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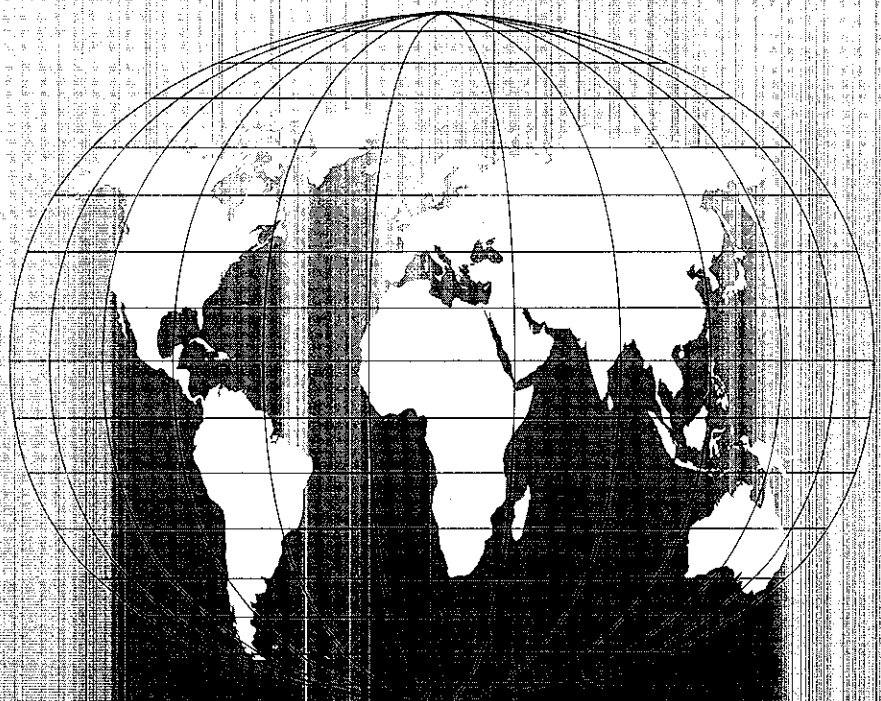
Report of Audit

Audit of USAID/Rwanda's Monitoring of the Performance of Its HIV/AIDS Program

Report No. 4-696-02-003-P
March 11, 2002



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INTERNATIONAL
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RIG/Pretoria

March 11, 2002

MEMORANDUM

FOR: Mission Director USAID/Rwanda, Dick Goldman

FROM: Acting Regional Inspector General Pretoria, Nancy J. Lawton

SUBJECT: Audit of USAID/Rwanda's Monitoring of the Performance of Its HIV/AIDS Program (Report No. 4-696-02-003-P)

This is our final report on the subject audit. In finalizing this report, we considered management's comments on our draft report. We have included those comments, in their entirety, as Appendix II to this report.

This report contains one recommendation. Based on actions taken, as reported by the Mission, a management decision has been reached on Recommendation No. 1. Please advise the Bureau of Management Planning and Innovation, Management and Innovation and Control Division (M/MPI/MIC) when final action is complete.

I appreciate the cooperation and courtesy extended to my staff during the audit.

Table of Contents

Summary of Results 3

Background 4

Audit Objectives 5

Audit Findings 5

Did USAID/Rwanda monitor performance of its HIV/AIDS program in accordance with Automated Directives System (ADS) guidance?

USAID/Rwanda Should Periodically Review Its Performance Monitoring Plan 6

USAID/Rwanda Should Implement Adequate Controls 8

Is USAID/Rwanda achieving intended results from its HIV/AIDS program? 13

What is the status of USAID/Rwanda's efforts to meet anticipated HIV/AIDS reporting requirements? 20

Management Comments and Our Evaluation 23

Appendix I – Scope and Methodology 24

Appendix II – Management Comments 27

Appendix III – Rapid Scale-Up and Intensive Focus Countries 30

Appendix IV – Summary of USAID/Rwanda's Selected Performance Monitoring Controls 31

Summary of Results

Over the last three years USAID funding for HIV/AIDS[1] has increased dramatically–from $142 million in fiscal year 1999 to over $300 million in fiscal year 2001. This increase has created a demand for greater accountability on the part of USAID and its operating units, both as to monitoring progress and achieving intended results. (See pages 4 to 5.)

USAID procedures for monitoring programs, including its HIV/AIDS programs, are contained in its Automated Directives System (ADS). The ADS sets forth requirements that operating units must follow in managing their programs, such as the establishment of indicators, identification of data sources, and planned methods by which data are to be collected. We tested USAID/Rwanda's monitoring of its HIV/AIDS program against eleven controls contained in the ADS. USAID/Rwanda had fully implemented only three of the eleven controls. In order for USAID/Rwanda to monitor performance of its HIV/AIDS program in accordance with the ADS requirements, we recommend that USAID/Rwanda fully implement the 11 monitoring controls and establish and follow a schedule in which its performance monitoring plan is reviewed at least annually. (See pages 5 to 12.)

Results-oriented management must be used to reasonably ensure that programs achieve their intended results. USAID/Rwanda (Mission) has seven indicators in its Performance Monitoring Plan to measure results in its HIV/AIDS program. However, data was collected for only three indicators which were the ones reported in the Results Review and Resource Request (R4)—condom use, sexually transmitted infection (STI) diagnosis and treatment, and STI/HIV knowledge. These were the indicators selected for audit testing.

However, we are unable to express an opinion on whether USAID/Rwanda is achieving intended results from its HIV/AIDS program because reliable and pertinent data was not available when the indicators were developed in February 2000. (See page 5.) Nevertheless, through its partners, the Mission had made progress in year 2000. The Mission and Rwanda continue to transit from an emergency response to a sustainable development basis and now the Mission is planning for the future. Based on these conditions, we are not making any recommendations. (See pages 13 to 20.)

To improve the monitoring process for its HIV/AIDS program, USAID has drafted monitoring and evaluation guidance, "USAID's Expanded Response to the Global HIV/AIDS Pandemic." The guidance establishes several global targets USAID expects to achieve as a result of the additional funding it anticipates receiving. The guidance also requires missions to routinely

[1] HIV is Human Immunodeficiency Virus and AIDS is Acquired Immunodeficiency Syndrome.

monitor and evaluate their HIV/AIDS programs using standard indicators. As a recipient of additional funding, USAID/Rwanda is preparing to meet these additional monitoring requirements. The results of our review indicate that the Mission is on its way to meeting its requirements under the newly drafted Guidance. (See pages 20 to 22.)

Background

USAID funding for HIV/AIDS has more than doubled over the past three years: from $142 million in fiscal year 1999 to over $300 million in fiscal year 2001. USAID is organizing its response to HIV/AIDS around three categories of countries: rapid scale up countries, intensive focus countries, and basic countries. (See Appendix III for descriptions of these categories.) Rwanda, a landlocked country in central Africa with a population of about 8.3 million, is one of thirteen intensive focus countries. USAID plans to increase funding to these countries to reduce prevalence rates, to reduce HIV transmission from mother to infant, and to increase support services for people with HIV/AIDS.

HIV/AIDS is a major public health problem in Rwanda, with an estimated prevalence rate of about 11 percent among the adult population (ages 11 to 45). Life expectancy has been reduced from 54 to 42 years as a result of AIDS, which is one of the three leading causes of death in Rwanda. Several factors contribute to the rapid spread of HIV/AIDS in Rwanda. These include the economic crisis; high rates of multiple sex partners; the early onset of sexual activity; the high presence of sexually transmitted infections; the availability of commercial sex; rape; and cultural beliefs, including the resistance to talk about sex or use condoms.

The instability of the transition period during which USAID/Rwanda implements its programs cannot be over emphasized. The civil war in Burundi and the crisis in eastern Congo have the potential to destabilize Rwanda internally. Under these circumstances, USAID and other key donors agree that the transition to a functioning democracy and more sustainable economic development will take at least another two to three years.

The situation in Rwanda today remains characterized by demographic shifts affecting as much as one-half of the population; resettlement and rehabilitation needs in all parts of the country; and a huge loss of human resources whether through flight, participation in the genocide, or death. More than 2.3 million refugees have returned to Rwanda. According to a 1997 study, HIV prevalence is rising among Rwanda's vast rural population. According to the study, the infection rate among youths (15- to 19-year olds) was 8.5 percent in rural areas and 3.4 percent in cities.

Funding for USAID's HIV/AIDS program in Rwanda, according to USAID/Washington, was $3 million in FY 1999, $3.5 million in FY 2000, and, according to USAID/Rwanda, $5.2 million in FY 2001.

Audit Objectives

This audit is one of a series of audits being conducted worldwide of USAID's monitoring of the performance of its HIV/AIDS program at the mission level. The Performance Audits Division of USAID's Office of Inspector General is leading the audits.

The audit objectives and its scope and methodology were developed in coordination with USAID's HIV/AIDS Division in the Bureau for Global Programs, Field Support and Research. The Regional Inspector General, Pretoria (RIG/Pretoria) performed this audit in Rwanda to review USAID/Rwanda's HIV/AIDS program and, specifically, to answer the following audit objectives:

- Did USAID/Rwanda monitor performance of its HIV/AIDS program in accordance with Automated Directives System (ADS) guidance?
- Is USAID/Rwanda achieving intended results from its HIV/AIDS program?
- What is the status of USAID/Rwanda's efforts to meet anticipated HIV/AIDS reporting requirements?

Appendix I describes the audit's scope and methodology.

Audit Findings

We cannot fully answer audit objective two because, prior to year 2000, reliable and pertinent data was not available from which USAID/Rwanda could choose baseline data that reflected indicator activities. Due to the lack of country data, the Mission used the baseline data considered closest to indicators chosen for reporting. However, the baseline data used a different age group and had broader definitions than the actual performance data reported in year 2000. Therefore, comparisons of baseline data and performance data produced no meaningful measures of progress. (See page 13.)

Did USAID/Rwanda monitor performance of its HIV/AIDS program in accordance with Automated Directives System (ADS) guidance?

USAID/Rwanda did not fully monitor performance of its HIV/AIDS program in accordance with the ADS. The ADS outlines USAID's policies and procedures for implementing a performance monitoring system. Two areas of the Mission's

performance monitoring system that should be improved are the frequency with which it updates its performance monitoring plan and the implementation of all performance monitoring controls.

USAID/Rwanda's performance monitoring plan (PMP) for its health strategic objective included seven performance indicators for monitoring its HIV/AIDS program. We selected a sample of three HIV/AIDS performance indicators for review: (1) condom use; (2) sexually transmitted infection (STI) diagnosis and treatment; and (3) STI/HIV knowledge.

In a cable dated October 1999 the Mission was instructed to develop indicators and to begin reporting on this. In February 2000, a consultant from Washington worked with Mission staff to develop a PMP with indicators. A review of this PMP showed that data sources were identified and data collection schedules were specified for the three indicators tested. The Mission also used other means of performance monitoring, such as portfolio reviews. (See Appendix IV.)

Mission focus has been on rebuilding and strengthening the country's health system by working with the Government of Rwanda. Until October 1999, USAID/Rwanda was exempt from much of the monitoring and evaluation policies the ADS usually requires. Consequently, 1999 was the first year in which these exemptions no longer applied.

And finally, Rwanda appears to be emerging from its turbulent period of civil war and genocide. During that period USAID focused activity on emergency humanitarian assistance, instead of developing health and social services for HIV/AIDS and changing behavior related to STIs. The Mission Director pointed out that, only a few years ago, forays into the Rwandan countryside required armed escort. During audit fieldwork, conditions had changed such that during daylight hours, it was possible to accompany the Mission's technical advisor on her first site visit to a Rwandan HIV/AIDS treatment center. These improved conditions should facilitate coordination and program activity assessment by program staff.

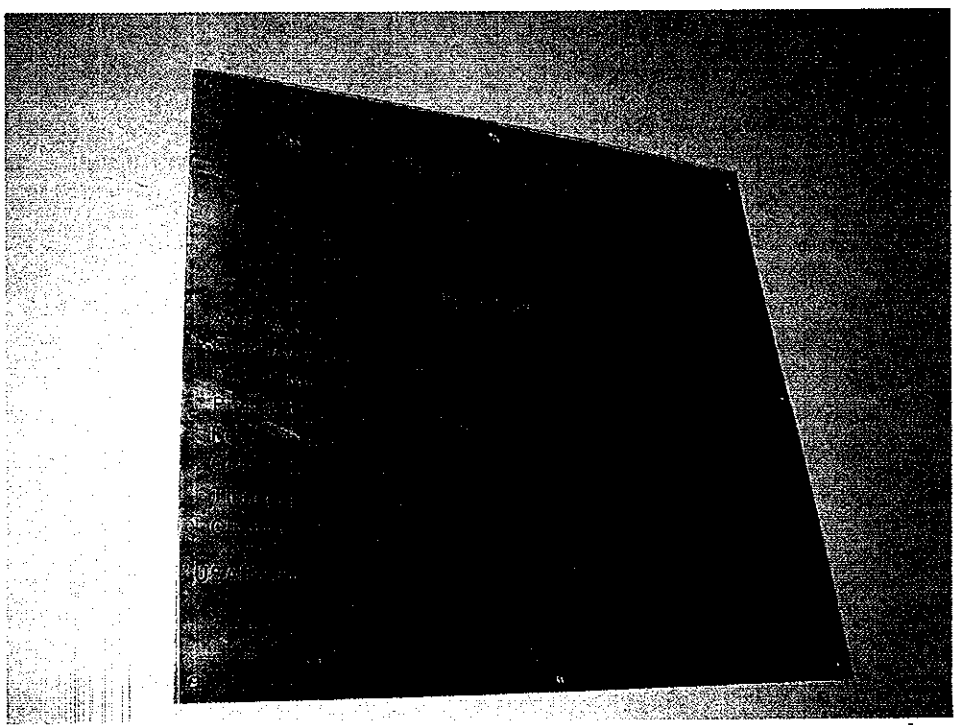
However, without updating its PMP or adequately implementing required performance monitoring controls, USAID/Rwanda did not fully monitor the progress of its HIV/AIDS program according to the ADS. These two areas are discussed below:

USAID/Rwanda Should Periodically Review Its Performance Monitoring Plan

At the time of the audit, the Mission's PMP had not been updated in almost two years (since February 2000). ADS 201 requires that the PMP be updated at least

annually as part of portfolio reviews and Results Review and Resource Request (R4) report preparation. Periodic updates ensure the usefulness and relevance of a PMP. Furthermore, ADS 203 states that a PMP should be the cornerstone of a strategic objective team's (SO team) performance management system. An outdated PMP provides little assistance in the timely and consistent collection of performance data.

The Mission Director suggested that the focus of the Mission had been on "performance, not evaluation and reporting". USAID/Rwanda's programs were emerging from an emergency period during which the host country suffered from devastating civil war and genocide. On the wall in the Mission are the names of more than a dozen Mission employees killed during that period.



Plaque in the USAID/Rwanda Mission reception area memorializing Mission employees killed during the 1994 genocide. (October 2001)

Also, the SO team members explained that the PMP may not have been updated because of limited staff. In fact, when the FY 2003 R4 was prepared, the SO team consisted of only one employee with technical expertise. At the time of the audit, the SO team had three technical employees, which should help to address this weakness.

USAID/Rwanda's explanations for why the PMP was not updated were compelling and have been fundamentally addressed. Nevertheless, the Mission had not been relieved of the "evaluation and reporting" to which the Mission Director referred. During the period in which the PMP was not updated, the ADS requirements applied to USAID/Rwanda. Moreover, it should be noted

that while PMPs are required by the ADS, they are intended for the benefit of the operating unit in planning, managing, evaluating and reporting.

In summary, by not updating its PMP, at least annually as required by ADS 201, USAID/Rwanda did not benefit from the evaluation and reporting methodology a PMP is intended to provide, i.e., a results-oriented approach to performance management. Such an approach would have gone far beyond simply collecting performance information and reporting it to Washington. By updating the PMP, USAID/Rwanda could have put performance information to work by using data continuously to inform key management decisions, improving tactics and organizational processes, identifying performance gaps, and setting goals for improvements. By analyzing and reporting in this way, USAID/Rwanda could have been better able to deliver sustainable development results.

To ensure that USAID/Rwanda does not continue to forgo the critical components of evaluation and reporting, as provided by an updated PMP, we are making one recommendation. However, because the two problem areas are interrelated, we are making a single recommendation at the end of the next problem area.

USAID/Rwanda Should Implement Adequate Controls

As mentioned in the previous section, USAID/Rwanda did not monitor its HIV/AIDS program in the way specified by the ADS. Most of the performance monitoring controls tested were found to be inadequate. ADS 201 specifies that certain performance monitoring controls must be implemented. Office of Management and Budget Circular A-123 adds clarity to this requirement with the instruction that federal managers must ensure the adequacy of control measures for results-oriented management. USAID/Rwanda did not institute the controls as required because of the relative newness of the indicator reporting requirements and limited staff. Because of these circumstances, there is significant doubt about USAID/Rwanda's effective monitoring of its HIV/AIDS program and its accuracy in reporting results.

We reviewed USAID/Rwanda's implementation of eleven performance monitoring controls contained in the ADS as they pertained to three performance indicators selected for the audit—condom use; STI diagnosis and treatment; and STI/HIV knowledge. As summarized in Appendix IV, eight of eleven controls were inadequately implemented for one or more of the selected indicators. The following is a detailed discussion comparing each of the eight controls to the relevant ADS requirement.

Indicator Precisely Defined – The three HIV/AIDS performance indicators selected for audit used technical terms that were neither explained nor precisely

defined. ADS 201 indicates that a PMP must provide a detailed description of the performance indicators to be tracked. All three indicators selected for the audit contained expressions such as "target group" and "target areas," which are ambiguous. The indicators also included imprecise technical elements such as "most recent act" and "national standards," which may be subject to different interpretations. Without clear and precise definitions, data collected could vary over time, reflecting subjective interpretations, independent of any actual change.

For example, the indicators for "condom use" and "STI/HIV knowledge" refer to "target group" within their indicator statements. However, this expression does not convey the true meaning of the population being measured. In fact, the data presented as baseline data for both indicators refers to 15- to 45-year olds, but the performance data refers to 15- to 19-year olds. Such variation compromises the reliability of the reported data and distorts reported performance. Specificity could help to prevent such variation, which in turn, leads to improved performance monitoring and reporting.

Data Collection Method Described – For the three indicators tested, the PMP provided no information about the data collection methods to be used, the method or approach of calculating the specific indicator data point and whether or not data manipulation was to be used. The ADS 201 requires that a PMP specify the methods for data collection. The SO team members indicated that the team relied heavily on partners to ensure that data collection methods resulted in good data quality and were reliable. Data reliability depends on the consistency of these processes and the ability to replicate them. But because the data collection methods were not described, it is uncertain whether data reported in the future will be reliable.

Responsibility Assigned – Data collection responsibilities were not assigned in the PMP for the three indicators tested. ADS 201 requires that a PMP assign responsibility for data collection to a specific office, team, or individual.

For example, data collection responsibilities were not assigned for the indicator "STI diagnosis and treatment." USAID/Rwanda did not receive year 2000 data for "STI diagnosis and treatment" until February 2001—one month before that year's R4 was to be published. In the end, the data was not included in the Mission's PMP or the R4 report.

The small size of the SO team may have limited the utility of assigning responsibility, such as ensuring the timely receipt of data. In February 2001, the SO team consisted of only one employee with technical experience. For much of the previous calendar year, the team consisted of only two such employees and neither was present for the entire year.

Nevertheless, the PMP is intended to be a tool to assist the SO team in planning and monitoring its HIV/AIDS program. Use of this tool would have defined and delegated responsibilities and could have assisted the SO team in accomplishing its monitoring and reporting duties for the "STI diagnosis and treatment" indicator.

Data Limitations Disclosed – Data limitations were inadequately and incompletely disclosed in the PMP for the three indicators tested. Data limitations disclosed in the PMP were not sufficient to allow an understanding of the degree one should rely on the data. ADS 201 indicates that a PMP describe the known data limitations.[2]

For example, for "condom use," the following inadequate data limitation was included, "Baseline data...may not be directly comparable." Since the performance data presented for this indicator showed a decline of approximately 50 percent in condom use reported by males (from 42 percent in 1998 to 20 percent in 2000),[3] users of the PMP might assume a decline in condom use. In fact, the baseline data was not comparable because it presented information on a different and larger age group (15- to 45-year olds) than the performance data (15- to 19-year olds). One cannot determine from the baseline and performance data presented in the PMP whether or not there had been a change in reported condom use among 15- to 19-year old males. This condition should have been disclosed.

This inadequate disclosure of data limitations in the PMP may lead the users of this data to make incorrect conclusions. The complete disclosure of data limitations permits users to understand to what degree one may rely on the data being presented.

Data Quality Assessment Procedures Described – No data quality assessment procedures were included in the PMP for any of the three indicators. ADS 201 requires that a PMP describe the quality assessment procedures that will be used to verify and validate the measured values of actual performance.

The PMP requirement was effective in June 2001, and USAID/Rwanda's PMP was last revised in February 2000. However TIPS No. 7, published in 1996, recommended that plans for how performance data are to be analyzed should be included in the PMP. Thus, by not planning for assessments, it was less likely that they would occur, with the end result that unreliable data was included in the PMP and R4 reports.

[2] This requirement was added to ADS 201 in August 2000, subsequent to the update of the Mission's PMP. However, in the R4 preparation guidance, missions were required to report on "known data limitations" for R4 indicators. All three indicators tested were used in USAID/Rwanda's R4.
[3] 1998 (baseline data) and 2000 (performance data) were the only years for which performance data was reported.

Data Quality Assessments Performed – USAID/Rwanda did not perform or document any data quality assessments either at the establishment of the selected indicators or after data collection. ADS 203 requires the performance monitoring control of performing data quality assessment when establishing the performance indicators and when choosing data collection sources and methods. For each indicator reported in the R4 performance data tables, data quality must be reassessed as needed, but no less than once every three years. Such assessments are intended to ensure that performance information is sufficiently complete, accurate, and consistent.

For two indicators—"condom use" and "STI/HIV knowledge"—assessments of performance data arc not considered as critical because the data was gathered via a survey conducted countrywide, under USAID centrally managed contracts. Such contracts typically specify numerous controls over data collection. However, data quality assessments would have allowed for better-informed monitoring and at the very least, they should have been performed on the other performance and baseline data. For example, during a site visit conducted as part of audit fieldwork, the Mission's technical advisor discovered a major data limitation for one indicator, "STI diagnosis and treatment." A data quality assessment should have been performed on the data for this indicator, but there was no evidence that one had been done.

The indicator measures the number of STI cases diagnosed and treated according to national standards. However, during the audit site visit the technical advisor learned that the specified procedures and data collected addressed only STI cases with evident symptoms. Not all STIs produce visible symptoms. For example, herpes may not produce any visible symptoms among infected women. Consequently, the performance indicator's measurement applied to a smaller population than USAID/Rwanda anticipated. The indicator's measurement may under represent certain populations and, as a consequence, lessen its usefulness for monitoring program performance.

The SO team stated that data quality assessments might not have been conducted previously because the team was understaffed and because they felt that the methods and partners were well established and reputable. Nevertheless, not only are such assessments required, but as the example above shows, they can increase understanding of the relevance of indicators and reveal data limitations for reporting purposes. Not having conducted such assessments, USAID/Rwanda had an imperfect understanding of program impact and presented data in the R4 without having knowledge or giving notice of its limitations.

Baseline Established – Each of the three indicators selected for this audit contained baseline data. However, for two indicators ("condom use" and "STI/HIV knowledge") the baseline data was not comparable with the

performance data. ADS 201 states that indicator baselines should reflect the value of each performance indicator at the beginning of the planning period. Then the comparison of subsequent performance data to baseline data allows operating units to determine program progress. Although the Mission's options in establishing baseline data may have been limited, the baselines for two indicators were not useful for such determinations.

To illustrate, for the indicator "STI/HIV knowledge," comparison of baseline data and subsequent performance data showed a decrease in reported HIV/AIDS knowledge by about one third. However, because the baseline data referred to a larger population than the performance data, the data was not comparable. In the end, program staff using the PMP and the R4, where the data was also reported, may be left wondering what, if any, progress was achieved.

Data Agrees to Source – Data presented in the PMP is not totally consistent with its data sources. ADS 203 requires data be accurately transcribed from its source. The ADS specifically mentions the R4, but this is an essential element of all data reporting.

For "condom use," data presented for females was incorrectly transcribed for 1998 baseline data and 2000 performance data. Additionally, the indicator statement for "STI diagnosis and treatment" was incorrectly stated and did not match the data presented. The SO team members could not explain the errors. As a result, data included in the PMP may not represent actual progress when the indicator is misstated or when there are errors in transcribing data.

In conclusion, by not fully implementing these eight performance monitoring controls, USAID/Rwanda did not benefit from the monitoring mechanisms the ADS provides. Similar to the problem area of not updating its PMP annually, most of the causes USAID/Rwanda offered for these deficiencies have been addressed—social and political conditions in Rwanda have improved and the SO team has increased its technical staff. However, to assist USAID/Rwanda in ensuring that it will accurately monitor progress of its HIV/AIDS program in accordance with the ADS, and will report R4 data that is both accurate and useful, we are making the following recommendation.

> **Recommendation No. 1: We recommend that, in accordance with Automated Directives System requirements, USAID/Rwanda fully implement the 11 performance monitoring controls discussed in this report, and establish and follow a schedule in which its performance monitoring plan is reviewed at least annually.**

Is USAID/Rwanda achieving intended results from its HIV/AIDS program?

As discussed on page 5, we cannot fully answer the audit objective. Nevertheless, USAID/Rwanda has made progress in its HIV/AIDS activities.

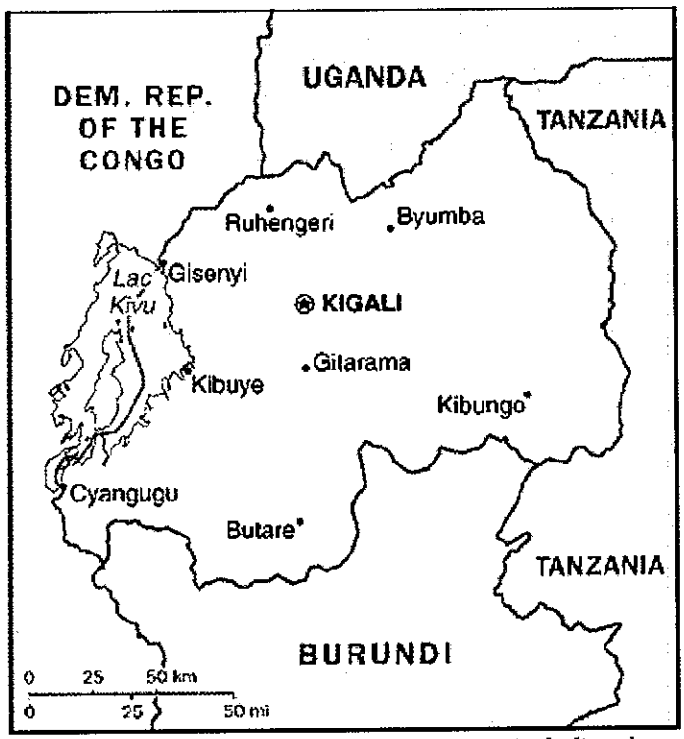
Office of Management and Budget Circular A-123 requires that agencies and individual federal managers take systematic and proactive measures to develop and implement management controls for results-oriented management. It goes on to state that management controls are the policies and procedures used to reasonably ensure that programs achieve their intended results. These controls consist of establishing indicators to manage for results, collecting baseline data for these indicators prior to project intervention, setting targets for these indicators, periodically collecting data to monitor results, and assessing the quality of the data being collected.

Indicator baselines should reflect the value of each performance indicator at the beginning of the planning. Due to the lack of country data prior to 2000, the Mission used the baseline data considered closest to indicators chosen for reporting in the FY 2002 R4 (1999 activity data) for two indicators. This baseline data used a different age group and had broader definitions that the performance data reported in 2000, and intended results set upon these baselines were much higher than could be achieved. According to the USAID/Rwanda's Revised Integrated Strategic Plan through FY 2004, genocide and civil war decimated the health infrastructures in Rwanda along with most of the relevant data necessary to track the health and well being of its citizens. Therefore, the Mission was unable to meet the Office of Management and Budget Circular A-123 baseline requirements.

Nevertheless, the Mission achieved progress in its HIV/AIDS activities through its partners in 2000. Those achievements were not quantifiable compared to the targets, but are evidenced by increased services to the community. Some examples are: same day Voluntary Testing and Counseling Centers were opened in target areas; Information, Education and Communication activities to spread STI/HIV knowledge in target areas continued; health workers and counselors were trained in STI symptomatic diagnosis and treatment; and Rwanda's Ministry of Health received support and training for its health regions. The first Behavioral Surveillance Survey since Rwanda's civil war was developed and published with USAID funding.

USAID/Rwanda's STI/HIV/AIDS activities in 2000 were primarily originated and developed through USAID's Bureau for Global Programs, Field Support and Research in Washington under a cooperative agreement with Family Health International (FHI). Due to limited staff, the Mission uses "buy-ins" or field support so that most administrative duties will be carried in Washington.

USAID/Rwanda's primary cooperating partner, FHI, developed a program called Implementing AIDS Prevention and Control Activities (IMPACT) to design, develop, manage, monitor and provide technical support of country-specific HIV/AIDS program interventions. In January 1998, through the IMPACT Project, FHI initiated a new program of activities in Rwanda directed at building the capacity of four health regions: Byumba, Kibungo, Gitarama, and Kigali. (See following map.)



Current map of Rwanda showing major towns, including the original target areas of Byumba, Kigali, Gitarama, and Kibungo and the recently added Kibuye and Butare areas.

The activities included control of sexually transmitted disease; information, education and communication for behavior change; and general program planning and management.

The Mission health strategic objective team (SO team) has seven indicators related to STI/HIV/AIDS in its PMP. We tested the following three indicators, which the SO team reported in the R4: (1) condom use; (2) STI diagnosis and treatment; and (3) STI/HIV knowledge. Following is a discussion of each indicator.

Condom Use – The full definition for this indicator is: "percentage of youth reporting condom use in most recent act with non-regular and non-commercial partner." While this indicator does not directly reflect program activities, it is

an internationally accepted measure of information, communication and education efforts.

As shown in Table 1, in year 2000, the performance data for condom use reported by USAID/Rwanda fell short of the targets for both males and females. USAID/Rwanda used a 1998 survey[4] for baseline data and to set targets for this indicator. However, the survey defined the population as adults who said that they had used condoms at least once, whereas, the actual performance data for year 2000 reported on youths aged 15 to 19 who had used a condom in their last act with a non-regular partner. As the indicator was established in February 2000, no targets were set for 1999. USAID/Rwanda's FY 2002 R4 (1999 activity data) recognized the weakness of the reported targets and stated that targets would be adjusted in year 2000 based on the Behavioral Surveillance Survey data.

Table 1
Percentage of youth reporting condom use in most recent act with non-regular partner
(Data not audited)

Year	Targets	Performance
1998	Baseline	M 42 F 8
1999	No target set	No data collected
2000	M 50 F 35	M 20 F 11

Note: M denotes males; F denotes females.

USAID/Rwanda has several programs through its partner FHI, which include activities designed to encourage condom use. FHI provides STI/HIV information and education through STI clinics and Voluntary Counseling and Testing centers. It also has information and education projects under Population Communication Service (PCS) and Johns Hopkins University.

The youth-focused information and education program seeks to overcome the stigma related to talking about sex and STI/HIV. The program purpose is to delay first sex among young people and encourage lifelong, mutually monogamous partnerships. The youth project is called KUBA, an acronym in Kinyarwandan for abstinence, fidelity and condom use.

During the audit, the audit team held a meeting with representative students to determine first hand what they have learned in the program. The students most often named abstinence and fidelity as means to prevent HIV/AIDS, but were reluctant to mention condom use. The Mission health SO team

[4] The 1998 Population Services International, "Sexual Behavior and Condom Use Survey."

expressed its intention to re-evaluate the project and try a new approach to reaching youth and overcoming the social and religious stigma to using condoms. To overcome the cultural resistance to using condoms, the Mission plans to develop a new information approach.

In summary, the "condom use" indicator is an indirect measurement for USAID/Rwanda's HIV/AIDS knowledge activities. We were not able to measure intended results due to the lack of comparable data available for establishing baseline and targets.

STI Diagnosis and Treatment – This indicator measures the percentage of persons with STIs properly diagnosed and treated, according to national standards, in target areas. USAID helped set these standards which include requirements for the facilities, training, and drug availability.

The Voluntary Counseling and Testing Center at Kabgayi, Gitarama where the STI/HIV information and prevention tape is shown.
USAID posters with information about HIV/AIDS and STIs are displayed.
(October 2001)

Sexually transmitted infections (STIs) are a major health problem in many countries because the presence of STIs increases the likelihood of HIV transmission. USAID/Rwanda promoted a basic diagnostic technique that substitutes an examination and interview approach for expensive—and often unavailable—laboratory testing. Properly trained personnel conduct the examination and interview to determine if an STI is present.

Working with the Rwanda Ministry of Health, FHI developed an agreement with each of the Ministry of Health target regions of Byumba, Kigali, Gitarama, and Kibungo under which:

- STI trainers and health care providers were trained in syndromic management of STIs,
- Clinic social workers (counselors) were trained in STI/HIV/AIDS counseling, and
- STI supervision protocols were developed and piloted.

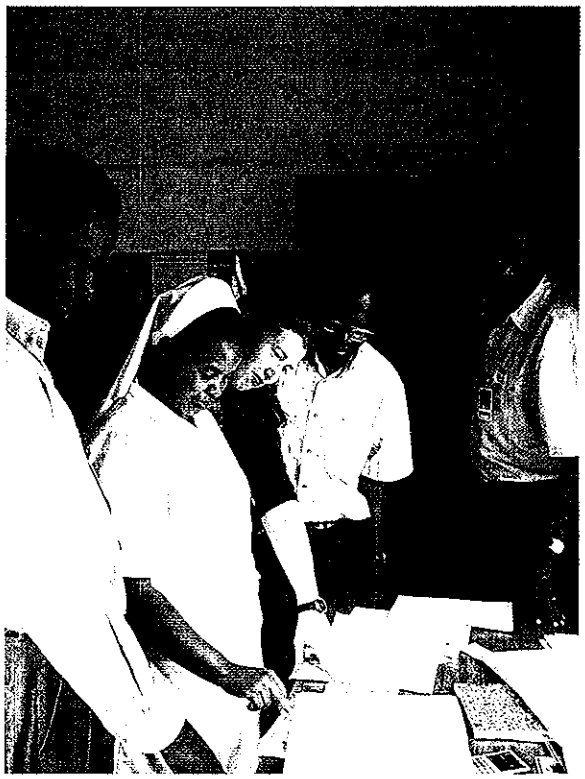
FHI also developed and helped to implement a supervision checklist for information, education and communication activities.

USAID/Rwanda's FY 2002 R4 reported 1999 data and was the first time reporting on indicators was required for the Mission. Prior to this, the Mission was exempt due to the emergency situation in Rwanda. As can be seen from Table 2, year 2000 results of 77 percent of all patients reported by FHI were below target. According to FHI, the reason for the 7 percentage points decrease from 1999 actuals was inadequate supervision by regional Ministry of Health supervisors in terms of frequency of visits to the clinics and diagnosis monitoring. In 2001, FHI trained additional supervisors and they are making more supervisory trips to the regional clinics.

Table 2
Percent of STI Cases Correctly Diagnosed and Treated in Target Areas
(Data not audited)

Year	Target	Performance
1997	Baseline	67
1998	80	**No data collection**
1999	85	84
2000	90	77

Note 1: The source for baseline information was a 1997 Evaluation of STD Training Programs in Rwanda from the AIDS Control and Prevention Project under Family Health International. It was based on results from three projects with a sample of 163 people.



The USAID health SO staff review data records and collection methods with the clinic nurse, the Ministry of Health supervisor, and FHI manager at the Nyarusange STI clinic. (October 2001)

STI/HIV Knowledge – This indicator was originally defined as the percentage of target group citing three effective means of protecting themselves from HIV infection. The three possible methods were abstinence, using condoms, and mutual monogamy. The Behavioral Surveillance Survey data was presented as at least two methods and, therefore, the indicator was changed to reflect the change in data definition.

A majority of the HIV/AIDS activities are focused on or contain a segment related to information, education and communication about STI/HIV/AIDS. Although there is greater awareness of STI/HIV/AIDS in USAID/Rwanda target areas compared to other regions, the levels of knowledge and behavior change reported were less that expected.

Rwanda is a very religious country and religious institutions and some denominations do not support condom use as an option for HIV prevention. According to the PMP and the data reported in the FY 2003 R4, USAID/Rwanda did not set targets for year 2000. As shown in Table 3, if performance data for youths aged 15 to 19 for year 2000 is compared to 1999 baseline data there was a decrease of thirty three percent in year 2000 for males (90 – 60 = 30/90) and thirty two percent for females (82 – 56 = 26/82). However, baseline data represent adults aged 15 to 45 who agree that condom

use prevents people from getting AIDS. Unfortunately, the baseline was not a good foundation and the actual results, as reported in the FY 2003 R4, showed no progress. Therefore, there is no real comparison between the baseline data and the activity performance data. USAID/Rwanda's FY 2002 R4 (1999 activity data) recognized the weakness of the baseline data and stated that future targets would be set in year 2000 based on the Behavioral Surveillance Survey data.

Table 3
Percentage of Youth Citing at Least Two Effective Means of Protecting Themselves from HIV Infection
(Data not audited)

Year	Target	Performance
1999 (2)	Baseline	M 90 F 82
2000	None	M 60 F 56

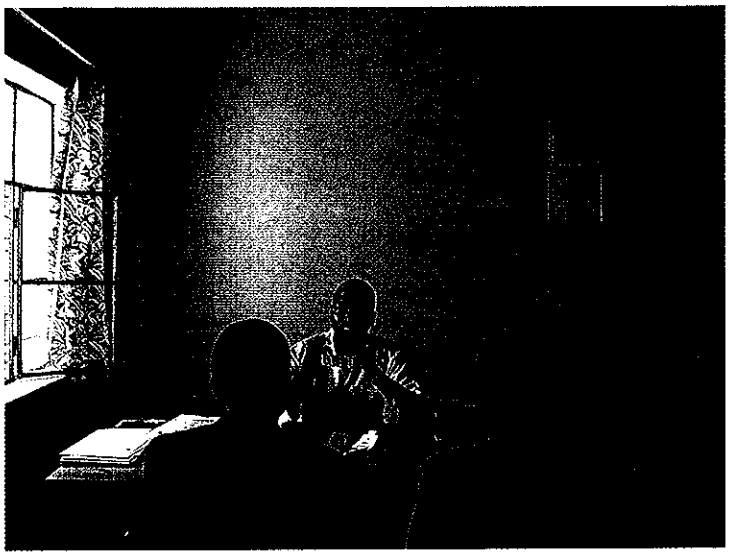
Note 1: M denotes males; F denotes females.
Note 2: The baseline data was erroneously reported as year 1999 in the R4, instead of year 1998.

As part of the Mission's plan to improve reporting, and as reported in the FY 2003 R4, the STI/HIV knowledge indicator analyzed above is expected to change for reporting of 2001 performance data to "the target population per month who voluntarily request an HIV test at USAID sponsored Voluntary Counseling and Testing sites." There is no current indicator for this activity, but it also supports STI/HIV information and education. In 2000, reported results data was 1,287 per month at four sites. The target for 2001 was 3,900 per month as the number of available testing sites was expected to increase to 20.

During fieldwork, the auditors visited one center in Kabgayi where patients are tested, counseled, and treated. The clinic is able to handle 20 patients and their families a day with two full time counselors. Often there are 60 persons seeking treatment. An STI/HIV film is shown prior to testing. Then one by one patients are tested (blood drawn) and they return later that day to receive the results. Results and individual/family counseling are given in rooms with private exits for patient confidentiality.

One of the many questions on the form for each patient at the Voluntary Counseling and Testing centers is the question: "Did you use a condom in most recent act with non-regular partner?" The data from these questionnaires are

entered into a computer data entry program and gathered countrywide for the Behavioral Surveillance Survey.



A counselor gives HIV test results and advises a couple on STI/AIDS prevention at the Kabgayi Voluntary Counseling and Testing Center. (October 2001)

To summarize, STI/HIV knowledge results were disappointing and the Mission plans to replace the current indicator and re-evaluate the activity.

In conclusion, due to the lack of measurable, comparative baseline data the audit work could not support an opinion as to whether USAID/Rwanda had achieved intended results from its HIV/AIDS program. However, the Mission has achieved progress in its HIV/AIDS activities in year 2000 by increased services to the community. The Mission and country continue to transit from an emergency response to a sustainable development basis and now USAID/Rwanda is planning for the future. The Mission plans to replace the STI/HIV indicator and use the Behavioral Surveillance Survey 2000 data for setting better targets for the future. The Mission is also in the process of developing a new performance monitoring plan. Based on the foregoing, we are not making any recommendations.

What is the status of USAID/Rwanda's efforts to meet anticipated HIV/AIDS reporting requirements?

USAID/Rwanda has begun the process of meeting future HIV/AIDS reporting requirements in USAID's newly drafted guidance.

Due to the significant increase in HIV/AIDS funding from 1999 to 2001, there has been a great deal of interest in monitoring the results of USAID's assistance in this area. In March 2000 USAID's Global Bureau developed a

handbook of standard indicators that operating units could use to measure the progress of their HIV/AIDS programs. In March 2001, the U.S. General Accounting Office issued its report on USAID's fight against AIDS in Africa, which reported the need to be able to better monitor progress. In its report the General Accounting Office recommended that USAID's operating units adopt standard indicators to measure program performance, gather performance data on a regular basis, and report data to a central location for analysis.

To improve the monitoring process for its HIV/AIDS program, USAID issued its draft monitoring and evaluation guidance, "USAID's Expanded Response to the Global HIV/AIDS Pandemic." This new guidance establishes several global targets USAID expects to achieve with its additional funding and requires missions to routinely monitor and evaluate their HIV/AIDS programs in a definitive, systematic way and to report on their progress. As an "intensive focus country," the draft guidance would require USAID/Rwanda to implement this enhanced monitoring and reporting system. The system would collect and report information at three levels:

- At the first level, USAID/Rwanda would be required, by 2007, to develop a national sentinel surveillance system to report annually on HIV incidence rates so as to measure the overall effect of national HIV/AIDS prevention and mitigation programs on the pandemic. The standard indicator for this measurement, according to the draft guidance, would be HIV-prevalence rates for 15- to 24-year-olds. The Centers for Disease Control arrived in Rwanda during the audit and began work with USAID, other donors, and the Government of Rwanda to start gathering the annual seroprevelance data. The first report of the Demographic and Health Survey of Rwanda containing 2001 data will be published in 2002.

- The second level would require the Mission to conduct standardized national sexual behavior surveys every three to five years, beginning in 2001. USAID/Rwanda has already contracted a partner to conduct this survey. In 2000, IMPACT undertook the first round of the Behavioral Surveillance Survey, which provides valuable data about HIV/AIDS-related knowledge, attitudes and behaviors. Standard indicators proposed in the draft guidance for this area are "number of sexual partners" and "condom use with last non-regular partner." The Mission is presently using one of the two standard indicators (condom use with last non-regular partner) as an indicator and has the necessary data from the survey to report on the second.

- At the third level, USAID/Rwanda would be required to report annually, not only on trends at the national level—which may or may not directly reflect USAID-funded activities—but on progress toward implementing USAID's HIV/AIDS programs and increasing the proportion of the target population covered by these and other donor programs to 80 percent.

USAID/Rwanda faces significant obstacles in this area as 83 percent of the population lives in rural areas, where security is still unstable and services are limited. Setting up clinics and hospitals in these regions will require a more peaceful environment and more trained health professionals. However, the Mission has already begun to move into Kibuye and Butare regions. Priority activities will be STI training and Voluntary Counseling and Testing complemented by community-based behavior change and care and support interventions.

The draft guidance lists seven standard indicators that missions might use to measure progress in selected program areas. USAID/Rwanda presently is using two of the standard indicators (percent of persons reporting condom use with last non-regular partner and percent of STI patients diagnosed and treated according to national standards). The Mission and its partners are considering the use of other standard indicators for its newer programs in the areas of voluntary counseling and testing, orphans and vulnerable children, and mother-to-child transmission.

In summary, USAID/Rwanda is on its way to meeting requirements for collecting all three levels of data anticipated by the draft guidance. The required biennial sexual behavior survey was in place in 2000. A national sentinel surveillance system will report 2001 data in 2002. Centers for Disease Control are helping develop the system to collect seroprevelance rates, and standard indicators either are being used or will be adopted to monitor the progress of USAID-funded activities.

Management Comments and Our Evaluation

USAID/Rwanda concurred with the audit findings and recommendation that the Mission fully implement the performance monitoring plan's performance monitoring controls in accordance with the ADS requirements and establish and follow a schedule in which its performance monitoring plan is reviewed at least annually. We reworded the audit recommendation in the final report, replacing the phrase: "fully implement the performance monitoring plan's performance monitoring control" with "fully implement the 11 performance monitoring controls discussed in this report." In our view, the revision does not change the meaning of the audit recommendation and the Mission's comments are responsive to the revised recommendation.

In their response, Mission management stated that it had already taken steps to begin implementing the performance monitoring requirements outlined in the ADS. For example, the Mission conducted a portfolio review of the health strategic objective in November 2001. The Mission also secured technical assistance to review and revise the PMP in accordance with the ADS guidelines. A revised set of indicators was prepared and reviewed with activity partners and the Mission plans to issue the revised PMP at the end of March 2002.

The Mission also reported that the technical advisor had attended a workshop focused on a national HIV monitoring and evaluation system, and that an assessment of current HIV activities was carried out to help develop future strategic prevention in behavior change and care and support.

The Mission took the opportunity to thank the auditors who worked on the assignment. In addition, the Mission identified a few points for clarification. We questioned their point that the funding level in FY 1999 was $2 million, and in subsequent correspondence, USAID/Rwanda concurred that the FY 1999 funding was $3 million as stated in the report. Regarding other points of clarification, we have revised the text as deemed necessary.

Based on USAID/Rwanda's response, Recommendation No. 1 is classified as having reached a management decision.

Scope and Methodology

Scope

The Regional Inspector General, Pretoria conducted this audit in accordance with generally accepted government auditing standards. The purpose of the audit was to determine: (1) if USAID/Rwanda was monitoring performance of its HIV/AIDS program in accordance with ADS guidance; (2) if USAID/Rwanda is achieving intended results from its HIV/AIDS program; and (3) what is the status of USAID/Rwanda's efforts to meet anticipated HIV/AIDS reporting requirements?

We are unable to express an opinion on whether USAID/Rwanda is achieving intended results from its HIV/AIDS program because reliable and pertinent data was not available when the indicators were developed in February 2000. (See page 5.)

For all three indicators, the audit covered performance data for 2000 activities plus baseline data reported in both USAID/Rwanda's Performance Monitoring Plan of February 2000 and the FY 2003 Results Review and Resource Request (R4). The data was not audited. The Mission used performance data reported in the Rwanda 2000 Behavioral Surveillance Survey to measure results for two indicators, condom use and STI/HIV knowledge. For the STI/HIV diagnosis and treatment indicator the Mission used FY 2000 performance data provided by the partner. The years for baseline data are varied. For condom use and STI/HIV knowledge, the Mission used a 1998 survey by Population Services International. For STI diagnosis and treatment the Mission used 1997 data from a 1997 evaluation from the AIDS Control and Prevention project. The review of management controls focused on USAID/Rwanda's Revised Integrated Strategic Plan through FY 2004; Performance Monitoring Plan (PMP); FY 2003 R4; and how well the Mission complied with USAID and Office of Management and Budget policies and guidance.

For objective two we analyzed the PMP; the data, discussion and self assessment in the FY 2003 R4; the Integrated Strategic Plan through FY 2004 for FY 2000-2003; partner documents; portfolio reviews; a partner meeting; site visits and discussions with the health team. Due to the lack of country data prior to year 2000, the Mission used the baseline data considered closest to indicators chosen for reporting in the FY 2002 R4 (1999 activity data) for two indicators. This baseline data used a different age group and had broader definitions than the performance data reported in 2000. However, performance data reported for 2000 was not comparable to the baseline and targets set for two of the indicators. Audit fieldwork was conducted at USAID/Rwanda in Kigali and in Nyarusange, Kabgayi, and Gitarama between September 27 and October 25, 2001.

To answer the third objective, USAID's handbook of indicators for HIV/AIDS/STI programs and monitoring and evaluation guidance, "USAID's Expanded Response to the Global HIV/AIDS Pandemic" (draft dated February 2001) was used to determine future reporting requirements.

Methodology

To answer the first audit objective, the Mission's Performance Monitoring Plan of February 2000 was compared to the requirements set forth in USAID's Automated Directives System with TIPS for clarification. We determined whether indicators were precisely defined; data collection methods were named, schedules were specified and responsibility was assigned; data limitations were disclosed; quality assessment procedures were described and followed; baselines were established; and if data agreed to source documents. Information was obtained as to what other methods were being used by the Mission for monitoring HIV/AIDS program performance.

To answer the second objective we analyzed the data, self assessment and discussion in the FY 2003 R4; partner reporting documents; portfolio reviews; and the Revised Integrated Strategic Plan through FY 2004; site visits plus a meeting with cooperating partners and discussions with Mission personnel; particularly the health strategic objective team.

To answer the third objective, we used USAID's handbook of indicators for HIV/AIDS/STI programs and monitoring and evaluation guidance, "USAID's Expanded Response to the Global HIV/AIDS Pandemic" (draft dated February 2001) to determine future reporting requirements. Discussions were held with Mission staff to determine the Mission's plans, constraints and resource requirements to develop conclusions as to the ability and progress of the Mission in meeting the coming requirements. In addition, we attended and considered a partner meeting, where standard indicators, progress and future planning were discussed.

On a site visit to Nyarusange Health Center, we observed diagnosis and treatment standards, examined sample data and verified data handling procedures. In addition, we visited a USAID-funded Voluntary Counseling and Testing Center at the Kabgayi Hospital where it was determined how many patients are treated daily, what testing and counseling procedures are followed, and the process for data gathering and quality control. A meeting was held with counselors and students of the KUBA Youth information project in Gitarama schools.

For all the above efforts, we reviewed applicable federal and USAID regulations and guidance; interviewed Mission officials and project officers; reviewed Mission documents; interviewed project officials; considered project

documents such as the Revised Integrated Strategic Plan through FY 2004 were; and visited program sites.

Two materiality thresholds were used in assessing accuracy. First, for transcription errors, an accuracy threshold of plus or minus one percent was set. Second, for computation accuracy, a threshold of plus or minus five percent was set.

Management Comments:

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AGENCY FOR INTERNATIONAL DEVELOPMENT
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Joseph Farinella
Regional Inspector General
USAID/Pretoria

February 7, 2002

Ref: AID 0090/02
08 FEB 2002

Dear Mr. Farinella:

On behalf of USAID/Rwanda, I would like to express our appreciation for the HIV Audit Team's visit in October, 2001. Having reviewed the draft report, the Mission concurs with the findings and the recommendation made by the Team.

During the visit, the Team provided several useful documents which have guided our efforts to update the Mission Health Team's Performance Monitoring Plan (PMP), with a special emphasis on HIV/AIDS-related indicators. As a result of the audit process, USAID/Rwanda has already taken steps to begin implementing the Performance Monitoring requirements outlined in the ADS:

- ✓ A Portfolio Review of the Strategic Objective (SO) for Health was conducted in November, 2001
- ✓ The Mission secured technical assistance from the REDSO Population, Health and Nutrition (PHN) Officer in January, 2002 to review and revise the SO Performance Monitoring Plan in accordance with ADS Guidance and the worksheets provided in "The Performance Management Toolkit, A Guide to Developing and Implementing Performance Monitoring Plans" by Price Waterhouse Coopers, January, 2001. During this visit, a revised set of draft indicators was prepared and subsequently reviewed during a consultation meeting with key implementation partners (the IMPACT and PRIME II project partners), the SO Team, and senior Mission staff. The revised PMP will be completed before the Mission Program Review, which is tentatively scheduled for March, 2002.
- ✓ The Mission's Technical Advisor for AIDS and Child Survival (TAACS) attended an HIV Monitoring and Evaluation Workshop with a multidisciplinary team of Rwandan health officials and project staff in Dakar, Senegal from February 4-6, 2002. The

result of the workshop, which is co-sponsored by USAID, CDC, and UNAIDS, will be a national HIV monitoring and evaluation system that follows the guidelines being established for measuring results of national HIV/AIDS control programs.

✓ USAID/Rwanda will carry out an HIV Assessment in February, 2002, to review current activities and to make recommendations for future strategic directions in HIV prevention, behavior change communication, and care and support (clinic and community-based). The Assessment Team will review and revise the HIV/AIDS-related indicators in the new version of the PMP.

We anticipate that a revised PMP that is in compliance with ADS requirements will be completed by March 31, 2002, and will include indicators to guide us through the transition period to our next strategy.

Regarding the text of the draft report, we have identified a few points for clarification.

- In the last paragraph of the Background section on page 5, please note that the HIV/AIDS funding level in FY1999 was $2 million.

- Regarding the Mission's STI/HIV/AIDS activities as described in the second paragraph on page 15, please note that, even with projects that are implemented through field support/buy-ins, the Mission does provide significant guidance regarding the initiation and development of in-country activities.

- Regarding the relationship and activities of FHI and JHU as discussed on pages 16 and 17, please note that, during the field visit, the Audit Team saw activities which are being implemented by two different USAID partners. The VCT Center and the STI treatment programs are IMPACT Project activities (Family Health International). The Team also observed some HIV prevention group activities for youth which are implemented by the Population Communication Service (PCS) Project (Johns Hopkins University).

- The policies and practices of churches in Rwanda with regard to condom use cannot be attributed to a single denomination as implied on page 19 of the report. In Rwanda, religious institutions have tremendous influence and some denominations do not support condom use as an option for HIV prevention.

- Regarding the Voluntary Counseling and Testing (VCT) data reported on page 20, please note that the figures quoted refer to all clients, not just youth.

In conclusion, our thanks again to the Audit Team for their visit. Please feel free to contact me or Dick Warin, the Mission Controller, at any time regarding audit issues.

Dick Goldman
Mission Director

Cleared by:
J. LaRosa MSC CID Date: 4/4/02
D. Warin CONT CID Date: 4/4/02

Rapid Scale-Up and Intensive Focus Countries

Rapid Scale-Up Countries are defined as countries that will receive a significant increase in resources to achieve measurable impact within one to two years. This will result in an extremely rapid scaling up of prevention programs and enhancement of care and support activities. Rapid Scale-Up countries include:

Cambodia Kenya Uganda Zambia

Intensive Focus Countries are defined as countries in which resources will be increased and targeted to reduce prevalence rates (or keep prevalence low in low-prevalence countries), to reduce HIV transmission from mother to infant and to increase support services for people (including children) living with and affected by AIDS within three to five years. Intensive Focus Countries include:

Ethiopia	Nigeria	Brazil
Ghana	Rwanda	India
Malawi	Senegal	Russia
Mozambique	South Africa	
Namibia	Tanzania	

Basic Countries are defined as countries in which USAID will support host country efforts to control the pandemic. USAID programs will continue to provide assistance, focusing on targeted interventions for populations who engage in high-risk behavior. In these countries, there will be an increased emphasis on maintaining credible surveillance systems in order to monitor HIV trends and allow timely warning of impending concentrated epidemics of HIV. In addition, USAID will assist country institutions to identify additional sources of funding to expand programming.

Appendix IV

Summary of USAID/Rwanda's Selected Performance Monitoring Controls

Indicator Number and Indicator Name:	*Performance Monitoring Plan (PMP)*										
	1. Indicator Precisely Defined	*2. Data Sources Identified*	*3. Data Collection Method Described*	*4. Data Collection Schedule Specified*	*5. Responsibility Assigned*	*6. Data Limitations Disclosed* (Note 1)	*7. Quality Assessment procedures described* (Note 1)	*8. Data Quality Assessment Done* (Note 2)	*9. Baseline Established*	*10. Data Agrees To Source*	*11. Other Means of Monitoring (If yes, indicate type)* (Note 3)
#1 "% of target group reporting condom use in most recent act with non-regular partner"	*No*	*Yes*	*No*	*Yes*	*No*	*No*	*No*	*No*	*No* (Note 4)	*No*	*Yes*
#2 "% of STI cases treated according to National standards in target areas" (Note 5)	*No*	*Yes*	*No*	*Yes*	*No*	*No*	*No*	*No*	*Yes*	*Yes*	*Yes*
#3 "% of target group citing at least two effective means of protecting themselves from HIV infection"	*No*	*Yes*	*No*	*Yes*	*No*	*No*	*No*	*No*	*No* (Note 4)	*Yes*	*Yes*

Note 1 These requirements were added to the ADS as of August 2000, and were effective June 1, 2001
Note 2 Data quality assessments are required only for R4 indicators. All others require that managers know the data's strengths and weaknesses.
Note 3 Program portfolio reviews and partner meetings are examples of "other monitoring tools" the Mission used to monitor performance.
Note 4 Baseline data is not comparable to performance data.
Note 5 The indicator was presented erroneously in the PMP as "% of health centers meeting functional requirements (as defined by established criteria) in "STI delivery in target areas."