to another popular spending destination, "malaria in pregnancy." The description for this activity reads, "Provide direct support to policy revision that included introduction of intermittent preventive therapy [IPT] for pregnant woman during routine antenatal visits."[35] As in nearly every description in the USAID report, no indication of the manner of "support" (or "assistance", "strengthening" etc…) is provided. What is certain, however, is that USAID did not use the funds to buy the medicine that IPT uses to protect pregnant women from malaria.

Allocations to ITN-related activities represent another common destination for USAID funding. USAID and the rest of the RBM community have identified ITNs as the most crucial prevention mechanism for reducing the malaria burden.[36] USAID funds this intervention under the auspices of its Netmark Plus program, a "$65.4 million dollar project designed to reduce the impact of malaria in sub-Saharan Africa through the increased use and sustainable supply of insecticide treated mosquito nets (ITNs), and insecticide treatments kits for nets, through partnership and joint investment with more than 20 multinational and African commercial partners" (AED 2002)

Netmark is mainly an ITN-selling program. Therefore, it promotes the use, distribution, and retreatment of nets, but spends little money providing funding for their purchase by those at risk for malaria. That strategy, while offering hope for a sustainable impact, often results in inefficient allocation decisions by USAID. In Senegal, for example, a 2000 Netmark survey funded by USAID found that half of respondents who did not own a net cited the inability to afford one as their reason for non-ownership (AED 2001). Only 10% said that nets were not available or they did not know where to get them. Yet in 2004, USAID allocated funds to Senegal's malaria prevention effort in order to "expand delivery of ITNs through the commercial sector."[37]

Unsurprisingly, the Netmark team seems to have ignored its own research in Senegal. According to the survey, supply problems in that country were insignificant. Also, residents knew about the beneficial properties of ITNs, as 99 percent of respondents cited advantages to using one. But drawing the logical conclusion from this data—that Senegal already had adequate ITN distributional mechanisms and public awareness—would have refuted the need for Netmark operations in that country. Certainly, the administrators of the Netmark program had no incentive to point this out to its USAID backers. Nor could they legitimately be expected to refuse funding, though such a move would have certainly boosted their credibility. Rather, USAID simply failed to evaluate

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[35] Ghana's "malaria in pregnancy" entry is more descriptive than many other countries. In Angola, $200,000 "supports efforts to improve the provision of malaria treatment and prevention measures through antenatal clinics including ITNs and Intermittent Preventive Therapy (IPT)." The report describes a $300,000 allocation in Mali only by "support IPT delivered through routine ante-natal care (ANC)." The report employs similar phrasing for the vast majority of countries with a "malaria in pregnancy" line-item.

[36] The ITN-centered approach to malaria control remains a contentious issue. Many malaria experts argue that IRS, the method used to eradicate malaria in the developed world, is the most effective prevention mechanism (see, for example, the testimony of Dr. Donald Roberts before a Senate subcommittee hearing on malaria in East Asia http://foreign.senate.gov/testimony/2004/RobertsTestimony041006.pdf).

[37] USAID also spent an unspecified amount in Senegal on targeted subsidies for ITNs in collaboration with UNICEF. But, as with all countries in which USAID reports funding subsidies, the Agency gives no indications of the amount of funds dedicated to this purpose.

how it could most usefully employ its malaria funds, despite the existence of available data, and so allocated money to a program with marginal potential.

Understanding the Consultation Approach
USAID's emphasis on consultation, as opposed to medication and tools for prevention, results from an intentional effort to eliminate procurement of life-saving interventions from Agency funded programs. In the 2004 version of its guidelines for appropriate uses of health funds,[38] USAID urges its missions to fund programs that promote "Increased *access to* and *appropriate use of* ITNs and, where appropriate, IRS; Improved *use of* effective drugs for effective treatment" (43) [italics added]. The phrasing deliberately discourages the direct funding of programs that purchase *and* use ITNs, IRS, and medicine.

The rhetorical distinction between supporting the use of an intervention and actually supplying it becomes clear when the word choice for the Malaria Activities section is compared with the Family Planning Activities section, where allowable programs include "supporting the *purchase and supply* of contraceptives and related materials" (45) [emphasis added]. If USAID were truly committed to purchase and use of ITNs, IRS equipment and ACTs, it would employ similar phrasing.

In following such a strategy, the Agency is attempting to give malarious countries the necessary 'skills' to battle the disease, but declining to provide the necessary tools. Effectively combating malaria without tools is impossible, but some still assert that USAID should continue with its narrow approach and allow other agencies to supply the proper mechanisms. Before a Senate Subcommittee, former Assistant Administrator Anne Peterson testified, "With USAID providing critical technical "know how" and the Global Fund providing the resources for the procurement of key commodities for the prevention and control of malaria there is a growing optimism that malaria endemic countries can soon begin turning the tide against malaria." [39] But such a claim of careful coordination is an exaggeration.

Except in a few isolated instances, there is little evidence that the type of cooperation Peterson described occurs[40]. The disorganized and decentralized nature of the Agency, as well as the political considerations governing many funding decisions and contracting methods, is antithetic to the notion that USAID might engage in full-scale global

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[38] The document in question is titled "Guidance on the Definition and Use of the Child Survival and Health Programs Fund and the Global HIV/AID Initiative Account." It is updated annually to reflect changes to statutory spending guidelines and available at http://www.usaid.gov/policy/ads/200/200mab.pdf

[39] Subcomittee on East Asian and Pacific Affairs, *Neglected Diseases in East Asia: Are Public Health Programs Working?* 108th Cong, Sess. 2, October 6, 2004. http://foreign.senate.gov/testimony/2004/PetersonTestimony041006.pdf

[40] Congressional testimony by USAID officials suggests claims of close cooperation are more rhetorical than actual. For example, on September 14, 2004, Peterson told the House International Relations Committee, "USAID is also presently working with 25 Global Fund Recipient countries in preparing detailed plans for the introduction of ACT over the next year" Eight months later, Deputy Assistant Administrator for Global Health Michael Miller indicated the lack of progress on this front by repeating the same claim, verbatim, in his written testimony to the Senate Subcommittee on Federal Financial Management.

cooperation with other aid agencies. Barring a major overhaul that includes radical improvements in Agency transparency and data management, transforming USAID into a collaborative program implementer at an international level is impractical in most circumstances.[41]

Another USAID explanation for not buying direct medical interventions is that the Agency avoids crowding out the private sector or other donors who will provide such interventions. Yet USAID applies this approach inconsistently. Their provision of advisory services also undermines local service providers. Indeed, some successful private sector responses to the malaria problem rely on contracting independently and for limited time with local African experts and not resorting to using USAID contractors (Sharp 2002)[42].

As described in the previous section, the aspect of malaria control that USAID has chosen to focus on, capacity building and technical assistance, constitutes the area least amenable to improvements through Agency funding. Its contractors, who enjoy the benefits of well paid and widely traveled consulting work, have no obvious incentive to build truly sustainable health networks free from dependence on their own input. Local organizations are much better suited to spearheading horizontal approaches to health problems due to their superior knowledge of local institutions, behaviors, cultures, and environments, as well as their considerable cost advantages. Further, it is inordinately difficult to scale up primary health interventions that do not have innately native stewardship. Yet even if Western NGOs can perform capacity building interventions adequately—and they occasionally do—their efforts are for naught without the proper tools (insecticides, ACTs, ITNs) with which to fight disease, and a contractual arrangement that allows successful programs sufficient time to achieve program goals.

USAID has been reluctant to offer a justification for its funding strategy. Some PVO employees and other critics have suggested that the Agency's unwillingness to purchase ITNs, insecticides and ACTs stems from the fact that US firms do not produce these products. The US is, however, replete with consulting and development NGOs eager to support the Agency as long as it funds their work.

An alternative explanation posits that funding large US firms to perform "technical assistance" and "capacity building" activities represents a safe and easy outlet for Agency funds. Unlike more concrete strategies, the sufficiently vague capacity approach has remained free from undesirable controversy generated by alternative methods like the utilization of insecticides and pharmaceutical purchases. Too disorganized to launch bold initiatives on its own, and too cowed by Congress to risk trusting its money to organizations whose employees do not speak English, USAID simply follows the path of least resistance when allocating its monies.

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[41] USAID does indeed cooperate with other aid agencies, but such collaboration is generally not pragmatic, and instead is limited to policies and goals (e.g. formulation of the RBM initiative). For more extensive analysis of the coordination issue, see Snook (1999) and Hyden and Mease (1999).

[42] See Sharp et. al. (2002) for details on an IRS spraying spearheaded by Konkola Copper Mines

Evidence for the 'path of least resistance' hypothesis is apparent in the Agency's handling of ACT treatment. In internal e-mails obtained by Freedom of Information Act requests, former head of the malaria team at USAID, Mary Ettling, advocates a cautious approach to switching over to these drugs. In an e-mail describing a meeting with RBM officials, Ettling explains how she intervened so that the officials "appreciated the difficulties of a rapid switch to coartem".[43] She tells another colleague, "let's not argue for SP+ART [a type of ACT] just now,"[44] and later writes to a group of USAID officials, "neither would I suggest bashing ahead in the field with coartem"[45]. Another senior USAID malaria official, Dennis Carroll, told the *New York Times* in 2002 that coartem was "not ready for prime time."[46] USAID's reluctance to support ACTs infuriated many malaria experts, who argued that resistance levels to the alternative drugs advocated by the Agency were unacceptably high and that the safety and efficacy of ACTs was demonstrated clearly during the 1990s (Attaran 2004).

Arguments that the Agency's undue preference for US-based procurement hampers best practice, and that USAID takes an overly cautious approach to public health in order to avoid controversy, both reflect poorly. Even if neither charge is completely true, they will continue to dog the Agency until it provides a convincing defense or changes its tactics. As yet, it has not.

[43] December 19, 2001.
[44] April 5, 2001
[45] January 9, 2002.
[46] McNeil D. New drug for malaria pits US against Africa. *New York Times*, May 28, 2002 .

VI. NOTES FROM THE FIELD

For the bulk of its $80 million malaria endowment, USAID gives little indication of how exactly the money is spent and what outcomes this funding generates. From the nature of the work—technical assistance, capacity building, policy reviews—it can be safely assumed that a large portion goes to the salaries, living allowances and travel expenses of Western consultants. For example, an analysis of the 2003 IRS Form 990 from MSH reveals that over sixty percent of that organization's *program* expenses are dedicated to compensation and travel.[47] As explained in previous sections, such work rarely generates publicly available documents with detailed descriptions of program results, and, as per USAID policy, the public are not privy to any information that might be construed as "proprietary". These types of activities have benefited most from the Agency's augmented malaria budget in recent years.

In contrast, certain programs at USAID are subject to strenuous evaluation available for outside scrutiny. Despite the elimination of evaluation requirements, certain branches of USAID, usually those in charge of awarding grants or well-defined contracts, have maintained rigorous standards of evaluation and information sharing. These projects usually fall under the label of "direct PVO programs," and clearly demonstrate that effective data collection and transparency are feasible. However, despite a five-fold increase in the Agency's malaria budget since 1998, direct PVO programs like CSHGP have not seen significant increases in funding.

The following three case studies, drawn from publicly available evaluations, illustrate how USAID's malaria strategy hinders effective programming. They do not represent a representative sample of malaria programs, but offer a more concrete illustration of the complications wrought by Agency weaknesses already discussed. These examples demonstrate how structural and strategic shortcomings hinder effective programming. Most importantly, the program summaries offer excellent insight into why increased Agency funding has not resulted in a decreased malaria burden, and why raising future funding levels is unlikely to produce excellent results without significant Agency reform.

[47] Due to deficiencies in MSH's disclosure of subcontracts, this number should be treated as a reasonable estimate. The real percentage may actually range as high as seventy percent, or as low as fifty-two percent.

1) THE BUNGOMA DISTRICT MALARIA INITIATIVE (BDMI), KENYA; 1998-2002

Operating in one of the world's most malarious areas with a $5 million budget, BDMI aimed "to reduce mortality and cases of severe illness due to malaria in Bungoma District" (Olenja et al. 2003: 6). Though typical in its indirect approach to fighting malaria, the program differed from many of USAID's global technical projects by working at a strictly district level, thus facilitating the incorporation of a strong monitoring and evaluation component. The Bungoma District Health Management Team (DHMT), representing Kenya's Ministry of Health, implemented the project, while American NGOs and CAs [cooperating agencies] provided "technical and logistical support"[48] (Olenja et al. 2003: 9).

In its design and implementation, BDMI shares several characteristics with other malaria projects: 1) it made no effort to measure whether the project made any progress towards its goal (reduction of deaths and severe illness due to malaria); 2) it instead measured several objectives (five in this case) loosely related to its goal; 3) it revised downward its targets for some of those objectives after the mid-term report revealed unsatisfactory progress; 4) it failed to meet many of these objectives (even downwardly revised ones); 5) US based NGOs providing technical assistance underperformed, due in large part to coordination problems; 6) it showed that the biggest obstacle to widespread use of an effective malaria intervention (in this case bednets) was financial; 7) it did not improve upon program weaknesses cited in the mid-term report; 8) despite unimpressive results, the final evaluation gave the program a positive assessment.

The program hoped to accomplish five objectives: improved management of fever and anemia (hallmarks of malaria) at health care facilities; improved management of fever and malaria at home; improved prevention and management of malaria in pregnancy; increased household use of insecticide treated materials; and effective collection and use of data. Regarding improved management of fever and anemia, the project scored some successes in training health care workers in diagnostic techniques and appropriate treatment courses.[49] However, of the four main indicators related to these two objectives, one target was not met (percentage of health care workers with training), and one (children with severe febrile disease correctly classified) was met only after revising the target downwards from 80 percent to 50 percent.

The connection between improving health care workers' skills in diagnosis and treatment according to specific guidelines and decreasing death and illness due to

[48] The NGOs and CAs that provided technical assistance were not named in the report, nor was the funding breakdown between USAID and the Kenyan government elucidated. Based on USAID funding methodology, it is reasonable to assume that USAID financed the NGOs, CAs, and certain activities of the DHMT.

[49] The training approach used is a widely used program referred to as Integrated Management of Childhood Illness (IMCI).

malaria is questionable when workers do not have the appropriate treatment medications. Like nearly all USAID programs, BDMI did not allocate funds for buying medications. As a result, in some health facilities an "irregular supply of drugs was experienced" (Olenja 2003). In addition, Olenja's final report noted that IMCI training "is very expensive" (27).

In its other objectives, BDMI fared even worse. Of the 11 combined indicators in these four categories, only two targets were achieved. Of these two, one (percentage of home-based caretakers who received educational messages) is barely relevant, and the other (an increase in the percentage of households with at least one ITN from 12 to 30) still remained at a low level. Perhaps most disturbingly, indicators of data collection activities in the district *decreased* during the project period.

Poor collaboration between the US based NGOs and CAs and the local DHMT hampered project implementation. Specifically, Olenja (2003) notes that "because a majority of the CAs were [*sic*] as not physically present in Kenya, planning and implementation of activities often presented a challenge" (38). In addition, "the coordinating agency [an international NGO] did not seem to have sufficient control over the CAs in the production of results" (39). Thus, the BDMI offers a clear example of the inherent problems that funding US based organizations pose. If contractors could not manage a presence in Kenya, which is stable, English speaking and well developed relative to other LDCs, there is little hope that they can be effective in more challenging venues. One wonders if USAID considers local presence at all when making contracting decisions.

Evaluation reports often include a substantial 'lessons learned' section, and Olenja's is no exception. But the prescient observations of evaluators are likely to fall upon deaf ears. Olenja's conclusions include such common sense but rarely heeded advice like, "Availability of nets is not necessarily equal to use. Financial access is a major factor in the use of nets." Yet USAID continues to ignore this commonly stated warning concerning the financial barrier to ITN access and continues to stress "social marketing" and "distribution networks." Nowhere was this folly more evident than in BDMI's complete failure to persuade pregnant women to sleep under ITNs. Olenja's explanation for the failure: "On discussion with the health providers and exit interviews with Ante Natal Clinic clients, the issue of cost was reported to stifle use of nets" (34).

Yet USAID, seemingly oblivious, has concentrated its 2004 malaria in pregnancy funding for another East African country, Tanzania, on marketing ITNs at ANCs and "a series of mass media TV, radio and billboard campaigns…to increase knowledge on malaria transmission, the toll of malaria on children and pregnant women and the protective efficacy of sleeping under ITNS"[50] These educational activities are important, but they cannot succeed without addressing the financial burden of ITN usage.

[50] Population Services International, *PSI/Tanzania*, February 28, 2005. (http://www.psi.org/where_we_work/tanzania.html)

Perhaps the report's most telling statement appears near the end: "For this end of project evaluation, it is more feasible to talk about trends, rather than impact" (43). The inability to detect a discernable impact at the conclusion of a multi-million dollar project should worry USAID officials and those with Congressional oversight.

Yet instead of offering legitimate critique, Olenja's report suffers from the same predilection afflicting many USAID-sponsored evaluations of its programs: it is unnecessarily complimentary when serious criticism is required. Despite the considerable failings of BDMI, the evaluation concludes with, "the overall impression is that the project has made notable contributions at policy and programmatic levels" (46). In measuring the success of a $5 million program, "notable contributions" is simply an inadequate yardstick.

2) THE STRENGTH PROJECT: SAVE THE CHILDREN, NORTHERN MOZAMBIQUE; September 30, 2000-September 30, 2003

The Strength Project operated in Mozambique on a $700,000 grant from USAID supplemented by $233,000 in matching funds from Save The Children (SC). The SC grant was awarded through the centrally funded Child Survival and Health Grants Program (CSHGP), a direct PVO program key to USAID fieldwork in several areas, including malaria.[51] As stated previously, CSHGP carries the distinction of requiring recipients of Agency money to submit detailed planning documents, implementation plans, progress reports and a comprehensive final evaluation spearheaded by a third party. Since the program is linked to the Child Survival and Resources Group (CORE), a consortium of American NGOs that share information and collaborate on strategy, key documents and information are widely accessible.

SC's Strength Project illustrates some major weaknesses endemic to many AID funded programs. Its limited funding and narrow capacity approach contributed greatly to its failure to make significant strides towards its main goal, namely "to sustainably reduce under five mortality and maternal mortality" (Utshudi 2003). Additionally, prospects for the sustainability of program accomplishments after the exit of SC are low. Finally, despite lackluster results based on monitoring objectives only loosely correlated with the goal of reducing mortality, the final evaluation report unjustifiably argued for the extension of the project to other areas of the country.

CSHGP almost always adopts a capacity approach to solving child survival problems, and the Strength Project is no exception. As per policy, USAID does not award CSHGP grants to proposals that include the funding of basic interventions to complement the capacity approach. Instead, the Agency favors a strict capacity approach that distributes program focus across a wide range of health problems, and thus handicaps most CSHGP programs before they even begin.

In the case of the Strength Project, the malaria control portion (15% of total project concentration) had only two objectives: that the percentage of mothers who seek care for feverous infants within 24 hours increase to 80 percent, and that "forty percent of children under five presented at health facilities will have two or more fever examination tasks completed" (11). The program largely failed to meet these two objectives. For the former objective, the percentage actually decreased from 57 percent to 40 percent in one district, though it increased from

[51] USAID's Child Survival and Health Grants Program (CSHGP) is a major way the Agency uses funds to fight deadly childhood maladies throughout the third world. In fiscal year 2004, USAID funded 71 such projects in 39 different countries at a total cost of $91,522,575. The 27 Private Voluntary Organizations (PVOs) who implemented these projects added $41,398,672 in matching funds. Grants typically last between two to five years and share the common overall goal of attempting to reduce child mortality. Since malaria constitutes a prime threat to children in many of the countries targeted by CSHGP, these grants represent one of the primary avenues for USAID to fight the disease 'on-the-ground'

66 percent to 80 percent in the other, and for the latter, program evaluators did not even bother to measure or write about it.

Of higher importance than the program's failure to achieve its malaria control objectives is the largely irrational and unexplained rationale that accomplishment of either objective might have a significant impact on deaths from malaria. Such knowledge activities have no chance of succeeding without accompanying interventions, as two explicit admissions of the Strength Project's final report demonstrate. In one, Utshudi (2003) explains an "unexpected constraint" to malaria control: "Frequent stock outs and unreliable supply of essential drugs at community-based health facilities contributed to difficulties in ensuring timely and effective case management of malaria at home and at the health facilities" (21).

In the other, Utshudi (2003) explains the outcome of ITN promotion efforts: "Mothers who were interviewed preferred using bednets because in the long run, it is more cost effective for malaria prevention in children and pregnant women. Unfortunately, due to the prevailing poverty in the project area, the cost to acquire ITNs is quite prohibitive" (25). According to a child survival specialist at SC, the only reason the Strength Project did not purchase and distribute bednets was due to severely limited funding for a large geographical area.[52]

Taken together, these revelations make a strong argument that capacity building and education alone hold little, if any, hope for achieving significant reductions to the malaria burden. Yet USAID continues to ignore the findings of its own reports and pushes impotent approaches to combating malaria.

The inherent difficulties of achieving sustainable outcomes in capacity building through the use of a US based NGO was also evident in the final evaluation. The report notes that "training alone, without the support from MOH [Ministry of Health] that carries out regular monitoring and follow up supervision of trained health workers, does not contribute to sustained effective delivery of quality services" (8). High staff turnover additionally hampered efforts to increase health care capacity in the region through training, a major project focus.[53] This turnover problem may result from health care workers leaving the program area for higher paid jobs after receiving training and indicates the inherent complications of a strict training approach to health programs.

Finally, like most projects, the Strength Project also failed to directly measure child mortality. Yet the evaluation, like most evaluations, provided unjustifiably positive conclusions. Out of 36 objectives (eighteen in each district), the project met an anemic seven targets. An alarming number of those missed targets also recorded *decreases* from baseline figures. Inexplicably, however, the final report recommends that the program's approach be "replicated in other parts of Mozambique" (40). Even more irrationally, USAID/Mozambique allocated

[52] Personal communication 6th January 2005.
[53] The report specifically notes that capacity building efforts "were not directed toward the equipment of health facilities but rather toward the strengthening of health worker knowledge and skills" (29).

bilateral funds to extend the project in other parts of the country shortly thereafter.[54]

[54] Personal Communication with Eric Swedberg, Save the Children Program Manager for the Strength Project. January 5, 2005.

3) World Relief Vurhonga II Project; Chokwe District, Mozambique; September 30, 1999-September 29, 2003.

Of all USAID programs that include malaria control as an integral component, World Relief's Vurhonga II stands sharply apart from the rest. Funded by a $1,000,000 USAID grant and $582,965 in private matching funds, the Vurhonga project defied many of the norms that prevent USAID projects from achieving child mortality goals. By utilizing a purely community based approach replete with 220 community Care Groups and 2,800 local volunteers, the designers of the Vurhonga project allowed community groups stewardship over its health projects. By directly measuring mortality, the Vurhonga project offered actual evidence, as opposed to the usual anecdotal conjecture, that its approach was valid and worthy of extension. However, the structural deficiencies inherent in USAID programs—no funding for interventions, poor coordination, and a contracting process disinclined to reward real results—crippled the project's full potential and continues to prevent those working in the area from making a substantial impact on the malaria burden.

Using a 'care group', community empowerment methodology, World Relief documented dramatic reductions in child mortality—initial measurements put the decline at over 60 percent[55]—while achieving all correlated program targets (e.g. use of ITNs, immunizations, nutritional goals etc.). But despite demonstrated results, enthusiastic support from Mozambique's USAID mission, the Ministry of Health, district leaders, and program evaluators, USAID declined the project's 'cost-extension' application. UNICEF saved the program by providing emergency funding after the evaluator, veteran Johns Hopkins public health expert Carl Taylor, convened a meeting in Maputo to beseech donors for funds. A source close to the project acknowledged, "Had UNICEF not recognized the significance of the work, much of the staff and momentum would have been lost."

World Relief eventually received an "expanded impact grant" from USAID in 2004 to scale up the project, but a proposal for a similar project in Malawi, again supported by the local USAID mission, Ministry Of Health and local partners, was turned down.

Taylor, after many years working with and around USAID, is critical. "What are [USAID application evaluators] looking at? I'm having trouble making sense of their priorities." He recalls surprise upon hearing that

[55] For fear of undermining the 'community empowerment' model, baseline data on births and deaths were gathered not by outsiders (as per standard scientific protocol), but by village workers. This aspect of data collection is a source of debate, as some (like Taylor) believe that the 'objectivity' justification for using outsiders is bunk. From Taylor's experience, outsiders are more apt to get untrue survey results due to cultural and linguistic communication barriers. Regardless, follow-up pregnancy histories (like those done by USAID in its Demographic Health Survey) are now being done by a follow-up team in order to confirm the mortality reduction results.

USAID was terminating support for the project he had just evaluated as an unqualified success. "The AID people in Mozambique said the decision had been made in Washington [not to extend funding] contrary to their opinion. It represented the kind of thing I see more and more with AID activities. The people in the field just don't have the [authority] to do what makes sense."

Aside from showcasing the inconsistencies apparent in USAID's funding process, Vurhonga demonstrates how USAID's misguided policies and poor organization hinder effective use of its own funds. Predictably, the project's 20% malaria focus contained no money to buy interventions like bed nets, drugs or IRS materials. Nor did the Agency coordinate with other donors to supply such tools to Chokwe (the program area). However, after a terrible flood struck the region in 2000, UNICEF, initially acting independently from USAID efforts, distributed free bed nets to everyone in Chokwe. With an actual intervention tool, the successful 'care group' mobilization approach influenced people to use the nets (85% reported usage rate for children under 5).

Similar luck did not strike the treatment aspect of the program. The malaria treatment protocol, which the program implemented with enormous success among the villages, was to bring a symptomatic child to a village First Aid post and treat the child with chloroquine, a drug weakened by widespread resistance throughout Mozambique. Despite excellent results in the area of education, the lack of an effective treatment drug and any prevention mechanism other than bednets dampened efforts to fight malaria in the region.

Indeed, program staff acknowledged that efforts to fight malaria did not contribute significantly to the observed decrease in mortality. With the added perspective of a follow-up study, an informed source confided that "mortality ascribed to malaria per verbal autopsy did not decrease as dramatically as we had anticipated considering marked improvements in bednet usage and rapid treatment seeking." The source also reported that chloroquine resistance was likely the culprit as "there were reports of children seeming to recover from malaria only to relapse and die later."

These suspicions were confirmed by project consultant Dr. P. Ernst, who is currently investigating the resistance problem in a follow up project and has identified a 50 percent resistance level in the program area.[56] Sadly, but not surprisingly, Ernst relates that efforts to convince USAID and UNICEF to persuade Mozambique's health ministry to change the type of drug included in the drug kits have failed due to cost concerns. Even today, children in Chokwe receive ineffective medicine.

[56] Personal electronic communication, 21st January 2005.

The Vurhonga project is indeed remarkable. USAID's insistence on funding child survival projects that provide none of the tools to help children survive (i.e. ITNs, drugs, vaccines) would seem to have doomed this project to failure from the beginning. Despite these shortcomings, its incredibly successful methodology of using community volunteers to promote behavior change saved lives—even if the magnitude of success proved less than originally thought. However, despite its demonstrated, measured success, and unanimous support from every relevant local institution, USAID's central office did not see fit to extend the project initially.

More importantly, though, follow-up in Chokwe has demonstrated that the program could have had a more successful malaria control component. Had USAID funded effective drugs, the program could have distributed useful medicine, decreasing substantially the number of children who died from malaria and augmenting the successful health improvements in other areas like nutrition and diarrhea.

The underlying lesson of Vurhonga is that when USAID takes a horizontal approach to malaria, it must ensure that programs have sufficient funding for basic interventions. If the Agency does not want to buy bednets or drugs, or fund spraying, than it must make sure it actually coordinates with donors who do. Given the disorganization and politicized nature of USAID, such coordination is not likely to happen. In Chokwe, it took—literally—an act of God to align a USAID health capacity program with an agency willing to fund an actual intervention. Perhaps, if the Agency undergoes substantial reforms that improve transparency and organization and limits political considerations in health aid, USAID might effectively work in tandem with other global agencies.

The Bottom Line: Why USAID Malaria efforts are Failing

Seven years into Roll Back Malaria, no progress has been made. Indeed, Attaran (2004) estimates a possible 10% increase globally since the inception of RBM, despite the availability of numerous prevention and treatment mechanisms. RBM's chief architects, both multilateral—like the WHO—and bilateral—like USAID—are complicit in squandering unprecedented funding for anti-malaria efforts. USAID, in particular, has failed to use American taxpayer money effectively.

USAID programs are simply too narrow in their approach to the malaria problem. The strict capacity approach ignores the simple reality that knowledge and policy alone cannot kill the vectors that transmit the illness or the parasites that cause it.

Larger problems also hamper the Agency's ability to make good use of its funding. Deficiencies in data collection and organization prevent needed internal coordination of its efforts, as well as practical collaboration with other donors who might provide necessary interventions. Unnecessary secrecy surrounding the use of malaria funds and the contracting process obstruct outside experts from assisting monitoring efforts and offering constructive criticism. Additionally, lack of transparency fosters lapses in accountability, as does a funding strategy that disseminates responsibility for malaria funds so widely across the Agency. The geographically diffuse funding approach also thwarts a concentration of resources in one place sufficient to make a substantial impact.

Inherent weaknesses in USAID's incentive structures likewise discourage fiscal responsibility. The political economy of the Agency's survival depends largely on the US based contractors who benefit from USAID's funding endowment. Furthermore, USAID asks these contractors to create sustainable systems in other countries that would eliminate the purpose of their existence. Expecting any organization to implement its own demise is unrealistic. In practice, these organizations constantly seek to enlarge their share of USAID funding, as evidenced by the frequent exhortations in program evaluations to expand failed initiatives. As one senior PVO official explained the misbegotten process: "The nature of awards by USAID is predicated on a lot of 'wordsmithing' in the proposals and final reports"[57].

USAID continues to take the path of least resistance approach to the malaria problem. Its funding strategy appeases its US based constituents, and its refusal to fund truly comprehensive intervention packages avoids undesirable controversy. By keeping most of its money within the US, USAID avoids the risk of embarrassing accounts of occasional acts of fraud by local organizations. Though its programs keep its more powerful stakeholders happy, they do not reflect the most effective way to reduce the malaria burden for its rightfully intended beneficiaries.

[57] Personal Communication 28th December 2004

VII. CONCLUSION

Malaria remains a major obstacle to development in many poor countries, especially those in sub-Saharan Africa. Over three thousand people, mainly children, die every day from this preventable disease. Most distressingly, malaria specific mortality rates continue to rise (Attaran 2004).

The world's wealthiest country, the United States, has funneled millions of dollars through its foreign aid agency, USAID, to fight this dreadful disease. However, funding is often poorly allocated. Despite the existence of proven mechanisms of prevention—IRS and ITNs—and effective treatments—ACTs—USAID spends less than five percent of its malaria budget purchasing these life-saving interventions. Instead, the Agency uses earmarked malaria funds for peripheral actions. These consist mainly of paying Washington-based contractors to consult with local health ministers on policy matters, give advice on management issues, train selected administrators and health care workers, and help run basic health education programs.

Some of these activities—commonly referred to as 'technical assistance' and 'capacity building'—are extremely important to ensuring that donor countries maintain adequate health systems. Insufficient capacity can stymie a recipient's ability to use life saving interventions. However, even the best policies and the strongest management systems cannot prevent a child from contracting malaria or cure his sickness. In order to properly deal with the problem, the physical tools to prevent and treat malaria must be either integrated into the malaria programs funded by USAID or provided by another organization in careful coordination with other Agency efforts. Short of that, even the most efficient policy program is doomed to failure.

Prescriptions for Change

With malaria rates continuing to rise in the face of increasing malaria budgets from the world's aid agencies, it's easy to be critical of USAID, the most influential bilateral institution in global health. Improving it, however, is a much greater, and ultimately more important, challenge. Yet despite the enormous difficulties of tackling any global health issue, let alone one as severe and widespread as malaria, USAID can make several changes that would greatly enhance its effectiveness, both with specific regard to malaria and general regard to its entire development operation.

1) Organization, Transparency and Accountability

   There is no greater obstacle to improving one's practices than ignorance of them. USAID faces an immense problem in changing its gross opacity. The scattered and disorganized nature of its malaria programs hinders not only Agency employees, who have trouble navigating the inscrutable bureaucracy and finding necessary information, but also outsiders that could offer constructive guidance. In fact, given the stonewalling and defensive reactions to anyone—researchers, congressman, scientists—who seeks information about or suggests improvements to existing programs, the Agency seems to suffer from a self-inflicted, autarkic etiolation.

USAID can go a long way towards solving these problems with a simple move towards greater transparency. Instead of keeping the details of procurement operations, program budgets, performance evaluations and contracts secret, the Agency should make this information available to the public. By making the data available to, and understandable by, outsiders, USAID would ensure that its own staff had access to information that is currently scattered between central headquarters, country missions, PVOs and contractors. And with data on its programs readily available, outside experts and watchdogs could supplement internal control measures against inefficiency and waste, as well as generate critical analysis and suggestions for improvements.

Adopting such an approach would neither be pioneering nor difficult, but it is nevertheless essential. USAID need only copy an existing model and adapt it to its own needs. That model is the Global Fund to Fight AIDS, TB and Malaria's excellent website, which does everything from listing individual grant proposals and agreements to comprehensively organizing data on overall levels of funding. While isolated cases of fraud or waste, such as the millions dedicated to agencies controlled by Burma's repressive military junta, may cause temporary embarrassment to the Fund, these instances can be quickly corrected. Though GFATM's record on fixing these problems has been less than perfect, progress on some fronts, like pulling funding from Burma, discourage future mischief.

Making the procurement process more transparent will have the added benefit of opening up bidding to outsiders and smaller contractors, who have difficulty navigating an obscure and secretive process that currently favors large insiders/incumbents. For contracting to work properly, greater and more equitable competition is necessary. As it stands now, insider knowledge of the procurement system gives selected bidders a significant unfair advantage, and large firms simply outspend smaller ones when preparing proposals.

Contractors will certainly protest any moves to make the procurement process and their use of taxpayer funds more transparent, as will some Agency employees. They will argue that such information is private, or that instituting transparency will add another layer of bureaucratic interference. However, these arguments are meant to disguise their real intention to insulate themselves from legitimate criticism and competition that may negatively affect their livelihoods. Such opposition to transparency improvements must be ignored. If USAID and its contractors have nothing to hide, then the full details of their operations should no longer remain a secret. In fact, for the majority of USAID, PVO and contractor employees, many of whom are talented and committed to development work, greater visibility will mean better programs, better organization and better results.

2) Consolidate and Expand

USAID operates malaria programs in over thirty countries in the developing world. Funding averages just under $1.5 million per country, an amount insufficient to tackle a problem as large as malaria. With such limited resources for each country, there is little hope of making a realistic and lasting dent in malaria morbidity and mortality, which is surely the main justification for funding.

Since successfully fighting malaria requires comprehensive programming and a substantial resource commitment, USAID must distribute its malaria funds more wisely. Instead of operating a few limited programs in numerous countries, it must consolidate those resources and expand the scope of its programs in fewer countries. That means prioritizing funding by both the extent of a country's malaria funding and the likelihood that programs will succeed. Countries lacking the political will and local institutions must be bypassed for ones that have the right structures but are simply lacking the resources.

While pulling money from malaria programs in countries with serious health problems may seem heartless, there is little evidence that current programs save many lives. Unfortunately, funding is limited, and it needs to be concentrated where it can do the most good. Countries like Uganda, Ghana and Zambia, which have severe malaria problems, are committed to fighting the disease and would apply more resources well.

3) Expand Correctly: Interventions that Work

As has been shown throughout this paper, USAID malaria funding is one-sided: heavy on providing 'expertise', very light (only 5 percent of the total malaria budget) on providing life-saving interventions. Successfully reducing the malaria burden with such an approach is extremely difficult. For maximum effectiveness, malaria resources must comprise a combination of both know-how and tools, though always a critical minimum of the latter.

There is no reason why USAID cannot change its disjointed, ineffectual programming scheme. The first step, program consolidation, will ensure sufficient resources to fund comprehensive, effective programs. The next step is simply to fund these programs.

If USAID diverts its malaria resources to fewer countries, funding spraying programs, buying bednets and purchasing effective drugs should be the first priority. USAID should provide ACTs so mothers trained to recognize malaria symptoms in their children and seek treatment from trained nurses will receive an effective drug and not ineffective chloroquine. USAID should provide nets so that villagers who learn the benefits of sleeping under bednets can put their knowledge to use. USAID should provide funding so health ministers that want to eradicate malaria from their districts with IRS can buy necessary chemicals and equipment, and USAID should stop using inaccurate environmental opposition to IRS to thwart these ministers. USAID must

adopt, rather than shun, these common sense approaches to malaria funding, if Agency officials are serious about stemming the malaria pandemic.

Global health programs are complex and difficult. Consequently, the recommendations provided here are strategic guides, and not hard and fast rules. If, for example, USAID can upgrade its organizational systems well enough to collaborate effectively with other agencies, situations may arise where providing only technical assistance is appropriate. However, in these cases, the Agency must ensure that its efforts are integrated into initiatives that utilize all the tools necessary for success.

4) Involvement of Local Institutions

Given the vast sums that USAID invests in capacity building, technical assistance and training, USAID should carry out these activities in an efficient, sustainable fashion. Unfortunately, due to the Agency's funding structure, this is not the case.

Unlike, for example, the GFATM, USAID funnels its money primarily to US based contractors, and uses US citizens (USAID mission personnel) to administer and monitor the programs locally. Such a system ensures that project ownership ultimately belongs to US based interests, even if they involve indigenous organizations. When USAID imposes aid in such a manner, especially when the goal is to build local capacity, it will rarely achieve sustainability. Since local institutions must comply with decisions coming from the US in order to maintain funding, they become dependent yes-men to their USAID patron (Snook 1999). Once funding and guidance dry up, they are unable to stand alone and quickly collapse.

Even when US personnel on the ground act with noble intentions, USAID's funding structure creates ineffective and unsustainable outcomes. At its simplest level, the incentives governing contractors clash with the very notion of sustainable, locally generated outcomes. Asking a technical advisor on health policy to help craft an entirely self-sufficient health ministry is a bit like asking an employee to train his lower-cost replacement. Individuals may be altruistic enough to be exceptions, but entire organizations are unlikely to eliminate the need for their own existence.

The development literature has long made these incentive and dependence arguments, but USAID continues to structure its funding in the least productive manner possible. Other aid agencies, like GFATM and Canada's IDRC, provide funds directly to developing country organizations and researchers. Such a model is especially appropriate to USAID's capacity building approach. A further advantage of direct grants is that they reduce the probability that aid projects will contribute to 'brain drain' problems in critical sectors of LDCs. Frequently, and especially in the health sector, the most well-educated local experts leave their critical government and private sector

jobs to work for international NGOs. In addition, training programs run by such agencies often collapse when they leave because newly skilled workers use their newfound abilities to migrate out of rural areas, or even out of the country altogether.

Instead of empowering US contractors to build capacity in other countries, USAID should empower indigenous organizations to build capacity in their own countries. By increasing direct grants to these groups, capacity building efforts in the health sector have a much greater chance of succeeding, and staying successful.

Thus far, we have directed suggestions for reform primarily at USAID itself. To be fair, however, many of the Agency's shortcomings result from larger US government policies and the Agency's role as a vehicle for advancing US interests abroad. In addition to the four specific suggestions outlined above, The US needs to change its development policy if malaria programs, and indeed any global health and development projects, are to succeed in assisting developing nations. These changes include separating foreign policy goals from global health programs and providing the necessary political support to relieve the Agency from its dependence on US contractors and overly cautious decision making.

President Bush has already articulated some needed change. In his 2003 State of the Union Address, the President announced $10 billion of new funding to fight AIDS and asserted that, "The qualities of courage and compassion that we strive for in America also determine our conduct abroad. The American flag stands for more than our power and our interests." Yet instead of altering USAID's mission in line with such a principle, he set up a separate organization to administer those funds.

The creation of PEPFAR implicitly acknowledged that USAID lacks the flexibility and expertise to implement health projects. Indeed, the Department of Health and Human Services, including the Center for Disease Control, has superior medical know-how, with fewer strategic and procurement restrictions. Thus, even if USAID can make the necessary transparency and accountability improvements, health programs may never reach their full potential under USAID. Consequently, if US policy makers are intent on preserving USAID under its present "foreign aid in the national interest" orientation in order to carry out other development objectives (i.e. reconstructing Iraq and Afghanistan, democracy and governance programs etc…), they should seriously consider transferring responsibility for global health programs to another agency.

The bottom line is that USAID cannot realistically hope to offer much help to developing nations if it continues to preoccupy itself with funding US organizations and adopting only the most conservative, least controversial, often least effective, strategies. Its informational deficiencies, organizational problems and insular disposition cast serious doubt on the agency's ability to make good use of its resources. The combination of these factors has led to a watered-down, ineffective malaria program lacking in transparency and organization.

Though the scope of this paper is limited to malaria programs, and some of the problems highlighted in this paper are specific to that effort, many are symptomatic of larger shortcomings. These failings jeopardize the efficacy of all aspects of USAID's development mission, weaken American foreign policy capacity and misuse tax dollars. And as a major donor and leading trendsetter, USAID policies influence the actions of public and private givers across the globe. For the benefit of both donor and recipient, reforms at USAID are urgently needed.

Glossary of Malaria and USAID-related Acronyms and Organizations

ACT Artemisinin-based Combination Therapy. Medication with low resistance levels used for treating malaria.

AED Academy for Educational Development. Non-profit focused on improving health, education, and economic opportunities in the US and developing countries.

AIM Africa Initiative for Malaria Control. Initial effort by USAID, World Bank, and WHO to fight malaria, which eventually became Roll Back Malaria.

ANC Ante-Natal Care. Care of pregnant women including counseling, risk assessment, and general health care.

BDMI Bungoma District Malaria Initiative. USAID-funded, district-level initiative to fight malaria, led by Kenya's Ministry of Health with support from NGOs and cooperating agencies.

CA Cooperative Agreement or Cooperative Agency. Agreement involving a general area of work, or Agency performing a general assignment.

CORE Child Survival and Resources Group. An association of international NGOs that promotes the health of women and children in developing countries.

CSH Child Survival and Health

CSHGP Child Survival and Health Grants Program. Supports U.S. non-profit, NGOs and local partners to implement maternal and child health, family planning, HIV/AIDS and infectious disease programs.

DDT Dichloro-diphenyl-trichloroethane. First used in 1939 as an agricultural insecticide and later to prevent malaria and typhus.

DHMI Defense Healthcare Management Institute

FAR Federal Acquisition Regulation. Regulation for all federal agencies in their acquisition of supplies and services with appropriated funds.

GFATM Global Fund to Fight AIDS, Tuberculosis, and Malaria. Partnership between governments, civil society, and the private sector to fight AIDS, TB, and malaria.

IQC Indefinite Quantity Contracts. Contractor performs a specific scope of work for USAID, and individual country missions are able to make additional purchases of that contractor's service, as well.

IDRC International Development Research Center. Canadian public corporation that works with researchers from the developing world on health and poverty issues.

IMCI Integrated Management of Childhood Illnesses. WHO and UNICEF's approach to child health that focuses on the well-being of the whole child.

IPT Intermittent Preventive Therapy. Effective intervention to protect both a woman and her newborn from malarial infection.

IRS Indoor Residual Spraying. Reduces transmission of malaria by reducing the survival of malaria vectors entering houses or sleeping units.

ITN Insecticide Treated Bednets. Effective vector control when coverage rates are high and a large proportion of human-biting takes place at night.

LDC Less Developed Country

MOH Ministry of Health

MSH Management Sciences for Health. A private non-profit that works with its worldwide partners to improve the management of and access to health services.

NPI New Partnership Initiative. USAID's channeling of development funds through NGOs to promote economic growth and bolster democracy.

PEPFAR The President's Emergency Plan for AIDS Relief. A five-year, $15 initiative for HIV/AIDS prevention, treatment, and care, headed by the Office of the Global AIDS Coordinator in the US Department of State.

PSI Population Services International. Washington D.C. based non-profit that deploys commercial marketing strategies to promote health products and services to low-income people.

PVO Private Voluntary Organization. Private US organization registered with USAID to receive grants for development projects.

RBM Roll Back Malaria. Initiative by USAID, World Bank, and WHO to fight malaria.

RFA Request for Assistance. A bureau poses a problem or challenge, and competing organizations propose a program that will provide a solution.

RFP Request for Proposal. A bureau specifies what work it wants accomplished and judges the subsequent proposal submissions.

SC Save the Children. Independent organization that is a member of the International Save the Children Alliance, comprising 27 national Save the Children organizations.

SO Strategic Objectives

SP+ART Type of ACT medication.

UNICEF The United Nations Children's Fund. Works for child welfare and protection in over 157 countries. The majority of UNICEF's budget, which reached $1.6 billion in 2003, is provided by donor governments

USAID United States' Agency for International Development. US bilateral foreign assistance organization working in support of US foreign policy goals.

WHO World Health Organization.

World Relief -- Baltimore-based, international humanitarian organization founded by the National Association of Evangelicals. It now works in over 20 countries, with the stated focus of helping the Church to reach the poor and suffering.

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