

Horizons Program—Guest Editorial

THE CHANGING FACE OF U.S. FUNDING FOR HIV PROGRAMS IN RESOURCE-LIMITED SETTINGS

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This special section of *Public Health Reports* provides a synthesis of research performed under the Horizons program, a global, more than 10-year (1997–2008) operations research program designed to investigate effective human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) programs and policies in the developing world. The Horizons program was started as a collaboration of U.S.-based and international organizations funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID), led by the Population Council working to prevent the spread of HIV/AIDS and mitigate its impact on individuals and communities.

U.S. government funding to affect the growing prevalence of HIV and AIDS throughout the developing world has evolved over time. Prior to the advent of PEPFAR in 2003, the field capacity to implement and scale up significant support for HIV prevention, care, and treatment was fragmented. Programmatic efforts in the late 1980s and early 1990s focused on laying the groundwork and scaling up services in anticipation of a cure, a vaccine, or, at the least, a treatment for HIV. To pay for these efforts, USAID used cooperative agreement mechanisms to fund flagship programs that served as vehicles to provide “in-country” services to ministries of health and USAID missions working on HIV issues. Early USAID-funded projects included Implementing AIDS Prevention Care (IMPACT) from Family Health International, AIDSMARK from Population Services International, and Horizons from the Population Council, in part to capitalize on longstanding relationships with nongovernmental organizations (NGOs) whose work was centered in resource-limited settings.

These initial efforts were funded through cooperative agreement mechanisms that allowed multi-year funding (i.e., up to five years at a time with the potential for five-year renewals), thus providing some flexibility and agility in being able to respond to different service-delivery and research needs. The ratio-

nale for this approach was due in part to the fact that the global community was at the time unsure about country-specific needs or effective strategies to scale up HIV efforts, and in part to simplify the contracting mechanism so that individual country programs could “buy in” at the country level and, thus, shorten start-up times by up to a year. In addition, this contracting approach avoided potential problems and delays around direct hiring of technical staff; in other words, NGOs administering these flagship programs could hire under these programs, but the employees they hired would not count against U.S. government hiring ceilings. These programs further allowed USAID, which was lacking in HIV/AIDS technical capacity at that time, to have access to technical capacity within the different programs without having to increase full-time USAID staff.

These programs initially supplied substantial core funding coupled with field support, and collegial relationships were formed between USAID and NGOs, allowing an exchange of ideas and a rapid mechanism to field test new approaches. Because the cooperative agreements were essentially front-loaded, there were no procurement requirements, and money could be programmed more efficiently. For most of the 1990s and into the early 2000s, these mechanisms provided an opportunity for infrastructure development, research, and service delivery.

Criticism of these large cooperative agreements began about five years after the original funding, when programs first came up for renewal. Concerns of decreased competition forced a rethinking of this funding mechanism as a means of meeting the HIV research and service-delivery needs in the Global South, a term used collectively to describe the nations of Africa, Central and Latin America, and most of Asia. Concurrently, USAID was charged with programming the newly formed PEPFAR funding. For a variety of reasons, not the least of which was political, the preferred mechanism for funding began with Annual Program Strategy funding, which allowed great leeway in the way USAID programmed PEPFAR funding (and, some would say, this method was inherently untransparent). As PEPFAR matured, USAID began relying on issuance of Indefinite Quantity Contracts (IQCs) as a means to fund PEPFAR's large-scale HIV activities. While IQCs can enable appropriate responses to the short- and long-term needs of USAID missions overseas

by establishing a competitive bidding process among short-listed contractors, a number of concerns regarding this funding mechanism exist.

IQCs generally did not provide core funding, a hallmark of cooperative agreements, which essentially limits the ability of NGOs to maintain high-quality staff outside of specific projects. In addition, while IQCs may be appropriate for certain acquisitions, such as procurement of goods, they are less amenable to the vagaries of conducting research or establishing programs where the objectives are known, but the process of how to accomplish the objectives is unclear. In general, there is less flexibility with IQCs because they are contracts, so the contractor is simply executing what USAID wants, potentially inhibiting exploration of new ideas or pilot programs not originally proposed. Perhaps the fundamental problem is with the defined role of USAID in a contract vs. a cooperative agreement. With cooperative agreements, the implementing agency and USAID mutually agree on outputs and a path to achieve them. With a contract, the principal responsibility for defining the course of the project lies with USAID, and the contractor is a mechanism to get the work done. While appropriate for many procurement issues, this may not be the best mechanism for the design and implementation of programs for which a clear way forward is not known.

Finally, while IQCs have sought to increase efficiency and competition in the USAID procurement process, they may have failed to address one of the enduring problems with funding of global health programs:

how best to scale up opportunities that research has identified as promising. In an ideal world, researchers would directly consult implementers on issues related to decreasing HIV transmission or increasing health-services delivery in a more efficient way. In the real world, this is normally accomplished via publication of results in peer-reviewed literature. Despite many years and billions of dollars spent, limited evidence-based data have emerged in easily accessible ways that allow researchers who have identified promising approaches to HIV prevention, care, and treatment to impart that knowledge to organizations that can expand those ideas in real time and on a larger stage. Diligence is required of these organizations funded to do research on best approaches to different aspects of the global HIV pandemic and to publish the results of their studies. Other organizations with the means to implement programs can then be made aware of the findings, implement them, and evaluate their effectiveness.

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