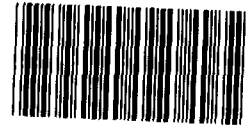


June 1992

FOREIGN ASSISTANCE

Combating HIV/AIDS in Developing Countries



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Washington, D.C. 20548

National Security and
International Affairs Division

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June 19, 1992

The Honorable Ted Weiss
Chairman, Subcommittee on Human
Resources and Intergovernmental
Relations
Committee on Government
Operations

The Honorable Jim McDermott
House of Representatives

This report provides the results of our review of the Agency for International Development's response to HIV/AIDS in developing countries. This report contains recommendations to the Administrator of the Agency for International Development that are intended to strengthen the agency's HIV/AIDS program management.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from its issue date. At that time, we will send copies to the Administrator of the Agency for International Development and to other interested parties. We will also make copies available to others upon request.

Please contact me at (202) 275-5790 if you or your staff have any questions concerning this report. Other major contributors to this report are listed in appendix II.

Harold J. Johnson
Director, Foreign Economic
Assistance Issues

Executive Summary

Purpose

The human immunodeficiency virus (HIV), the virus that causes acquired immune deficiency syndrome (AIDS), has spread quickly throughout the developing world. Millions of people are infected by the virus, and many have died. The Chairman of the Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations, and Representative Jim McDermott requested that GAO review the response of the Agency for International Development (AID) to HIV/AIDS in developing countries. GAO's objectives were to assess (1) the priority the agency places on HIV/AIDS prevention; (2) the agency's implementation strategy; (3) whether the agency has evaluated the disease's impact on its development programs; and (4) the management, implementation, and oversight of the AIDS Technical Support Project.

Background

Congress has appropriated \$168 million since 1986 specifically to support HIV/AIDS prevention activities. The World Health Organization's HIV/AIDS program received \$88.5 million of this amount, and \$79.5 million was designated for AID's bilateral HIV/AIDS activities. AID estimates that it has obligated another \$68 million from other accounts to combat HIV/AIDS.

To help AID officials in-country accomplish the HIV/AIDS prevention objectives, the agency initiated the AIDS Technical Support Project in 1987. The project is managed centrally through the AIDS Division. In 1991, AID redesigned the project, a major component of which is AIDS Control and Prevention (AIDSCAP), which focuses funds, although not exclusively, on priority countries. AID plans to spend \$167.7 million for AIDSCAP over the next 5 years.

Results in Brief

AID's 1987 policy guidance states that because of other priorities, resources to combat HIV/AIDS are limited. Nonetheless, AID has spent more over the past 5 years to combat HIV/AIDS than Congress specifically appropriated for that purpose. The agency's response to the disease has evolved from being reactive and piecemeal to being proactive and targeted. Although AID recognizes that HIV/AIDS is a serious health problem that could have serious consequences for its development programs, it has not (1) assessed the long-term impact the disease may have on its development programs or on the economic development of countries with a high prevalence rate, (2) developed an agencywide strategy for carrying out HIV/AIDS prevention policies, or (3) emphasized HIV/AIDS issues in programming and budgeting decisions.

The AIDS Technical Support Project lacked sufficient direction and coordination. The agency did not have reasonable assurances that project activities were being implemented as intended, objectives were being met, policies were being followed, and resources were being effectively used. The AIDS Division did not develop detailed management plans for the project. A shortage of staff contributed to these management and oversight deficiencies.

Agency officials said AIDSCAP will draw on lessons learned from its earlier project, and will retain some of its flexibilities. However, GAO identified potential impediments to the new project's success. AID has been slow to identify priority countries to receive project support; indicators to evaluate project impact have not been agreed upon; and no specific plans exist to meet the expected increase in condom demand.

Principal Findings

AID's Policy Toward HIV/AIDS Activities

AID's policy guidance on HIV/AIDS, issued in 1987, states that missions should not mount large HIV/AIDS-specific programs because the disease is a sensitive subject in many countries and because agency funds and staff are needed for other priorities. Some information contained in the policy guidance is outdated, but the guidance has never been updated. AID mission officials said they continue to give HIV/AIDS a lower priority than some other agency objectives.

The agency's policy guidance warns of (1) alarming increases in the spread of the virus, (2) the potential impact of the disease on AID programs, and (3) the costs that governments could incur in the areas of health, family planning, and education as a result of the disease. Preliminary AID and World Bank studies have concluded that HIV/AIDS threatens to halt or reverse the social and economic gains made in developing countries.

Despite its recognition of the disease's long-term impact, AID is just now planning to study the disease's impact on different sectors of its development programs. Moreover, the agency has not developed a strategy linking the policy guidance with regional and central bureau operations.

HIV/AIDS Issues Not Emphasized in Agency Planning

AID officials acknowledged that its policy guidance is out of date but said AID's senior management has been engaged in HIV/AIDS issues. These officials cited the establishment of an HIV/AIDS Working Group, the Administrator's trip to Africa to study HIV/AIDS issues, and several presentations to the Administrator and his senior staff as evidence of top management attention to the problem.

Despite this involvement, the agency's program and budget planning processes have not given HIV/AIDS-related development issues formalized consideration. Program planning decisions are based primarily on 5-year Country Development Strategy Statements and Annual Action Plans submitted, but information on HIV/AIDS activities is usually subordinated under other mission objectives. Also, the prevalence of the virus is not an indicator used to assess the needs of developing countries, and the agency's guidance to missions for submitting their annual budgets does not address HIV/AIDS activities.

AIDS Technical Support Project Lacked Direction and Effective Oversight

In six countries GAO reviewed, the AIDS Technical Support Project was, in some cases, not implemented in accordance with agency regulations. Clear direction for implementing project activities was lacking. The AIDS Division implemented activities on a piecemeal basis, reacting to ad hoc requests for assistance by individual missions rather than targeting resources to countries most in need of assistance. As a result, since 1987, the project has supported 650 activities spread among 74 countries. The project also lacked coordination, and actual monitoring and evaluation of HIV/AIDS activities was weak. AID believes the AIDSCAP approach of focusing on fewer priority countries is more likely to have a measurable impact on the spread of the virus.

The AIDS Division relied on semiannual reports submitted by contractors, as well as periodic meetings with the contractors, to monitor project activities. However, these reports contained insufficient information on the status, progress, and problems of project activities. AIDS Division staff did not routinely verify the information submitted and conducted few site visits. Further, the agency typically does not know whether project activities were effective because it rarely evaluated their impact. Agency officials said they lacked staff in the AIDS Division and the field to adequately manage and oversee project activities.

Potential Impediments to the Success of the AIDSCAP Project

Prompted by (1) rapidly approaching funding ceilings for the AIDS Technical Support Project, (2) a perception that project resources were spread too thinly to be effective, and (3) the recognition of the need for management changes, AID redesigned the support project into AIDSCAP. AIDSCAP is to focus on about 10 to 15 priority countries. In redesigning the project, AID drew from new developments in HIV/AIDS research and incorporated lessons learned from its previous HIV/AIDS activities. Public health experts told GAO that the prevention strategy AIDSCAP envisions could be effective in slowing the spread of the virus. However, GAO identified three potential impediments to the success of the project.

- A substantial portion of funding for HIV/AIDS prevention is to be provided by missions in priority countries, but a final list of priority countries had not been developed as of May 1992. The AIDS Division has had difficulty working with regional bureaus to define priority countries.
- Although AIDSCAP was initiated in October 1991, impact evaluation indicators, necessary for effective evaluations, had not been finalized.
- Project plans make no provision for meeting the demand for condoms that AIDSCAP is expected to generate. AID officials hope that other donors will meet this demand.

AIDSCAP will retain some flexibility of the earlier project; for example, non-priority countries may draw on AIDSCAP resources, and AID missions may use their bilateral funds to combat the disease.

Recommendations

GAO recommends that the Administrator of AID (1) expedite the completion of the planned study of the impact the virus will likely have on development, (2) update the 1987 policy guidance, (3) develop an agencywide strategy for implementing this policy, and (4) incorporate HIV/AIDS issues into program and budget planning processes.

GAO also recommends that the Administrator confirm a list of priority countries for HIV/AIDS assistance, develop a standard set of indicators for use in evaluating AIDSCAP's impact, and seek ways to satisfy the demand for condoms expected to be generated.

Agency Comments

As requested, GAO did not obtain AID's comments on this report. However, GAO did discuss the results of its work with program officials and has incorporated their comments where appropriate.

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Abbreviations

AID	Agency for International Development
AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention
AIDSCOM	AIDS Public Health Communication Project
AIDSTECH	AIDS Technical Project
ATSP	AIDS Technical Support Project
CDC	Centers for Disease Control
GAO	General Accounting Office
HAPA	HIV/AIDS Prevention in Africa
HIV	human immunodeficiency virus
WHO	World Health Organization

Introduction

In a relatively short time, acquired immune deficiency syndrome (AIDS) has become one of the world's most serious health problems. According to World Health Organization (WHO) estimates, between 9 and 11 million people are infected with the human immunodeficiency virus (HIV), the virus that causes the fatal disease, and 5,000 people are being infected every day. By the year 2000, 30 to 40 million more people are projected to be infected.

Whereas the virus was initially spread by bisexual and homosexual men and by prostitutes in the early 1980s, today, particularly in developing countries, it is beginning to be widely spread among the general population through the exchange of body fluids during sexual intercourse between heterosexual couples.

Spread of HIV/AIDS in the Developing World

The developing world has been hardest hit by the disease. In sub-Saharan Africa alone, 6 million people—1 in every 40 adults—are estimated by WHO to be infected, and about 1 million cases of the disease had been reported as of January 1992. In Latin America and the Caribbean, between 750,000 to 1 million are infected, according to Pan American Health Organization estimates. The prevalence of the virus has been lower in Asia, but infection is spreading rapidly in South and Southeast Asia among those in high-risk groups.¹ Moreover, WHO believes data reported by developing countries understates the extent of HIV infections and AIDS cases.

During the early years of the spread of the disease, HIV/AIDS was an extremely sensitive topic among governments in the developing world. Further, information regarding HIV/AIDS prevention and treatment was limited. These factors may have affected the response by the international donor community.

U.S. Assistance for HIV/AIDS Prevention

Concerned over the spread of the virus in developing countries, Congress appropriated \$168 million to the Agency for International Development (AID) between fiscal years 1986 and 1991 specifically for HIV/AIDS prevention activities. As shown in table 1.1, this amount comprised \$88.5 million earmarked for WHO's HIV/AIDS program and \$79.5 million for AID's bilateral HIV/AIDS activities. AID estimates that it obligated an additional \$68.1 million from other accounts during this period on HIV/AIDS prevention activities.

¹High-risk groups are intravenous drug users, bisexuals, homosexuals, and prostitutes.

Table 1.1: U.S. Assistance for HIV/AIDS Prevention Activities

Dollars in millions

Fiscal year	Amount used by AID from HIV/AIDS account	Amount provided to WHO from HIV/AIDS account	Total appropriated specifically for HIV/AIDS activities	Amount obligated by AID from other accounts for HIV/AIDS activities
1986	0	\$2.0	\$2.0	0
1987	0	2.0	2.0	\$11.4
1988	\$15.0	15.0	30.0	10.7
1989	14.5	25.5	40.0	9.8
1990	21.0	21.0	42.0	9.8
1991	29.0	23.0	52.0	26.4
Total	\$79.5	\$88.5	\$168.0	\$68.1

Source: AID.

AID's HIV/AIDS Prevention Activities

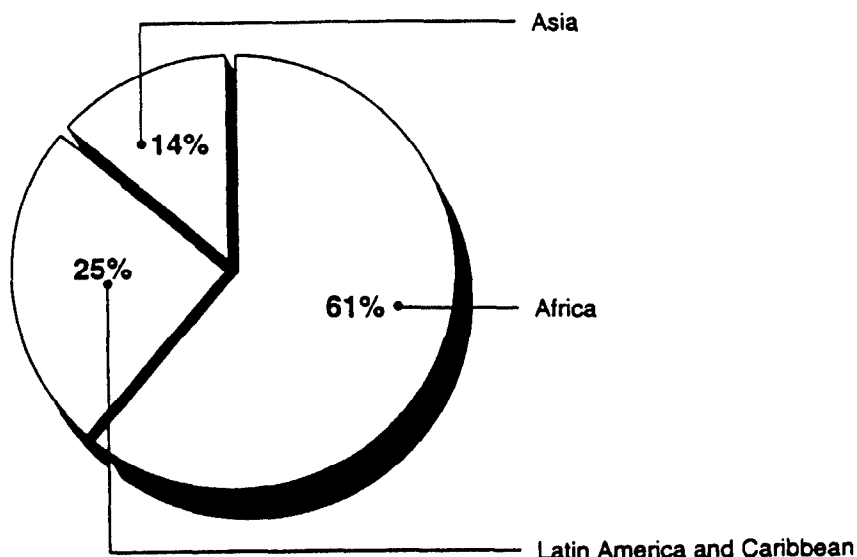
The HIV/AIDS activities supported by AID are intended to assist developing countries in preventing the spread of the virus. The activities are designed, among other things, to develop communications campaigns informing people about the disease; identify high-risk groups and teach them how to reduce their chances of becoming infected; and provide needed supplies, such as condoms and blood-screening equipment.

The following are examples of the 650 HIV/AIDS prevention activities supported by AID in 74 countries:

- In the Dominican Republic, agency staff assisted in designing a comic book and flyer for prostitutes that explained how the virus is transmitted and emphasized the importance of using condoms.
- In Malawi, the agency funded a seminar for employees of a regional electric company. The employees were encouraged to give lectures on the virus at work and encourage their peers to use condoms.
- In Brazil, social workers trained by the agency taught homeless street children about HIV/AIDS and other sexually transmitted diseases and encouraged them to abstain from having sex.
- In Kenya, truckers received condoms at truck stops, and health technicians were trained to educate people in poor communities about the disease.

As shown in figure 1.1, the agency has obligated more than half of the funding for HIV/AIDS activities to countries in Africa.

Figure 1.1: AID Funding for HIV/AIDS Prevention by Region (Fiscal Years 1988-91)



Note: Funds earmarked for WHO and for general worldwide activities are not included.

Source: GAO analysis of data in AID's coding system for tracking funds obligated in areas of special interest to Congress. (See ch. 2.)

The AIDS Technical Support Project

To help AID country missions develop and implement HIV/AIDS activities, the agency in 1987 initiated the AIDS Technical Support Project (ATSP). The project has been managed centrally through the AIDS Division within the Research and Development Bureau's Office of Health.

The two major sub-projects under ATSP have been the AIDS Public Health Communication Project (AIDSCOM)² and the AIDS Technical Project (AIDSTECH), both of which were designed to provide centrally procured and managed services and commodities that support the agency's bilateral and regional projects. Under AIDSCOM, the agency developed communications strategies and techniques for informing people about the disease. AIDSTECH's objectives were to screen blood supplies for HIV, identify

²From 1987 to 1989, AIDSCOM was managed by AID's Office of Education.

high-risk groups of people, develop education programs, and promote the use of condoms. AIDSCOM and AIDSTECH, which are managed by separate contractors, are scheduled for completion in 1992.

The Centers for Disease Control (CDC) has been involved extensively in ATSP.³ Three health experts from CDC have been assigned full time to the AIDS Division. According to a senior CDC official, another 30 CDC personnel are working on HIV/AIDS programs under an interagency agreement to provide technical assistance in such areas as surveillance, diagnosis and treatment, and prevention research.

Other ATSP activities include

- establishing relationships with other federal agencies, private voluntary organizations, and scientists to keep abreast of technical advances in HIV/AIDS research;
- creating statistical modeling to track the disease;
- participating in interagency efforts to review the impact of the virus on developing countries and develop a modeling data base;
- sponsoring conferences and meetings to share information with HIV/AIDS experts; and
- obtaining expertise and technical assistance on HIV/AIDS from the Bureau of the Census and the National Institutes of Health.

ATSP is integrated with segments of the agency's health and population programs. For example, the logistics management system used to plan, estimate, procure, and distribute contraceptives for population programs provides and distributes condoms for HIV/AIDS programs. Also, methods for promoting the use of sterile needles in the immunization program and strategies devised to change behavior for diarrheal disease control and other programs have been incorporated into ATSP.

Relationship With the WHO Program

ATSP is designed to complement and support the WHO HIV/AIDS program, initially called Special Program on AIDS and currently called Global Program on AIDS. Established in 1986 and funded through multilateral donations, the WHO program is recognized as the global coordinating entity for HIV/AIDS prevention activities. Under the program, WHO provides governments with guidelines and strategies for establishing a national HIV/AIDS program and for gathering and reporting data on the virus. Some

³CDC, part of the Public Health Service within the Department of Health and Human Services, administers programs in the prevention and control of communicable disease and other preventable conditions.

AID officials participate as members of the program's technical and management steering committees and contribute technical expertise that supports global prevention efforts.

AID's Redesigned Support Project

In 1991, AID's Research and Development Bureau redesigned ATSP based on new research on the disease and lessons learned from managing the project. A major component of the redesigned project is called AIDS Control and Prevention (AIDSCAP). AIDSCAP is intended to focus efforts on 10 to 15 countries designated as top priorities for HIV/AIDS prevention activities. Other countries are expected to continue to receive short-term technical assistance.

To implement AIDSCAP, AID plans to spend \$167.6 million between fiscal years 1992 and 1997. Project documents show that the Research and Development Bureau plans to provide \$68.5 million and expects regional bureaus and missions to provide the other \$99.2 million, with most of this funding coming from the budgets of missions in priority countries. AIDSCAP is being managed by a contractor, Family Health International, through a 5-year cooperative agreement with the agency.

Objectives, Scope, and Methodology

The Chairman of the Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations, and Representative Jim McDermott requested that we assess (1) the priority AID places on HIV/AIDS prevention; (2) the agency's implementation strategy; (3) whether the agency has evaluated the disease's impact on its development programs; and (4) the management, implementation, and oversight of ATSP.

To perform our review, we interviewed officials at the AIDS Division, Research and Development Bureau, regional bureaus, and policy directorate at AID's headquarters in Washington, D.C., and agency officials in Brazil, the Dominican Republic, Kenya, Malawi, Uganda, and Thailand. We also reviewed the agency's HIV/AIDS policy guidance, program strategies, program budgets, and other relevant documents. To assess the oversight and monitoring of HIV/AIDS activities, we reviewed AID mission files in the countries we visited. We also reviewed AIDSCOM and AIDSTECH activities in these countries and analyzed documents designed for pilot projects.

In addition, we reviewed pertinent documents at CDC and the National Institutes of Health, and we discussed HIV/AIDS issues with officials at WHO, the Pan American Health Organization, United Nations organizations providing technical assistance for HIV/AIDS prevention, and U.S. and foreign-based organizations that have received funding from AID. Finally, we interviewed government officials in the countries we visited and officials of private volunteer organizations involved in HIV/AIDS activities, national and international family planning organizations, and national blood banks.

We conducted our review from April 1991 through May 1992 in accordance with generally accepted government auditing standards. As requested, we did not obtain AID's comments on this report. However, we discussed the results of our work with program officials and have incorporated their comments where appropriate.

AID's Policy on HIV/AIDS Prevention Is Outdated

The United States has been a prominent donor to international efforts aimed at slowing the spread of HIV/AIDS in developing countries, yet, according to AID's policy guidance, resources for the prevention of the disease have been limited because of other AID priorities. The agency's official policy guidance on HIV/AIDS prevention still instructs missions to address other agency priorities first and keep their involvement with HIV/AIDS prevention minimal.

Although the official policy statement contains outdated information and has not been updated since it was issued in 1987, actual implementation of the policy has evolved substantially since that time. Despite this evolution of policy implementation, AID has not formulated an agencywide strategy linking its policy with bureau and mission operations. Although top AID officials have taken action to stay abreast of HIV/AIDS issues, AID has not institutionalized HIV/AIDS issues in the planning and budgeting processes used routinely by senior AID management. Consequently, the potentially serious impact the disease may have on AID's economic development programs is not formally considered. Despite this, in each year since fiscal year 1987, AID has obligated more for its bilateral HIV/AIDS programs than the amount Congress appropriated specifically for this purpose.

United States Is a Significant Donor to International HIV/AIDS Prevention Efforts

U.S. involvement in HIV/AIDS prevention in the international donor community has been significant. Congress has appropriated funds to AID for international HIV/AIDS prevention activities, and a portion of these funds have been earmarked for the WHO Global Program on AIDS. Through these congressionally earmarked AID appropriations—which have increased since 1986—the United States has been the single largest source of funds for the WHO HIV/AIDS program. Bilateral assistance for HIV/AIDS prevention has also increased, and as shown in table 1.1, the overall obligations for HIV/AIDS prevention activities have routinely exceeded the amount Congress specifically appropriated for that purpose.

AID's obligations for HIV/AIDS activities differ from the amount specifically appropriated for HIV/AIDS because the agency's coding system tracks funds obligated in areas of special interest to Congress. AID attributes a percentage of expenditures for specific projects to these special interest areas, one of which is HIV/AIDS prevention, using its Activity Codes/Special Interest tracking system. However, agency officials said that the system is subjective and cannot precisely show how much is obligated for a particular special interest area.

The data in the system is provided by individual project officers, who determine the percentage of their project activities attributed to special interest areas at the end of each fiscal year. Projects that have attributed some of their activities to HIV/AIDS prevention are child survival, health, and private enterprise. In Thailand, for example, the project officer for the private voluntary organization co-financing project estimated that 55 percent of project activities in fiscal year 1991 had been related to HIV/AIDS prevention; consequently, 55 percent of project funds (\$741,000) were attributed to HIV/AIDS and added into the agency's overall reporting of HIV/AIDS obligations. We could not verify AID's data on obligations attributed to HIV/AIDS activities.

AID Policy Instructs Missions to Keep HIV/AIDS Involvement Minimal

AID's official policy guidance on HIV/AIDS, issued in 1987, states that AID resources to combat the disease, both funds and staff, were limited because of other AID priorities. The policy outlines areas considered appropriate for bilateral assistance. For example, missions could support the WHO program; information and education campaigns on HIV/AIDS prevention; purchases of condoms and blood-screening equipment; and certain types of research. However, the policy advised missions to avoid mounting bilateral programs specifically addressing HIV/AIDS and to address the disease after other agency priorities.

In guiding missions to make minimal efforts in the area of HIV/AIDS prevention, the policy cited limited agency resources and the political sensitivity associated with this disease. For example, the policy states that U.S. motives for pursuing HIV/AIDS prevention activities, such as promoting the use and distribution of condoms, could be misconstrued for political reasons and potentially jeopardize other bilateral efforts.

Outdated Information in 1987 Policy Has Not Been Revised

AID's 1987 policy guidance has not been revised, even though it contains outdated information. Specifically, the policy's instructions to missions to make minimal efforts in HIV/AIDS prevention is at odds with the agency's redesigned AIDSCAP project, which emphasizes the need to intensively focus agency resources on a small number of priority countries. Despite this fundamental change in the program and a statement in the policy that it will be "reviewed and revised as knowledge and understanding of the disease and its spread are accumulated," senior AID officials told us that policy revisions regarding HIV/AIDS prevention have not been a high agency priority.

The priority initially assigned to HIV/AIDS prevention activities within the agency appears to be at odds with other statements in the policy that recognize the potentially significant impact of the disease on economic development. The policy warns overseas offices and missions of (1) the alarming estimates concerning the spread of the virus, (2) the serious implications for ongoing AID programs, and (3) the costs that host government programs could incur in the areas of health, family planning, and education as a result of the disease.

In addition, preliminary AID and World Bank studies conclude that HIV/AIDS threatens to halt or reverse the social and economic gains in developing countries.¹ The studies indicate that deaths caused by HIV/AIDS primarily occur among people 30 to 40 years old in their most productive years. Thus, each death represents the loss of a potential productive worker. When large numbers of people in their most productive years are stricken, these studies suggest, the labor force will become inexperienced and will be reduced, resulting in declines in productivity, particularly in agriculturally based, labor-dependent economies. In urban areas, which are populated by the most educated and skilled members of society, valued human resources are placed at risk.

While AID-supported studies and demographic models such as the AIDS Impact Model are used to help policymakers and health officials in developing countries review the potential impact HIV/AIDS will have on national health care systems and on other sectors of society, the agency has not used the studies or models to assess the impact the virus could have on its own development programs. An agency official stated that the studies are preliminary and that the data used to support the studies is biased and incomplete. Thus, although funding for HIV/AIDS prevention is increasing in AID, the agency has not considered the effects of the disease on AID development programs.

HIV/AIDS also could have devastating effects on health-related development programs. In one African city, AIDS is the leading cause of death among males and the second leading cause among females. As HIV/AIDS deaths increase in African countries, advances made in increasing life expectancy

¹Family Health International, AIDSTECH, The Direct Costs of AIDS: Current and Projected Resource Requirements in Mexico (Research Triangle Park, North Carolina, 1991).

World Bank, The World Bank's Agenda For Action on AIDS and Other Sexually Transmitted Diseases (STDS) In Africa, A Review and Update (Washington, D.C., 1991) pp. i, 5-6.

Center for International Research, The Demographic Impact of AIDS in Sub-Sahara Africa (Bureau of the Census, Washington, D.C., 1991) pp. 1-3.

are threatened. WHO reports that as of mid-1991, 1 million children were infected with the virus, and it expects that half of those children will either develop AIDS or will die before their fifth birthday. WHO health experts fear that the large number of children dying from AIDS could erase major achievements made by child survival programs.²

Although AID has conducted preliminary studies, we found that the agency had not conducted comprehensive assessments of the economic, political, and social impact of HIV/AIDS, even for countries thought to be the most seriously affected. AID officials stated that a Central Intelligence Agency report issued in late 1991 outlines the potential threat that AIDS could have on economic development in countries receiving U.S. development assistance. Officials stated that the report warns of the threat that HIV/AIDS poses to the successes in other development areas of assistance, such as child survival.

In October 1991, 4 years after AID began supporting HIV/AIDS prevention activities, AID's Office of Strategic Planning within the Policy Directorate was tasked by the Administrator to study the effects of HIV/AIDS on overall development. AID plans to study the effects of the disease on different sectors of development in three countries, but the study had not begun as of April 1992.

AID Has Not Developed an Agencywide HIV/AIDS Strategy

While AID has not revised its official policy statement on HIV/AIDS, its response to the disease has evolved from being reactive and piecemeal to being proactive and targeted. AID's Policy Directorate is responsible for developing agencywide strategies linking policy guidance on various development issues with regional and central bureau and mission operations. The Directorate has developed such strategies for child survival and environmental issues but has not developed a strategy for HIV/AIDS prevention. To develop an agencywide strategy for a particular issue, the Directorate compiles information from the bureaus and missions on the activities they are implementing and compares this information to the policy guidance. Missions and bureaus can then refer to the strategy when they are designing projects.

²Dr. Michael Merson, "AIDS: Threat To The Developing World's Children," testimony before the House Select Committee on Hunger (June 1991), p. 2.

World Health Organization, Current and Future Dimensions of the HIV/AIDS Pandemic: A Capsule Summary, January 1992 (Switzerland, 1992), p. 3.

World Health Organization, Current and Future Dimensions of the HIV/AIDS Pandemic: A Capsule Summary, April 1991 (Switzerland, 1991), p. 2.

Without an agencywide strategy for HIV/AIDS prevention, missions and bureaus do not have direction in designing projects. Some mission officials we interviewed in Africa could not articulate the agency's strategy for HIV/AIDS prevention. In many cases, project managers used mission guidance and the AIDSCOM and AIDSTECH project papers for direction in implementing HIV/AIDS activities.

HIV/AIDS Issues Not Emphasized in Planning

AID's senior management has been engaged in HIV/AIDS prevention issues, and agency officials cited the following activities as examples.

- In January 1991, the AID Administrator traveled to Africa with the Secretary of Health and Human Services to specifically study the HIV/AIDS problem.
- The Administrator established an AIDS Working Group, which has been active for 4 years.
- The Administrator and his senior staff have received several presentations on HIV/AIDS issues.
- Senior management uses the Activity Codes/Special Interest System to track agency funding of HIV/AIDS prevention activities.

However, senior managers do not have a formal process for considering the potential impact of the virus on development programs, and according to one AID official, the current AID planning and budgeting processes do not elevate the issue to top management's attention.

Program Planning

AID management's program planning decisions are based primarily on the "strategic objectives" identified in key planning documents that are submitted by bureaus, missions, and offices and that are to reflect agency priorities. These planning documents are the 5-year Country Development Strategy Statements and Annual Action Plans. Our review of these planning documents for selected missions showed that information on HIV/AIDS was usually subordinated under other strategic objectives. The plans rarely isolated HIV/AIDS prevention as a distinct strategic objective or discuss the disease's impact on other strategic objectives.

One reason HIV/AIDS issues are not included as a separate item in planning documents is that AID has recently been attempting to limit the number of strategic objectives for each recipient country. AID has instructed missions to "focus and concentrate" their resources on a limited number of priority areas to increase the impact of the agency's programs. Although

concentrating on fewer objectives may allow AID to have greater impact on those areas selected for concentration, one effect of this policy has been to limit the visibility at the policy level of areas of special interest to Congress, such as HIV/AIDS prevention. Missions generally list only two or three strategic objectives, and if special interest areas are included, they are usually grouped under one objective.

Of the African missions, only the mission in Malawi identified HIV/AIDS as a priority in its Country Development Strategy Statement, and it was able to do so because it listed five, rather than two or three, strategic objectives. Other missions either included HIV/AIDS under a larger "health" objective or identified HIV/AIDS as a peripheral "target of opportunity."

Senior AID management has recognized that as a result of efforts to focus and concentrate resources, some missions have decided to terminate low-priority activities and propose less funding for certain areas than has been acceptable to Congress. To continue to focus and concentrate resources and at the same time ensure adequate funding for areas of special interest to Congress, a senior AID official stated that some missions may "be encouraged (told) to adopt programs in certain areas rather than others they might prefer. In effect, Washington will intervene in the focus and concentration process to encourage missions to remain in or adopt certain types of programs."

Budget Planning

HIV/AIDS issues are not incorporated into budget allocation decisions because the agency's regional bureaus have not considered the disease when assessing the conditions and needs of developing countries. When making these assessments, regional bureaus have used a variety of indicators, such as a country's infant mortality rate, its stance on democracy, and its economic policies. The rate of HIV infection and the number of AIDS cases are not used as indicators. The assessments play a key role in the budget allocation process, but because HIV rates and AIDS cases are excluded as indicators, missions' funding levels may not be set to reflect the impact of the disease on developing countries.

Planned Decrease in HIV/AIDS Obligations in Africa Illustrates Lack of Planning

The AID Africa Bureau's plan to decrease obligations for HIV/AIDS prevention in fiscal year 1992 illustrates the weak planning for HIV/AIDS activities. The planned decrease came at a time when Congress was expected to increase funding for Africa in its appropriations for the Development Fund for

Africa from \$800 million in fiscal year 1991 to \$1 billion in fiscal year 1992³ and establish a target for funding for HIV/AIDS activities in the region.⁴ The target was projected to be an amount equal to 5 percent of the appropriation for the Development Fund for Africa. To meet this target with an anticipated \$1 billion budget for the fund, the agency would have had to obligate \$50 million for fiscal year 1992—nearly double what the agency obligated in fiscal year 1991.

Although senior AID managers we interviewed anticipated by mid-1991 that Congress was likely to increase funding for Africa and establish the 5-percent target, the Africa Bureau had planned to decrease HIV/AIDS prevention obligations from \$28 million for fiscal year 1992 to \$24 million for fiscal year 1993. The Africa Bureau did not notify missions of the congressional expectation for AID to increase its support for HIV/AIDS prevention activities in fiscal year 1992.

In January 1992, at the end of the fiscal year 1993 budget planning cycle, the Africa Bureau notified the missions of the likely increase in the HIV/AIDS prevention funding from \$28 million to \$40 million for fiscal year 1992 and from \$24 million to \$42 million for fiscal year 1993. As a result, African missions' planned obligations for HIV/AIDS prevention have increased dramatically, even though they did not develop comparable programs in this area. For example, in Senegal, the mission now plans to obligate \$2 million for HIV/AIDS activities in fiscal year 1992, whereas its action plans and strategy documents show that originally it did not intend to participate in HIV/AIDS prevention activities. While Senegal is now a tentative priority country, a senior AID official said that this change was due to the anticipated congressional target for HIV/AIDS prevention activities in Africa. The official also said that planned obligations in other program areas, such as private enterprise and agriculture, would have to be reduced to offset planned increases in HIV/AIDS funding.

The target for HIV/AIDS prevention activities in Africa is contained in the fiscal year 1992 foreign assistance bill, as well as a report accompanying the fiscal year 1992 appropriations bill. Neither bill has been enacted, and the agency is operating under a continuing resolution.⁵ AID officials said that they were unsure about how they will proceed with respect to funding

³H.R. 2621, 102d Cong., 1st Sess. (1991).

⁴H.R. 2508, 102d Cong., 1st Sess. (1991).

⁵Under the continuing resolution, Public Law 102-145, fiscal year 1992 funding is maintained at fiscal year 1991 levels.

levels for HIV/AIDS prevention activities in the African region in the absence of a prescribed legislative target.

Conclusions

AID has not effectively addressed the serious implications of the spread of the virus in developing countries. The agency has not completed the study of the effects of the virus on overall development or developed an agencywide strategy for implementing its policies. Furthermore, the agency has not institutionalized HIV/AIDS issues in its formal program and budget planning processes so that these issues are routinely brought to the attention of senior management.

Recommendations

We recommend that the Administrator of AID expedite the completion of the planned study to examine the effects of HIV/AIDS on overall development.

We also recommend that upon completion of this study, the Administrator revise and update the 1987 policy, develop an agencywide strategy for implementing this policy, and formally incorporate HIV/AIDS issues into program and budget planning processes.

Management and Oversight Weaknesses in ATSP

AID's management and oversight of ATSP were weak from 1987, when the project began, until 1991, when it was redesigned. The agency's management approach lacked coordination and clear direction guiding the implementation and control of project activities. Guidance cited in AID Handbook 3 requires that program managers use an operational plan as a dynamic tool to direct, assess, and monitor project implementation. AIDS Division managers had no operational plan.

AIDS Division staff did not adequately monitor ATSP as required by guidance cited in AID Handbook 13, which defines monitoring activities. Additionally, AIDS Division staff did not include evaluation plans in the project design, also as required by AID Handbook 3 and the AID Evaluation Handbook. Agency officials cited inadequate staffing both at the AIDS Division and in the field as a reason AID's Handbook guidance was not followed.

AID missions in the six countries we visited—Brazil, the Dominican Republic, Kenya, Malawi, Uganda, and Thailand—did not always implement the programs in accordance with AID regulations since the AIDSCOM and AIDSTECH contractors would respond to a mission's request for technical assistance without planning or coordinating with AIDS Division staff. Agency officials expect the redesigned AIDSCAP project will be better managed and will draw from lessons learned in ATSP to focus resources to enhance the potential of the program to make an impact on the virus. However, we identified three problems that could impede the project's success. AID lacked (1) a final list of priority countries, (2) a standard set of impact indicators, and (3) provisions for meeting the expected increased demand for condoms.

Program Management Was Not Effective

AID's management of ATSP generally was consistent with its decentralization approach to management. Although primary management responsibility for the project rested centrally with the AIDS Division, missions generally determined their own country's needs for assistance provided through the AIDSCOM and AIDSTECH sub-projects. However, AIDS Division officials told us that the two contractors responsible for implementing project activities in the field were difficult to manage because they were in competition with each other.

In addition, AID did not focus its efforts and resources in countries based on HIV infection rates. Project design documents state that assistance would be provided upon request. In other words, missions were allowed to

decide whether and to what extent they wanted to participate in ATSP, and the project gave them programming and budgeting flexibility in supporting HIV/AIDS prevention activities. The following are examples of this flexibility:

- Missions without experience or strong expertise in this area could tap into the expertise of AIDSTECH and AIDSCOM contractors, whose projects had already been designed and approved and could be implemented quickly. For example, the Brazil mission programmed \$50,000 to purchase technical assistance from AIDSTECH to provide five HIV/AIDS prevention training workshops for health professionals. The mission also purchased educational materials produced by AIDSCOM to support the workshops.
- Missions with HIV/AIDS expertise could design and implement their own prevention activities, tailoring them to respond to the needs they believed exist. The Uganda mission, for instance, developed and managed most of its own HIV/AIDS activities, which included a \$12 million grant to the nonprofit organization Experiment in International Living. Mission officials told us that they wanted these activities under their own control rather than under the control of the AIDS Division and its contractors. These officials believe that programs such as ATSP result in obtaining technical assistance from experts who are unaware of the specific needs of a given country, and consequently, they preferred to manage their own activities.
- Missions in Africa could obtain funding and management assistance through the HIV/AIDS Prevention in Africa (HAPA) project. HAPA eliminated steps normally required to initiate new projects and relieved missions of project management responsibilities. HAPA could contract for services through ATSP or private voluntary organizations involved in HIV/AIDS prevention. For example, the Malawi mission allocated \$100,000 in fiscal year 1991 through HAPA to obtain HIV/AIDS assistance provided by AIDSTECH.

While this reactive approach provided flexibility, the lack of direction for implementing ATSP activities meant that project resources were spread among many countries. In December 1990, the Chief of the AIDS Division stated, "While much has been accomplished in a relatively short time, several important things have not been accomplished: We have not prevented much HIV due in part to too few resources. We've been too spread out and too small . . ." In fiscal year 1990, the AIDS Division reported that agency funding for HIV/AIDS prevention activities ranged that year from \$2,000 to \$2 million in the 46 countries.

Contractors Did Not Work Together Effectively

A 1989 consultant's report conducted for the AIDS Division and a consultant's 1991 interim assessment of ATSP for the Research and

Development Bureau disclosed that the contractors were not working together effectively. Our review showed that the two contractors communicated poorly with each other and did not coordinate their activities. In the Dominican Republic, for example, AIDSCOM produced a training video that was intended to educate health professionals. AIDSTECH organized training sessions but was unaware of the existence of the video.

Two consultant studies show that one reason for the contractors' coordination problems was an overlap in their scope of work, resulting in competition between them and duplication of effort. One of AIDSTECH's primary goals, for instance, was to assist in improved blood screening and quality assurance to prevent the transmission of the virus through blood. As it evolved, AIDSTECH took on additional tasks, such as behavior modification research. However, this was a primary area in which AIDSCOM had been involved. Close collaboration between the contractors and AID management was recognized as necessary to avoid duplication of effort and to efficiently provide technical assistance, but this generally did not occur. Both contractors employed different strategies in behavioral research, and this has raised questions about the future quality and comparability of research projects in countries, like the Dominican Republic, where both contractors provide assistance.

Mission officials expressed concern about management and quality control. According to these officials, when they were dissatisfied with the services provided by one of the contractors, they could not deal with the situation directly, but had to work through the AIDS Division. Mission officials in Uganda stated that, in general, centrally managed projects such as ATSP often create a "revolving door" of technical experts entering the country, resulting in a lack of continuity in the project.

Project Monitoring and Evaluation Were Inadequate

AID did not adequately monitor the HIV/AIDS activities supported by ATSP. Thus, the agency did not have reasonable assurances that project activities were being implemented as intended, objectives were being met, policies were being followed, or resources were being effectively used. AID also lacked an impact evaluation program for ATSP. Without impact evaluations, senior AID management could not make informed decisions concerning the project.

AIDS Division staff acknowledged that there were management problems with ATSP and said they intended to incorporate plans in the AIDSCAP project designed to correct those problems. AID and contractor officials

stated that they were in the process of developing program management guidance and strategies for accomplishing program goals. Additionally, AID officials recognized that the program needed to focus and concentrate resources, and they were designing AIDSCAP to concentrate resources according to a targeted AIDS strategic plan in priority countries.

Contractors' Reports Did Not Provide Sufficient Information on Project Activities

To obtain information about project activities, AID relied in part on reports that the AIDSCOM and AIDSTECH contractors were to submit semiannually.¹ We found that the semiannual reports did not contain detailed information on the status, progress, and problems of project activities as required by AID Handbook 13 and Handbook 3. For example, one contractor's semiannual report did not (1) capture the major costs associated with field activities, (2) provide data on subcontractors' activities, (3) discuss condom management issues, or (4) address criteria for assessing program impact. Agency officials acknowledged the weaknesses of the semiannual reports and stated that AID would revise the reporting requirements.

We also found that the accuracy of information included in the semiannual reports was not routinely verified by AIDS Division staff. AIDS Division staff did not conduct regular site visits to determine whether documentation maintained by the contractors was consistent with the information provided in the semiannual reports. Mission officials we interviewed in several countries said that HIV/AIDS activities in the field were monitored only on an informal basis.

No Impact Evaluation Agenda

AID does not know if ATSP activities were effective because it did not assess their impact on preventing the spread of the virus. No evaluation agenda was established to determine the long-term results attributable to these activities, and no mechanisms were built into the project design to measure the effectiveness of either the program's methodology or the interventions designed to modify behavior.

The Research and Development Bureau's interim assessment of ATSP in 1991 focused mainly on management concerns and did not include an impact evaluation. Agency officials acknowledged that impact evaluation had not been a top priority.

¹In addition to these reports, project managers use periodic meetings with contractors, reviews of subagreements, and peer reviews to monitor project activities.

Officials at one mission told us that data on project impact was often difficult to obtain because of the complexity of the disease and the environment in which some projects were implemented. Additionally, an agency official stated “with all of the competing priorities and pressures facing the AIDS Division, and the lack of staff, attending to impact evaluations and updating the AIDS policy have not been a high priority.” AID officials also said that although it was too soon to evaluate the impact of many projects, some HIV/AIDS activities had succeeded in helping to prevent the spread of the virus. For example, AID officials attributed the leveling of the infection rate among intravenous drug users in Bangkok, Thailand, to an AIDSTECH education campaign that discouraged the sharing of needles. However, AID officials in Thailand also told us that the results of various HIV/AIDS activities were not compiled and analyzed for use in developing future activities.

AIDS Division Did Not Develop Detailed Management Plans

The AIDS Division did not develop detailed management plans to support the direction, monitoring, and assessment of project implementation. Agency regulations in Handbook 13 require that an “operational implementation plan” be developed for large, complex projects such as ATSP. Among other things, the regulations call for a plan to

- specify all actions to be taken to implement the project,
- indicate the times when actions are to begin and be completed, and
- identify the resources needed to complete the tasks and those responsible for these tasks.

A typical plan might include a master schedule of key events and activities; a logistics schedule of materials and equipment required; a procurement plan for obtaining goods and services; a staffing schedule showing recruitment, training, and personnel placement; a financial schedule; administrative activities, such as key decision points, coordination actions, and reporting arrangements; and an evaluation plan. According to the regulations, an operational implementation plan should be an outgrowth of pre-project planning and be expanded and periodically updated as new information becomes available.

AIDS Division officials told us that no plan was developed because the division lacked staff. In the absence of a plan, ATSP was guided by the original project paper developed in 1987 by the Research and Development Bureau and the contract and cooperative agreement requirements for AIDSCOM and AIDSTECH. The project paper provides a

rationale for and description of the project and includes broad information on its implementation, financing, and oversight. The contract and cooperative agreement provide information regarding the specific requirements of AIDSCOM and AIDSTECH. However, none of these documents provide detailed direction for the overall management of ATSP.

Staffing Levels Reflect Program Resource Limitations

AID officials we interviewed said that the AIDS Division did not have enough staff and that this contributed to the ATSP management and oversight problems. The AIDS Division had 11 staff members, 3 of whom were direct-hire employees who had oversight and signatory authority. The others were three CDC employees, three Johns Hopkins Child Survival Fellows, one Bureau of the Census employee, and one American Association for the Advancement of Science Fellow. The Senate Committee on Appropriations, in its report accompanying the 1991 foreign assistance appropriations act, expressed concern over the small number of direct-hire staff devoted to HIV/AIDS assistance and urged AID to review its personnel allocations and "make every effort" to increase staff in the AIDS Division.

AID has cited staff shortages in the Research and Development Bureau as a continuing problem. In its fiscal year 1990 assessment of internal control weaknesses, AID reported that staff limitations restricted the bureau's ability to support and monitor projects. In addition, the Director of AID's Office of Health advocated in 1990 that staff be added to the AIDS Division. In a memorandum to the Assistant Administrator of the Research and Development Bureau, the director stated, "The AIDS Division, which is responsible for over 75 percent of the agency AIDS resources is operating with two full-time and two part-time direct-hire staff." Our review shows that no net direct-hire positions were added to the AIDS Division, although the two part-time positions were eliminated and replaced by a full-time position.

Agency officials also said there was an imbalance at the missions between personnel needs and actual staffing patterns. In Zimbabwe, Brazil, and Nigeria, all of which have been hit hard by HIV/AIDS, the missions have established only limited HIV/AIDS programs because none have a health officer on staff to run more extensive programs. According to the directors of AID's Office of Health and the Office of Population,

"No established process exists in AID to ensure that direct-hire staffing needs are matched with global priorities in the health, population, and nutrition sector. As a result, in addition

to absolute shortages of staff, the agency staffing program contains such anomalies as having a BS-50 [health officer] position for Swaziland (population 1 million) which is neither a global population, child survival, or AIDS priority country, while in Nigeria (population 120 million) which is both a global population, HIV, and child survival country, there is not one BS-50 position.”

Mission officials in Latin America and Africa told us that they did not have enough direct-hire staff to work on HIV/AIDS activities, and there was a shortage of health professionals within the agency.

Missions Have Been Able to Implement ATSP Activities

Despite the management problems we identified, missions were able to implement ATSP activities.

- In Brazil, the mission arranged a conference on HIV/AIDS in the workplace. Following the conference, participants from the banking sector became interested in additional HIV/AIDS prevention activities, which the mission agreed to fund.
- In Kenya, the mission funded two workshops to train community-based distributors of contraceptives in (1) HIV/AIDS prevention, education, and counseling; (2) the production of education materials; and (3) the planning of outreach activities. In fiscal year 1990, nearly 1 million condoms were distributed.
- In Thailand, the mission funded a project in fiscal year 1989 to evaluate the feasibility of using Bangkok taxi drivers as HIV/AIDS educators and condom distributors. More than 750 drivers were recruited, and educational materials were produced for placement in taxis. The project was later determined to be unsuccessful because the taxi drivers were not distributing the information.

Redesigned ATSP May Have Impediments to Its Success

The Research and Development Bureau's redesign of ATSP in 1991 was prompted by (1) the rapidly approaching funding ceilings of AIDSCOM and AIDSTECH, (2) a growing recognition that project resources were spread too thinly to achieve impact, and (3) the acknowledgement of the need for management change. Bureau officials stated that AIDSCAP, the 5-year, \$167.6 million redesigned ATSP, will draw from lessons learned in ATSP and from recent research on methods for combating the spread of the virus. More specifically, AIDSCAP will target resources to fewer countries and on activities that will seek to (1) increase demand for condoms, (2) control sexually transmitted diseases through improved diagnosis and treatment services, and (3) decrease the number of sexual partners.

One of the most significant changes from ATSP is the decision for AIDSCAP to target resources at countries where the most impact could be made. This approach is based on the Research and Development Bureau's determination that AID is more likely to have a measurable impact on the spread of the virus if it focuses its efforts on priority countries and on a limited number of proven prevention methods. AID's goal is to identify 10 to 15 priority countries for participation in the AIDSCAP project. Priority countries are defined by the following criteria outlined by the Research and Development Bureau:

- AID mission commitment and availability of mission resources.
- Potential for HIV transmission.
- Population size and distribution within the country.
- Country commitment and capacity for country to respond.
- Availability of other donor funds.

Although it is too early to evaluate the impact of AIDSCAP, our review of the project indicated that it could resolve many of the problems we identified in ATSP. The redesigned project appears to better focus agency resources and, in contrast with ATSP, provides for impact evaluations. Health experts we consulted said that the prevention strategy envisioned in AIDSCAP could be effective in helping to slow the spread of the virus in the priority countries. In addition, the project paper developed for AIDSCAP is significantly more detailed than that developed for ATSP, although it does not provide a specific timetable of key events during the life of the project.

Despite these improvements, we identified three potential impediments to the project's success: (1) a final list of priority countries had not been completed 8 months after the project's start-up date, (2) indicators used to measure program impact had not been fully developed, and (3) the project did not provide the means for meeting the expected increased demand for condoms.

**Priority Countries for
AIDSCAP Have Not Been
Finalized**

Although AIDSCAP began in October 1991, a final list of priority countries had not been completed as of May 1992. AID had developed a tentative list of 12 countries, but the list has changed several times since October 1991, and, according to AID officials, is still subject to change. (See app. I for a tentative list of AIDSCAP priority countries as of May 1992.) According to AID officials, the selection process has been delayed primarily because the Research and Development Bureau and regional bureaus have not been able to work successfully together in selecting priority countries. Although higher-level AID management officials said that there had been no difficulty in working relationships between the bureaus, regional bureau officials stated that the Research and Development Bureau had not kept them informed during the country selection process, and Research and Development Bureau officials stated that the regional bureaus demonstrated a lack of interest in AIDSCAP. Cooperation between regional bureaus and the Research and Development Bureau is necessary to obtain the appropriate resources required for AIDSCAP implementation.

As a result of this lack of cooperation, some missions interested in becoming priority countries have been unable to obtain appropriate resources for AIDSCAP. Conversely, missions that wish to control their own program have been unwilling to commit their resources to AIDSCAP. AIDSCAP requires missions in priority countries to allocate about \$1.5 million annually to the 5-year project. The funding and programming needs required of a mission to be a priority country requires the support of the regional bureau. Regional bureau staff warned in February 1991, when the redesigned project was being drafted, that obtaining mission funds to support AIDSCAP in priority country missions may be difficult if regional bureaus are not involved in the priority country selection process. As the selection process proceeded, AID missions in several countries with high HIV/AIDS prevalence expressed interest in becoming AIDSCAP priority countries, but at least initially they lacked the necessary resources and staff to participate. AID officials stated that the delay in identifying AIDSCAP priority countries may be slowing the implementation of the AIDSCAP project.

**Indicators for Program
Impact Not Final**

Although AIDSCAP includes an extensive evaluation agenda, indicators to assess program impact have not been finalized. AID, in collaboration with WHO, has been involved in developing indicators to help measure the impact of donor assistance in HIV/AIDS prevention. Eleven indicators have been tentatively identified, but field testing of them has not been

completed. AID anticipates that WHO will complete field testing these indicators by December 1992.

To have an effective evaluation plan for the AIDSCAP project, standardized indicators must be part of project design. Although AID will try to incorporate at least 2 or 3 of the 11 proposed indicators in the project designs for countries beginning HIV/AIDS prevention projects in fiscal year 1992, officials are concerned that baseline data and program impact may be difficult to establish because a complete set of standardized indicators will not be available until 1993, 2 years after the initiation of AIDSCAP.

**No Provision Made to Meet
Condom Demand Created
by AIDSCAP**

One of AIDSCAP's specific goals is to increase the use of condoms to prevent the spread of the virus; however, project plans do not provide for meeting the expected increased demand. The AIDS Division does not plan to provide funding for condom procurement, aside from a small fund to meet emergency requests. However, AID officials acknowledged that a steady supply of condoms is essential to AIDS prevention and control programs. AID procured 137 million condoms for HIV/AIDS programs at a cost of \$10.1 million between fiscal years 1987 and 1990. At AID's urging, WHO provided 137 million condoms in 1990. As they do now, missions can procure condoms through the Office of Population, but during our review, mission officials did not indicate a willingness to increase mission funds to supply condoms as the demand increases.

Other donors' commitments to fund condom supplies for HIV/AIDS prevention are still uncertain, and the AIDSCAP project has not included a budget for condom procurement. The AIDS Division stated that in fiscal year 1992, bilateral missions will be expected to pay for condoms ordered for AIDS prevention. AID hopes that host governments will look to other donors, such as the WHO, for future condom supplies. AID believes that WHO, being the lead global organization for HIV/AIDS activities, should take the lead in making condoms available for HIV/AIDS prevention programs. In addition, WHO and other United Nations organizations are able to obtain condoms at a lower cost than AID because they are not constrained by "buy-American" restrictions. Yet, as of early 1992, WHO had no plans to increase condom procurement for HIV/AIDS programs. We also found no evidence that other international donors were willing to supply condoms for HIV/AIDS programs.

Conclusions

The AIDS Division did not manage and monitor ATSP in accordance with agency regulations that require officials to plan and monitor complex programs to ensure that agency officials are held accountable for decisions made and that projects conform to agency design and planning requirements.

Although AIDSCAP, the redesigned ATSP project, may resolve some of the problems we identified in ATSP, it may face difficulties if the agency does not designate priority countries to receive assistance with HIV/AIDS prevention and establish a set of indicators to measure and evaluate program impact. Without a final list of priority countries supported by the agency, funding and programming support needed to implement AIDSCAP will be difficult to obtain. Delays in establishing a standard set of indicators will affect the agency's ability to effectively evaluate the impact of the \$167.6 million AIDSCAP project.

Agency officials acknowledge that AIDSCAP will increase the demand for condoms, but the project makes no provision to supply the expected increase in demand. Since WHO and other international donors have not announced plans to increase their funding support for condoms, the AIDSCAP project may create a demand for condoms without providing the means to meet it.

Recommendation

We recommend that the Administrator of AID confirm a list of priority countries for HIV/AIDS prevention assistance under AIDSCAP, develop a standardized set of indicators for use in evaluating program impact, and seek ways for satisfying the increased demand for condoms expected to be generated by the AIDSCAP project.

Tentative AIDSCAP Priority Countries (as of May 1992)

Latin America and the Caribbean

Haiti
Dominican Republic
Jamaica
Brazil

Africa

Malawi
Senegal
Nigeria
Ethiopia
South Africa
Tanzania

Asia

Thailand
India

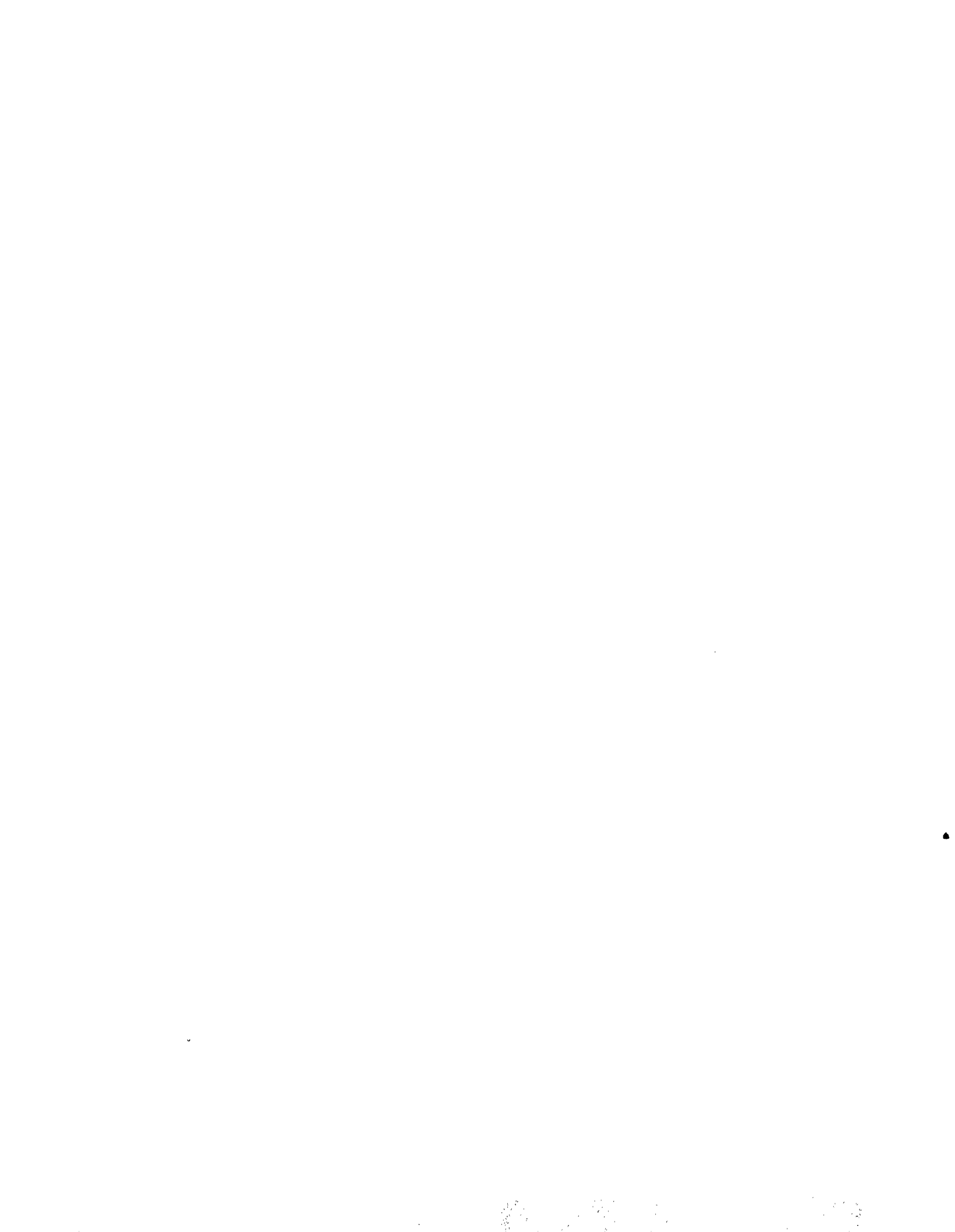
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