

# PEPFAR Country/Regional Operational Plan (COP/ROP) 2015 Guidance

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U.S. DEPARTMENT OF STATE

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## **1.0 COP BASICS**

## 1.1 What is a COP?

The Country Operational Plan (COP)<sup>1</sup> documents U.S. government (USG) annual investments and anticipated results in the global fight against HIV/AIDS and is the basis for approval of annual USG bilateral HIV/AIDS funding in most partner countries. The COP also serves as the basis for Congressional notification, allocation, and tracking of budget and targets and as an annual work plan for the USG activities in global HIV/AIDS. Data from the COP are essential to the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) transparency and accountability to key stakeholders.

The COP 2015 has been redesigned to emphasize use of data to improve decision-making and enhance program focus. The COP submission is comprised of four primary elements:

- The Strategic Direction Summary (SDS)
- The Supplementary Data Pack (Targeted Assistance/Technical Collaboration [TA/TC] programs exempt)
- Site, geographic, mechanism and technical area targets
- Agency and mechanism budgets and other required documentation

The SDS outlines key data and analysis results, the strategic plan for the coming year, and the monitoring framework that will be used to measure progress. The SDS is submitted in FACTS Info as a supplemental document. Microsoft Word format is recommended and a template has been provided to assist country teams prepare a comprehensive SDS.

The Supplemental Data Pack has been provided to country teams in Microsoft Excel format and is intended to be a template and analysis tool to assist PEPFAR field teams use data for decision making and successfully complete the SDS template. The workbook is also intended to assist reviewers to understand the data analysis completed by the country teams and limit the need for extensive verbal or written clarification. The workbook is submitted in FACTS Info as a supplemental document.

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<sup>1</sup> Throughout this document, the term 'COP(s)' includes Regional Operating Plans (ROPs) except as specified, and the term 'country teams' includes also includes regional teams for programs completing a ROP.

This year, targets will be submitted through PEPFAR's new data collection system: DATIM<sup>2</sup>. Targets are required at the site, geographic, mechanism and technical area levels.

The budget and other required documentation are submitted in FACTS Info by direct entry in the user interface.

The most important part of the COP process is the interagency, country-level planning process, which should be driven by analysis of program, expenditure and epidemiologic data. All USG agencies responding to the HIV/AIDS epidemic in each partner country are expected to work together to review and analyze the data, and use the results as a basis for decision-making. Under the leadership of the U.S. Ambassador in country, the PEPFAR team develops the SDS, targets and the budget, which will be reviewed during Regional COP review meetings and then approved by the Ambassador-At-Large and Coordinator of U.S. Government Activities to Combat HIV/AIDS.

Several multi-country platforms develop Regional Operational Plans (ROPs). This guidance applies to those programs equally (except where noted), whether ROPs are explicitly referenced or not. Please note there are ROP-specific considerations built into this guidance to help geographically complex programs better explain their PEPFAR investments and strategic direction.

## **1.2 Which Programs Prepare a COP?**

The following programs are required to complete a Fiscal Year (FY) 2015 COP: Angola, Botswana, Burma, Burundi, Cambodia, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Ghana, Guyana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Papua New Guinea, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zambia and Zimbabwe. ROPs are required from the Asia Regional Program, and Caribbean, Central America and Central Asia field teams.

Smaller PEPFAR programs that do not complete a COP/ROP will account for PEPFAR resources through the preparation of a Foreign Assistance Operational Plan. The Office of U.S. Foreign Assistance Resources (F) at the Department of State coordinates the development the Foreign

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<sup>2</sup> Operating Units that will not submit through DATIM include the Regional Programs: Central Asia, Caribbean, Central America and Asia Regional, Dominican Republic, Guyana, Ukraine, Burma, Cambodia, India, Indonesia, and PNG. The format for targets is forthcoming.



Assistance Operational Plans. HHS/CDC programs in countries/regions that do not prepare COPs will account for their resources through CDC Country or Regional Assistance Plans.

## 1.3 COP Timeline

Each PEPFAR operating unit has been grouped regionally to facilitate in-person headquarter reviews. Five regional reviews are scheduled between April and June of 2015. Based on review assignments, COPs/ROPs are due either April 3, 2015 (first wave) or May 1, 2015 (second wave). A full list of countries/regional programs, required dates for submission, and review dates are listed in table 1.3.1 below. Requests for extensions will not be granted.

<b>1.3.1 REGIONAL COP/ROP 15 REVIEWS</b>		
<b>COP/ROP Submission Deadline 3 April, 2015</b>		
<b>Regional Review 1</b>	<b>Atlanta</b>	<b>April 20-24, 2015</b>
Caribbean Regional	Ghana	
Central America Regional	Guyana	
Dominican Republic	Ukraine	
Ethiopia	Zambia	
<b>Regional Review 2</b>	<b>Bangkok</b>	<b>May 4-8, 2015</b>
Asia Regional	India	
Burma	Indonesia	
Cambodia	PNG	
Central Asia Regional	Vietnam	
<b>Regional Review 3</b>	<b>Johannesburg</b>	<b>May 11-15, 2015</b>
Angola	Kenya	
Botswana	South Sudan	
Burundi	Zimbabwe	
Cote d'Ivoire		
<b>COP/ROP Submission Deadline 1 May, 2015</b>		
<b>Regional Review 4</b>	<b>Windhoek</b>	<b>June 8-12, 2015</b>
Cameroon	Namibia	
Lesotho	Uganda	
Malawi		
Mozambique		
<b>Regional Review 5</b>	<b>Dar es Salaam</b>	<b>June 22-26, 2015</b>
DRC	South Africa	

Haiti	Swaziland
Nigeria	Tanzania
Rwanda	

## 1.4 Required COP Elements Checklist

Table 1.4.1 below outlines which elements are required for the FY 2015 COP/ROP. For a full list of required supplements, templates, and instructions, see section 9.0.

1.4.1 Required COP Elements Checklist	
COP Element	Required/Optional
Strategic Direction Summary (SDS)	Required
Supplementary Data Pack	Required for LTS programs
Targets:	
National Level Indicators	Required
Technical Area Level Indicators	Required
Implementing Mechanism Level Indicators	Required
Site level indicators	Required
Implementing Mechanism Details:	
Partner name	Required for all IMs
G2G check box and Managing Agency	Required for all IMs
Funding Agency	Required for all IMs
Procurement Type	Required for all IMs
IM Name	Required for all IMs
Mechanism IDs	Required for all IMs
Agreement Timeframe	Required for all IMs
TBD check box	Required for all IMs
New IM check box	Required for all IMs
Construction Renovation check box and project plans	Required for all IMs
Motor Vehicles check box and numbers	Required for all IMs
Funding Source allocations, including applied pipeline figure	Required for all IMs
Budget Code Allocations	Required for all IMs
Crosscutting Budget Allocations	Required if applicable
Crosscutting Budget Allocation: Gender Activity Check-list	Required if Gender-GBV or Gender Equality crosscutting is ticked
Crosscutting Budget Allocation: Key Populations Check-list	Required if Key Populations is ticked

Vehicle Information	Required if applicable
Construction or Renovation Project Plan	Required if applicable
Government to Government Funding	Required if applicable
PPP	Required if applicable
Management and Operations	
Agency Costs of Doing Business, including total and applied pipeline figures	Required
Staffing Data	Required
Agency functional staff charts	Required
Chief of Mission Letter	Required from all OUs
Financial Supplemental Worksheet	Required from all OUs
Budgetary Requirements Justification	Required if COP budget does not meet hard earmarks
Justification for partner funding	Required if partner exceeds 8 percent of budget
Local Civil Society Planning and Participation Overview in FY 2015 COP	Required from all OUs
Laboratory Construction or Renovation Project Plan Supplemental	Required for BSL-3 and enhanced BSL-2 laboratory projects
New IM Activity Table	Required from all OUs
Implementation Science and Impact Evaluation Concept Note	Required if conducting research/evaluations
SIMS Site Monitoring Plan	Required from all OUs
Sustainability Index and Dashboard (SID) 2015	Required for all COP programs
Human Rights Referral System Description	Required from all OUs

## **2.0 PEPFAR'S NEW APPROACH TO PROGRAM PLANNING AND DECISION-MAKING**

## 2.1 Global Overview and Context

On World AIDS Day 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) released its report ***Fast-Track – Ending the AIDS epidemic by 2030*** which sets clear 2020 targets for treatment, prevention and discrimination that will “break” the epidemic in order to reach the 2030 targets of 95 percent treatment coverage, reduced new infections so that AIDS is no longer a global health threat and zero discrimination.<sup>3</sup> In Fast-Track, UNAIDS builds on its 2014 Gap Report, which provides data, information and analysis on how to reach epidemic control by 2030 and ensure that no affected and impacted populations are left behind.<sup>4</sup> The UNAIDS Gap Report shows that when people find out their HIV-positive status they seek life-saving treatment. Research shows that in sub-Saharan Africa, 76 percent of people on antiretroviral therapy (ART) have achieved viral suppression, whereby they are unlikely to transmit the virus to their sexual partners. By fast-tracking the AIDS response in low- and middle-income countries, the world would avert 28 million new HIV infections between 2015 and 2030 and 21 million AIDS-related deaths between 2015 and 2030. To reach the 2030 Fast-Track targets, “...the number of new HIV infections and AIDS-related deaths will need to decline by 90 percent compared to 2010.”

**New data analysis demonstrates that for each 10 percent increase in ART coverage, the population-level transmission rate decreases by 1 percent.** Moreover, analysis of the latest estimates shows evidence of the effect of ART on transmission. Among the 30 low and middle income countries with the highest levels of ART coverage, the percent of new infections is about half of what it is in the 30 countries with the lowest levels of ART coverage.

To reach epidemic control, the UNAIDS Gap Report emphasizes the importance of **location and population**, showing how focusing on populations that are underserved and at higher risk of HIV will be key to ending the AIDS epidemic. The old concept of concentrated, mixed and generalized epidemics is making way for a new approach that requires analyzing, understanding, and responding to subnational and local diversity of the AIDS epidemic, including knowing which populations are most affected within local epidemics.

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<sup>3</sup> UNAIDS. (2014). *Fast-Track: Ending the AIDS Epidemic by 2030*. Geneva, Switzerland: Author.

<sup>4</sup> UNAIDS. (2014, September). *The Gap Report*. Geneva, Switzerland: Author.

This approach is also reflected in the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) New Funding Model which is designed to deliver strategic investments that make the most of resources and maximize the impact of Global Fund grants. Throughout their grant making process, the Global Fund emphasizes the importance of prioritized, strategic choices based on evidence (especially sub-national and sub-population epidemiologic data) and national plans.

### **2.1.1 PEPFAR's Role and Response**

For COP 2015, the goal for PEPFAR teams is to advance progress toward sustainable control of the HIV epidemic and, ultimately, achieve an AIDS-free generation. To reach this goal, COP 2015 must be aligned with the *PEPFAR Blueprint: Creating an AIDS-free Generation*, and its five core principles:

- Make strategic, scientifically sound investments to rapidly scale-up core HIV prevention, treatment, and care interventions and maximize impact.
- Work with partner countries, donor nations, civil society, people living with HIV, faith-based organizations, the private sector, foundations and multilateral institutions to effectively mobilize, coordinate, and efficiently utilize resources to expand high-impact strategies, saving more lives sooner.
- Focus on women and girls to increase gender equality in HIV services.
- End stigma and discrimination against people living with HIV and key populations, improving their access to, and uptake of, comprehensive HIV services.
- Set benchmarks for outcomes and programmatic efficiencies through regularly assessed planning and reporting processes to ensure goals are being met.<sup>5</sup>

The vision for the PEPFAR Blueprint is simple: “Scientific advances and their successful implementation have brought the world to a tipping point in the fight against AIDS. The United States believes that by making smart investments based on sound science, and a shared global responsibility, we can save millions of lives and achieve an AIDS-free generation.”<sup>6</sup>

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<sup>5</sup> The Office of the U.S. Global AIDS Coordinator. (2012). *PEPFAR Blueprint: Creating an AIDS-free Generation*. Washington, DC.

<sup>6</sup> The Office of the U.S. Global AIDS Coordinator. (2012). *PEPFAR Blueprint: Creating an AIDS-free Generation*. Washington, DC.

Our success will be measured by how effectively we target and tailor our efforts, together with our partners, towards sustainable control of the epidemic. Teams should refer to the 2014 report, PEPFAR 3.0 – *Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*, which describes how **PEPFAR can best support sustainable control of the epidemic by pivoting to a data-driven approach that strategically targets geographic areas and populations where HIV/AIDS is most prevalent, and in which we can achieve the greatest impact for our investments.**<sup>7</sup> The report outlines PEPFAR's five action agendas that advance the five core principles of the *PEPFAR Blueprint* and provide a pathway toward sustainable control of the epidemic:

- **Impact Action Agenda** – Do the right things, in the right places, at the right time.
- **Efficiency Action Agenda** – Increase transparency, oversight, and accountability across PEPFAR and its interagency partners.
- **Sustainability Action Agenda** – As services are expanded to reach epidemic control, ensure that the factors required to maintain control are in place.
- **Partnership Action Agenda** – Share responsibility with our partners to achieve an AIDS-free generation.
- **Human Rights Action Agenda** – Protect human rights and address the human rights challenges faced by those living with and affected by HIV/AIDS.

Through the Impact Agenda, PEPFAR is focused on delivering ***the right thing, in the right place, at the right time***. Specifically, this means:

- The **right thing** means focusing on the highest impact interventions. When we focus on these interventions and bring them to scale, we see tremendous results. When we fail to focus and/or to reach scale, progress is slow or stalls.
- The **right place** means focusing our resources in key geographic areas, including at the sub-national level, and reaching the most vulnerable populations.
- The **right time** means getting ahead of and ultimately controlling the epidemic. Continually fighting an expanding epidemic is not programmatically or financially sustainable.

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<sup>7</sup> The Office of the U.S. Global AIDS Coordinator. (2014). *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. Retrieved from <http://www.pepfar.gov/documents/organization/234744.pdf>

As PEPFAR and global partners focus on controlling the epidemic in each country to achieve a sustainable response, how we approach our work in PEPFAR is changing. We have a role in supporting countries to reach epidemic control and we can be counted on to:

- Deliberately focus on core combination prevention interventions.
- Assess which investments are core, near-core and non-core to PEPFAR within each country context and make budgetary decisions accordingly.
- Evaluate each site's performance and focus geographically and by site for all care, treatment and prevention interventions.
- Ensure transparency and the use of real-time data for performance-based decision-making and to ensure maximum impact.
- Foster sustainability by increasing implementation of services and programs through, and building capacity of local institutions, systems and workforce.

In June 2014, a revised 2015 COP development process is part of a larger transformation of the PEPFAR business model to standardize the use of data for implementation, oversight, and monitoring of progress. With a redesigned COP development process (e.g., consolidation of requirements, concise Strategic Direction Summary, in-person regional review, and accelerated approval), the stage is now set for routine quarterly data analysis and monitoring by field teams and PEPFAR headquarters, in partnership with external stakeholders (e.g., host government, civil society and multilateral partners). This quarterly process will enable a shared understanding of each PEPFAR program on a year-round basis and allow for ongoing program improvement, including updates to policy, technical guidelines or performance management plans. Through a focused quarterly process, teams will be able to use critical data elements—Monitoring and Evaluation Reporting (MER), Expenditure Analysis (EA), Site Improvement Monitoring System (SIMS), Sustainability Index and Dashboard, financial outlays, etc.) in an integrated way to guide implementation decisions in order to mark progress towards sustained epidemic control. Moreover, DATIM will provide PEPFAR partners, field teams, headquarters and the Interagency Collaborative for Program Improvement (ICPI) with a streamlined system that will allow for ease of data collection, review, and visualization. Quarterly reviews will enable routine interagency discussion of the program in the field and at headquarters focused on results, quality and financial data.

To launch this data-centered business model in the 2015 COP planning process, PEPFAR teams will conduct a series of enhanced data analysis and interpretation steps. The purpose of this approach is to enable teams to validate that PEPFAR programs are optimally focused to accelerate the scale-up of





combination prevention interventions in prioritized populations and geographic areas. Importantly, the analysis and interpretation process will provide teams with the information needed to ensure that **PEPFAR programs are focused within countries on the locations and populations with the highest burden of HIV disease.**

Further, the PEPFAR Technical Considerations have been restructured for the 2015 COP to include technical area priorities, updated background and scientific evidence to support these priorities, and other relevant technical information. The SIMS Core Essential Elements have been mapped to the corresponding areas of the PEPFAR Technical Considerations to facilitate use of the Technical Considerations in supporting quality program improvement.

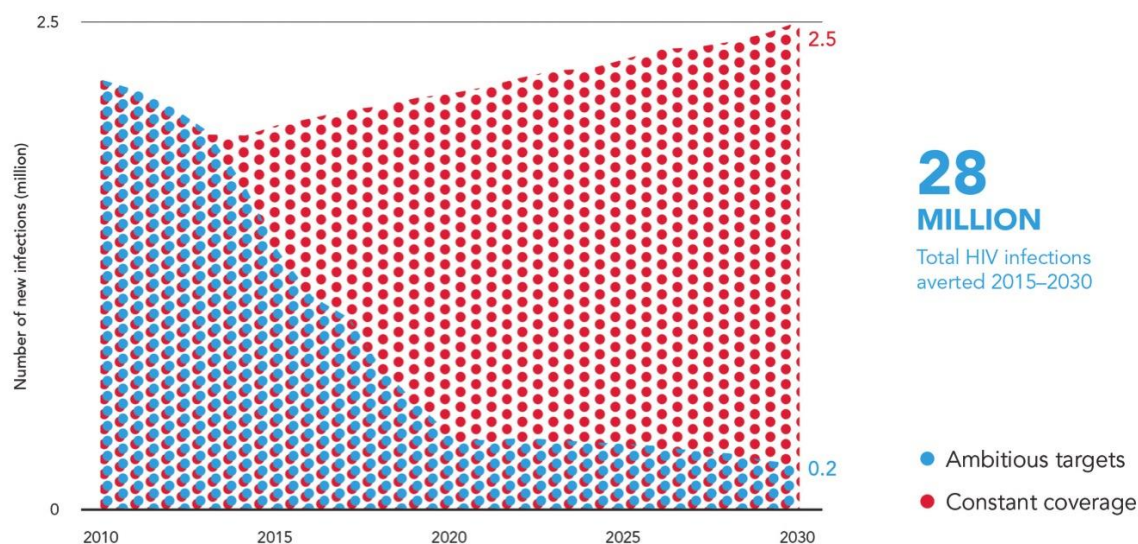
## 2.2 Defining program goals to accelerate epidemic control

PEPFAR defines **epidemic control** as *the point at which new HIV infections have decreased and fall below the number of AIDS-related deaths*. Epidemic control is a critical milestone for achieving an AIDS-free generation and should be a central focus of all PEPFAR planning and monitoring activities. Achieving and sustaining epidemic control will stem the global pandemic, reduce the disease burden on communities and health systems, decrease the future costs of care and treatment, and enhance economic stability in resource-constrained settings by increasing the productive potential of people living in these areas.

The availability and use of high-quality data is a critical component of epidemic control. Data on HIV **incidence**, mortality, and other key elements are essential to evaluating progress toward the achievement of epidemic control. In settings representing the highest burden of HIV, these data are often unavailable, not collected in sufficient detail (i.e., sub-nationally or by population), or collected too infrequently to inform short-term program decisions. Further complicating the measurement of impact is the time lag between program implementation and changes in incidence. Together with host country governments, PEPFAR and other stakeholders are working to improve the frequency and quality of key epidemiologic markers; however, implementing these studies and building surveillance systems requires substantial planning and resources. The HIV Impact Assessments will provide necessary data to monitor coverage and impact of programs and will be a valuable in understanding the gaps to reach epidemic control. Given the urgency in achieving the goal of epidemic control and the necessity for constant monitoring and course correction when needed, HIV program planners need a set of indicators that can serve as a proxy for epidemic control and can be routinely collected and analyzed to monitor program results. Within PEPFAR, teams are asked to design activities and set targets aimed at accelerating epidemic control and enhance the systematic gathering, analysis, synthesis, and interpretation of program data to more routinely measure progress. PEPFAR has defined a core set of indicators to be collected and reviewed at least quarterly, as well as adopted the **UNAIDS 90-90-90** global targets for “breaking” the AIDS epidemic by 2020 as a framework for program planning.

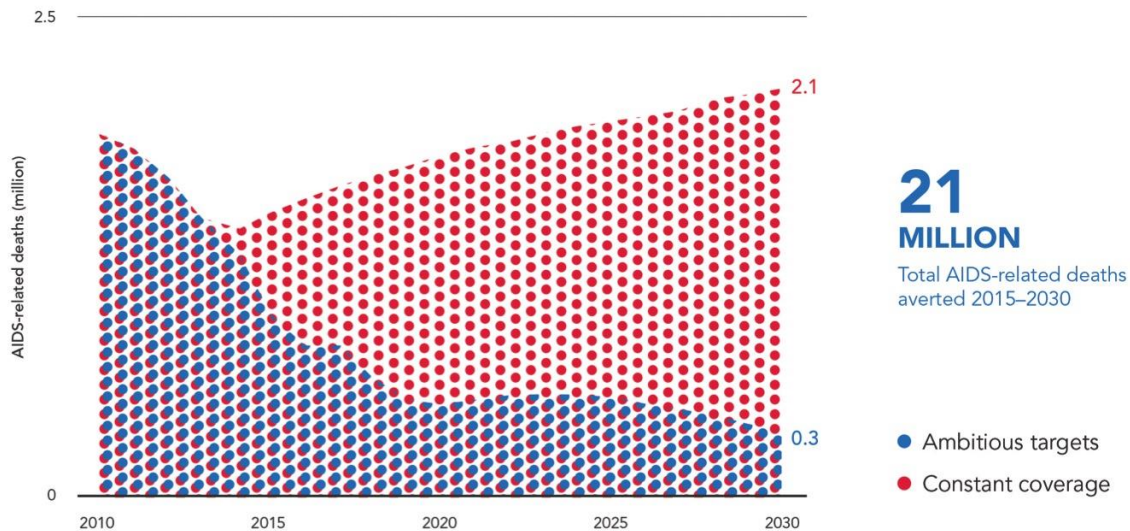
In the recent publication, “90-90-90 An ambitious treatment target to help end the AIDS epidemic<sup>8</sup>,” UNAIDS presents a compelling case for increasing global targets to achieve rapid scale-up of critical interventions proven to be most effective in reducing HIV transmission. As the figures below demonstrates, achieving the UNAIDS Fast Track Targets can prevent 21 million AIDS-related deaths, 28 million infections can be averted, 5.9 million infections among children can be averted and 15-fold return on investment.

**Figure 2.2.1 New HIV infections in LMIC, 2010-2030, with achievement of ambitious Fast-Track Targets, compared to maintaining 2013 coverage**



<sup>8</sup> UNAIDS. (2014, December). Fast-Track: ending the AIDS epidemic by 2030. Retrieved from [http://www.unaids.org/en/resources/documents/2014/JC2686\\_WAD2014report](http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report)

**Figure 2.2.2 AIDS-related deaths in LMIC, 2010-2030, with achievement of ambitious Fast Track Targets, compared to maintaining 2013 coverage**



As the UNAIDS report outlines, achieving an end to AIDS by 2030 requires investments in a number of proven strategies, including those interventions known to be most effective in preventing transmission. These include the provision of ART, prevention of mother-to-child transmission (PMTCT), HIV testing and counseling (HTC), voluntary medical male circumcision (VMMC), condoms, and targeted prevention for key and priority populations—referred to jointly as ‘**combination prevention**<sup>9</sup>.’ In addition, barriers for uptake and access of combination prevention, such as stigma and discrimination and health systems limitations, must be addressed to achieve the 2030 goals. Though all of the aforementioned strategies are critical, the report clearly emphasizes the requisite scale-up of ART and improvements in adherence and retention if incidence is to fall as rapidly as models purport; i.e., “It will be impossible to end the epidemic without bringing HIV treatment to all who need it.”<sup>10</sup> At the United Nations General Assembly 2014, African leaders expressed commitment to the UNAIDS goal of 90-90-90 by 2020.

Recognizing the centrality of increasing ART coverage for epidemic control and elimination, UNAIDS has proposed ambitious global treatment targets for 2020. These include:

<sup>9</sup> Please refer to the PEPFAR Technical Considerations 2014 for more detail on each component of combination prevention.

<sup>10</sup> UNAIDS. (2014, October). *90-90-90 An ambitious treatment target to help end the AIDS epidemic*. Retrieved from [http://www.unaids.org/sites/default/files/media\\_asset/90-90-90\\_en\\_0.pdf](http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf)

- *By 2020, 90 percent of all people living with HIV will know their HIV status.*
- *By 2020, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.*
- *By 2020, 90 percent of all people receiving antiretroviral therapy will have viral suppression.*

“Modelling suggests that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits.”<sup>10</sup> These targets focus on increasing enrollment of people living with HIV (PLHIV) in ART programs and virologic suppression. It is important to note that modeling to derive estimates for incidence and mortality by 2030 also assumes rapid scale-up of other, critical combination prevention interventions, notably VMMC, condoms and targeted prevention for key and priority populations. UNAIDS is expected to release similar global targets for these interventions in 2015.

The 90-90-90 treatment targets outlined above are meant to be inclusive of all countries and PLHIV; however, PEPFAR teams are asked to apply the same framework to specific locations and populations as a way to contextualize current program coverage, focus on the areas and populations with the largest gaps and highest burden of disease, and more routinely monitor progress towards epidemic control and elimination. Given the differential impact of HIV geographically and by population group, the UNAIDS 90-90-90 framework for targeting should be applied with specificity to ensure programs are scaling testing and treatment first in areas with the highest unmet need and serving populations most likely to contribute to new HIV infections. Starting with **this COP cycle**, **PEPFAR field teams are asked to employ the 90-90-90 framework in conjunction with epidemiologic data at the lowest sub-national unit available when setting targets and designing program activities.**

Employing the 90-90-90 framework specifically means translating those targets into specific percentages of PLHIV identified, enrolled and virally suppressed in each country. The UNAIDS 90-90-90 treatment targets translate to 81 percent of all PLHIV on ART ( $90\% \times 90\% = 81\%$ ) and 73 percent of all PLHIV virally suppressed ( $90\% \times 90\% \times 90\% = 73\%$ ). The resources required to diagnose, enroll in care, and treat over 80 percent of all PLHIV with ART in most countries are substantial. PEPFAR is often one of the largest funders of the HIV response in countries and regions in which we operate and USG resources are not sufficient to fully finance the gap between current ART coverage and 81 percent in any PEPFAR operating unit. This underscores the need for our investments to be tightly focused on the areas and populations where the number of new infections is likely to be highest and well-coordinated with others in the national response. It also requires that each dollar be invested in

the optimal mix of interventions and support for a given context, and that programs are implemented with increasing efficiency and quality, as demonstrated by routine results and performance data.

PEPFAR recognizes countries are on different paths in the progression towards epidemic control. As such, PEPFAR teams are asked in planning for this year's COP to mobilize all available data, systematically engage with the host country government and key stakeholders to comprehensively outline the national/regional context for the HIV response, and define tangible goals for sustainable epidemic control in the near term. Specifically:

***PEPFAR teams are expected to submit COPs that are strategic and set targets that will assist host country governments reach 80 percent coverage of PLHIV on ART by the end of USG fiscal year 2017 (September 30, 2017) in select high-burden sub-national units and/or populations.***

Teams will need to balance and align the priority for achieving 80 percent ART coverage in specific geographic areas and populations with goals of scaling other critical combination prevention interventions and alleviating gaps and barriers that impede sustained success. Achieving 80 percent coverage of PLHIV with ART should not be the only component of a plan to achieve sustained epidemic control; however, **it is a minimum requirement for locations and HIV-infected populations selected for focus.**

Understanding where and in what populations new infections are most likely to occur and the barriers to reaching program scale will likely require new ways of gathering, analyzing, synthesizing and interpreting data to best inform program decisions. Interagency decisions about geographic and population focus and the optimal mix of services and support to achieve the stated goal for sustained epidemic control should be data driven and anchored in science, standards of practice, and implementation realities. In particular, populations should not be prioritized purely on the basis of risk behavior, without data indicating elevated prevalence relative to the general population.

PEPFAR supports countries and regions through a variety of program activities at various levels in the health system. Targeted assistance (TA) and technical collaboration (TC) countries typically work above the site to strengthen key components of national systems and the HIV response and may also support community based activities. Country programs designated long-term strategy (LTS) typically implement activities at all levels, including direct service provision to PEPFAR beneficiaries. Though the types of services and support are often different between TA/TC and LTS operating units, the ultimate goal remains the same—epidemic control in a subset of locations and populations by the end



of USG fiscal year 2017. In TA/TC countries, this means that PEPFAR investments should be associated with demonstrable increases in, and sustainability of, coverage of testing, treatment and prevention services, even if PEPFAR is not directly paying for those services.

**In order to define data-driven, near-term, and achievable goals for sustained epidemic control, it is recommended PEPFAR field teams adopt an enhanced strategic approach to program planning and COP development. This approach requires adequately addressing six primary questions in each unique program context:**

1. What does it take to get to epidemic control?
2. How will PEPFAR invest more strategically to maximize impact of the program?
3. How will decisions be monitored throughout the year with data and deliverables?
4. How are the key challenges for a sustainable national response being addressed, especially through health diplomacy, technical support and/or other interventions?
5. How were civil society and other key stakeholders, including the partner government and the Global Fund, engaged in COP development?
6. How are significant human rights issues for key and priority populations being addressed by the PEPFAR team?

Sufficiently addressing each of these questions requires key data elements, analytics, and process milestones. The subsequent sections in this chapter will focus on questions 1-5. Recommended approaches to adequately address questions 6 can be found in section 2.3.

## **2.3 Coordination and Strategic Communication with External Partners during COP Planning**

To achieve sustained control of the HIV/AIDS epidemic and, ultimately, an AIDS-free generation, it is essential that PEPFAR teams actively and routinely coordinate and communicate with our external partners. These partners include host country governments, multilateral organizations, bilateral donors, the private sector, civil society, and faith-based organizations.

### **2.3.1 Host Country Governments**

During the COP development progress, PEPFAR country teams should regularly consult and communicate with the Ministry of Health, the National AIDS Control Authority (or its equivalent), other relevant Line Ministries and other relevant government leaders, e.g. Office of the President and/or Prime Minister. This engagement is critical to ensure that PEPFAR's role in the national response, as well as its strategic focus on achieving and sustaining epidemic control, is well-understood.

Consultation and collaborative planning with the host country government is also critical to ensure that prioritized interventions are pursued, geographic priorities are shared, and that all available resources for HIV/AIDS in the country are optimally utilized. This consultation should start at the very beginning of the COP planning process, ideally with the initiation of the Sustainability Index and Dashboard development (see Section 4), and continue at regular intervals throughout the COP's development to maximize its utility in informing PEPFAR and host country government planning. Throughout COP development teams should review data analysis and results with host country counterparts and discuss interpretation. This engagement should continue throughout the annual implementation cycle, especially as PEPFAR reviews on a routine basis results, quality and financial data for enhanced impact.

### **2.3.2 Multilateral and Private Sector Partners**

PEPFAR country teams should collaborate with bilateral donors and multilateral stakeholders during the COP development process. Teams should consult with the UNAIDS Secretariat and key co-sponsors during COP development and fully engage in key strategic planning processes, including the UNAIDS Investment Approach and the Global Fund Concept Note development, as these are pivotal opportunities to prioritize interventions in a coordinated, efficient manner. Teams are expected to ensure alignment between national, Global Fund, UNAIDS, bilateral donor, and other investments with PEPFAR priorities, planning, and implementation.

In particular, it is critical that PEPFAR resources be integrated into the Global Fund's Concept Note planning to ensure that the country's entire funding envelope is considered. This engagement should result in strategically aligned resources, agreed upon yield cost-effectiveness, gaps filled, and reduced potential duplication of co-funded activities/partners.



As PEPFAR country teams consider geographic focus and site investment, and move to maintenance in identified sub-national units, discussions with Global Fund country teams are essential to ensure a smooth implementation of the PEPFAR COP 2015 program changes.

PEPFAR country teams should also engage multilateral partners at other stages in the PEPFAR business cycle, including portfolio reviews or site visits, reviewing Semi-/Annual Program Results (S/APR), organizing technical assistance visits (TDYs), and revising technical area guidance. Teams are also encouraged to build and develop public-private partnerships that draw on a diverse set of stakeholders from the private sector and that bring additional resources to PEPFAR programs to support core- and near-core programmatic activity via network meetings and strategic planning.

### 2.3.3 Active Engagement with Civil Society

Active engagement with local civil society organizations in PEPFAR planning implementation, monitoring, and accountability continues to be an important requirement of the PEPFAR Program. Building upon last year's State Cable 13 STATE 89700, PEPFAR teams are expected to expand their engagement with local civil society, both as a feedback loop to improve PEPFAR programs, and as a way to spur greater local civil society engagement and accountability with partner-country governments.

The primary objective is to formally establish contact with civil society for ongoing engagement throughout PEPFAR's programming cycle, not simply an annual COP consultation. Ongoing engagement and dialogue throughout the year (COPs development, reviews, APR/SAPR reviews, ongoing program monitoring and evaluation, etc.) will have the outcome of strengthening the capacity within civil society to effectively monitor the HIV response and advocate for accountability and transparency. These efforts should focus on strengthening of local indigenous civil society organizations, including activists and advocacy groups, to ensure they are actively engaged in PEPFAR planning and review processes, as well as, in the country-level AIDS response. PEPFAR Teams should plan civil society consultations through **a formal structure on a quarterly basis** so that relationships can be ongoing and feedback responsible to topical issues as needed. There is a four step process explained below which all PEPFAR country teams are required to do for COP 2015.

## *Who to Engage?*

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Local civil society organizations include: non-governmental local organizations; networks/coalitions; professional associations; activist and advocacy groups; including groups representing key affected populations, women, children, LGBT/gender and sexual minority, drug user networks, and sex worker organizations; groups representing populations highly affected by the epidemic, such as persons with disabilities; PEPFAR program beneficiaries or end users; faith-based organizations; community associations; and not-for-profit organizations at national, district and local levels.

PEPFAR teams should seek inclusion of a diverse range of civil society members in consultations, taking into account that this process will likely require proactive outreach to ensure all populations are represented. Establishing linkages with credible networks and coalitions is an important consideration, so that a broader civil society representation can be achieved. There should be efforts made to ensure participation from civil society organizations that are based outside of the capital. Teams should work with both the Embassy human rights officer as well as the UNAIDS country or regional staff, the Global Fund, and other multilateral partners, to assist with identifying the best mix of representatives. The presumption should be to include all groups who voice interest in engagement—recognizing that if that number grows too large it may require multiple early process meetings. This outreach and feedback process should at all times be open and transparent to allow all groups/individuals to participate. There should also be a method for sharing information and receiving input from those not able to attend an in-person consultation. As noted above, PEPFAR teams should develop plans and ensure sufficient resources are available to ensure broad civil representation in the consultation process.

## *Action Steps for Effective Engagement*

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At minimum, there are **four steps** for civil society engagement that each country team should follow in the COP planning process:

**STEP 1: DEVELOP CIVIL SOCIETY COP ENGAGEMENT PLAN:** Each country will prepare a plan for engagement with civil society. This plan is not just for the COP development process but should include how to best continue the partnership between PEPFAR and civil society in implementing and

monitoring progress throughout the COP year. Further technical guidance on developing this plan can be found in the *Technical Considerations 2015, PEPFAR 3.0 Civil Society Engagement Strategy*.

**STEP 2: CONVENE ENGAGEMENT MEETINGS:** PEPFAR teams should hold meetings with a diverse group of civil society organizations representing various PEPFAR constituencies during COP planning and development. Through these civil society meetings, PEPFAR teams should structure an ongoing engagement, creating an iterative feedback loop, rather than a one-time interaction.

In addition to the two large COP meetings outlined in the Technical Considerations, PEPFAR teams should establish a process to host or attend roundtable discussions to meet with community members that are more amenable to directly providing feedback. These meetings should recognize that certain populations will require more focused attention and may need a “safe space” in order to express their feedback.

PEPFAR teams may want to consider providing some orienting questions to civil society prior to the meetings so that the feedback is directly related to the COP 2015. For example, civil society could be asked to provide feedback on:

- Is PEPFAR appropriately targeting key and/or priority populations?
- If you had to prioritize certain geographic areas and/or populations, which would those be?
- What do you see as the principal bottlenecks to XXXX?

**STEP 3: SOLICIT WRITTEN FEEDBACK FROM CIVIL SOCIETY:** PEPFAR teams will solicit written feedback from civil society on the proposed COP goals, budgets and targets and on current performance. It is the team's role to ensure groups have sufficient information about the program for this to be meaningful. S/GAC requires PEPFAR teams to share the written civil society feedback received with your SCL/CL. PEPFAR teams should also ask for feedback on other overarching issues, processes or knowledge that civil society organizations would like to share. *PEPFAR teams should submit written feedback from civil society as part of the Local Civil Society Planning and Participation Overview in FY 2015 COP at the time of COP submission.*

**STEP 4: PROVIDE WRITTEN FEEDBACK TO CIVIL SOCIETY:** PEPFAR teams will provide written feedback to civil society groups regarding the impact of their participation, including a specific explanation of which inputs were incorporated into the COP and which were not, and why these decisions were taken, prior to the finalization of COP 2015. Once the COP is approved, teams should convene a subsequent meeting to provide details regarding the approved COP 2015. S/GAC requires

PEPFAR teams to share the written feedback provided to in-country civil society with the SCL/CL. PEPFAR teams should also include in written feedback how PEPFAR will continue to engage with CSOs throughout the year. *PEPFAR Country Teams should submit written feedback that they provide to civil society as part of the Local Civil Society Planning and Participation Overview in FY 2015 COP at the time of COP15 submission.*

### ***Civil Society Engagement Process Documentation Requirement***

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PEPFAR teams are required to respond to a series of questions about their civil society engagement process. The completed two-page summary, “*Local Civil Society Planning and Participation Overview*” should be submitted as a supplemental document in FACTS Info at the time of COP submission, including copies of feedback to/from civil society. Section 3.3.1 contains the template for the *Local Civil Society Planning and Participation Overview* that teams need to respond to as well as a check-list that teams can use as they plan their annual engagement with civil society.

### **FOR SPECIAL CONSIDERATION**

After Headquarters have cleared the SAPR and APR, these results should be shared with civil society groups as part of the ongoing outreach process.

#### **2.3.4 Coordination among U.S. Government Agencies**

A key feature of PEPFAR is its whole-of-government approach that rests on a robust and productive U.S. government interagency response. In practice, this requires U.S. government agencies working in a country or region to gather, analyze and discuss financial, epidemiologic and program data, to help inform planning and implementation of a unified country program as one U.S. government team. In most cases, a PEPFAR Coordinator facilitates a process that supports this principle. **It is essential that all USG agencies working on HIV/AIDS programs in a country be included in all levels of discussion regarding the COP.** For agencies that have in-country programs but no direct in-country presence, this includes communication through email and telephone. In addition, dialogue with the interagency PEPFAR Oversight and Accountability Response (POART) teams at headquarters is encouraged to ensure a well-vetted COP is reached prior to submission. Country programs may have several sources of USG HIV/AIDS funding (e.g. State, USAID, GAP funds); however, all HIV/AIDS programming decisions are to be made as an interagency U.S. government team with final coordination and approval by S/GAC. If any agency does not have staff or activities in-country, the

country team may still draw on the expertise of a non-presence agency to benefit the program and may use the COP process to solicit that agency's expertise.

Given the emphasis on data use and analysis to drive decision making, data sharing and transparency is critical to a successful COP process. Agencies are expected to work together to share and analyze all available programmatic, epidemiologic and financial data, which will include partner work plans, and partner and site level data.

In preparing the COP and throughout the year, PEPFAR programmatic staff should consult with relevant non-program offices in all agencies, such as human resources, management, financial, general services, scientific review, acquisition, grants, general counsel, and policy officials at the appropriate levels to ensure that there is sufficient administrative and management support to facilitate PEPFAR activities. For example, the Embassy Management and Human Resources Offices are key partners in evaluating current and planned staffing for program management, oversight and accountability. Similarly, all procurement and assistance actions must be coordinated with the appropriate agency's procurement office prior to COP approval and during implementation. In addition, COP implementation for each agency must utilize any established agency forecasting systems.

Finally, it is a recommended best practice and it is expected, that draft scopes of work for any new/renewed procurements will be carefully reviewed in an interagency manner at the country level before being included in the COP and/or being submitted into official agency acquisition and award processes.

### **2.3.5 Human Rights**

Reaching the goal of an AIDS Free Generation not only requires robust clinical interventions, but simultaneously requires addressing social, cultural and legal barriers that result in hostile environments creating barriers to equal access to health services for all people living with and affected by HIV. This requires not only the training of those at a local level who interact with people living with HIV (PLHIV) or other vulnerable populations but also building the capacity of civil society organizations, engaging host country governments, and working in concert with our multilateral and other bilateral partners. In these partnerships and throughout all of our programs, we are committed to ensuring that grantees receiving PEPFAR funds implement their programs in a way that supports promotion, protection, and respect for human rights.

While each of the actions outlined in this guidance is discrete, they all are part of a framework to address stigma and discrimination by creating an enabling environment (e.g., social and legal) where access to HIV prevention, treatment and care is possible.

In this context, four core principles should be considered in all PEPFAR programs and service delivery points:

- **Availability:** Are there functioning HIV facilities, commodities, services, and programs in sufficient quantity?
- **Accessibility:** Are HIV services accessible, including facilities, signs and medical equipment with accommodation for the physically, visually or hearing impaired? Is information provided in an accessible way (for example, in plain language that the individual can understand)?
- **Acceptability:** Are services respectful of medical ethics (i.e., including the principles of non-disclosure, non-coerciveness, and informed consent), culturally appropriate, and sensitive to age, gender and sexuality?
- **Quality:** Are HIV service delivery, research, and data gathering practices scientifically and medically appropriate? Are all patients treated with respect in the provision of high-quality services?

PEPFAR's human rights framework will focus on these key areas:

- Reducing stigma and discrimination in HIV service delivery/health care settings.
- Ensuring that environmental assessments and data for decision-making are gathered to optimize patient care, improve program monitoring and strengthen services provided.
- Supporting advocacy initiatives and educational programs to promote Patient Rights and Access to Quality Services.

### ***COP 2015 Requirements and Recommendations for Human Rights Agenda***

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Below are the **Required** Actions for PEPFAR field teams.

## **Trainings on Non-Discrimination**

1. Include a section on non-discrimination in PEPFAR trainings.
2. Completed the inaugural Gender and Sexual Diversity Training by June 1, 2015.

## **Data for Decision Making and Creating an Enabling Environment**

3. Conduct a Legal Environment Assessment (LEA) if it has not been done in the last three years. An LEA analyzes the extent to which the legal, regulatory and policy framework in a country supports or hinders effective national and local responses to HIV and AIDS.

If a LEA has been conducted in the last three years, convene or support a process to implement the outcome's recommendations.

## **Supporting Patient Rights and Access to Quality Services**

4. Provide a two-page assessment of the country's current referral mechanism and/or system to report incidents of stigma/discrimination preventing access to PEPFAR services and/or violations of patient rights to appropriate social or legal services

The purpose of this two-page assessment is to describe the current context for patients to report incidents of stigma/discrimination and/or violations of their patient's rights in HIV/AIDS settings. The assessment will assist headquarters staff better understand if there are barriers to accessing HIV/AIDS services that relate to stigma, discrimination and human rights. Key questions to consider include:

- Are there are laws/policies in place which prevent discrimination in the health setting? Are those laws are enforced or not? Is enforcement only possible where a person has access to quality legal services? Even with legal services, are there mechanisms for redress?

The two-page assessment should therefore include:

- A. A brief description of the process which the average person would take if they experienced a violation of their human rights which resulted in their not accessing HIV/AIDS services. This description should recognize the various options or lack of options for an individual.
- B. A brief statement of the current laws/policy regarding non-discrimination in health care setting. And a general assessment on how well these are, or are not, enforced.



- C. Observations about any specific groups which are especially vulnerable to stigma and/or discrimination.
- D. As available, any information on successful efforts within the national context that promote the prevention of stigma, discrimination and/or violations of human rights for individuals infected with and affected by HIV/AIDS. This might include remarks on sites that are well known for the positive treatment of patients, particular civil society groups who have positively influenced a governments laws and policies or groups providing social and legal services, and/or government leaders who have been outspoken on, or taken actions to, further the goals of non-discrimination in health care setting.
- E. Where possible assessment should describe any specific information on how the above would be different for members of key populations.

Below are the **Recommended** Actions for PEPFAR Country Teams

### **Trainings on Non-Discrimination**

- 1. Develop service and delivery models that reduce the effect of stigma and discrimination. This may include co-location and integration of services.
- 2. Create capacity and train health facility staff and/or recruit legal advisors to provide legal literacy education and support referrals to legal services.

### **Data for Decision Making and Creating an Enabling Environment**

- 3. Provide funding for operational research and implementation science to assess barriers to HIV services faced by members of key populations, and to test and evaluate innovative interventions and HIV service delivery models that decrease barriers to service access and help lower the threshold for service access and retention among members of key populations.
- 4. Provide funding for outcome evaluations of programs that support efforts to promote, protect, and respect human rights for enhancing scale and effectiveness.
- 5. Support the collection of data to inform the six MERG-approved indicators on stigma and discrimination in healthcare settings. This includes support to surveys among health care providers to collect such data.



6. Support inclusion into existing data collection surveys of the general population stigma and discrimination questions for the three indicators approved by UNAIDS MERG (Indicators 1069, 1071 and 1072).

### **Supporting Patient Rights and Access to Quality Services**

7. Ensure that all clinics and other PEPFAR-supported settings where HIV-related services are provided display information on the rights of patients
8. Support dialogue between any domestic human rights institutions, human rights defenders, and members of populations most impacted by the epidemic including PLWHA, key populations, and other with particularly vulnerable to HIV including, women and girls, people with disabilities, and their families
9. Undertake actions to empower and ensure participation and meaningful involvement of people living with HIV, key populations and persons with disabilities, and their families.

## **3.0 Modular Planning Steps to Implement Enhanced Strategic Approach**

## 3.1 Modular Planning Steps

Successful implementation of the enhanced strategic approach requires a series of key analyses and decision points. Given the unique context of each PEPFAR operating unit (OU) and availability of data elements, prescription of a single step-wise approach to decision making is not possible. However, there are clear steps that every PEPFAR OU should complete to meet planning requirements and draft a technically strong Strategic Direction Summary (SDS). These steps are as follows:

1. [Understand the current program context](#)
2. [Assess alignment of current PEPFAR investments and program focus](#)
3. [Determine priority locations and populations and set targets to achieve goal for accelerated epidemic control](#)
4. [Document gaps and barriers to achieve goal for accelerated epidemic control and outline program support and system-level activities in which PEPFAR will invest](#)
5. [Determine core package of services and support, expected volume of services, and expected investment for other locations and populations](#)
6. [Project total PEPFAR resources required to implement program plans and reconcile with planned spending level](#)
7. [Set site, geographic and mechanism targets and budgets in accordance with strategic direction](#)
8. [Determine monitoring strategy for planned activities in accordance with requirements and assess staffing pattern to achieve goals and accountability of results](#)

**Each planning step is intended to be modular**, meaning there is not a prescribed order in which to complete each step. There are, however, certain dependencies between steps. For example, it would not be prudent to complete Step 7—setting site mechanism targets and budgets—until other steps have been completed. Further, it is likely several steps will be iterative (need to be revisited) as scenarios are compared and decisions are made. Section 3.2 below outlines these dependencies and as recommended workflow for successfully completing steps.

Regardless of order, each planning step will require review of essential data and specific analysis techniques to successfully complete. To improve ease of reference, call-out boxes are inserted within each planning step to highlight the following:

- **Key data elements and potential sources**

- **Tools, templates, and frameworks (TTFs)** available to assist country teams organize or analyze key data
- **Targeted assistance (TA) and Technical Collaboration (TC) special considerations**
- **Regional operating plan (ROP) special considerations**

Critically, within each step, there are ***milestones*** identified that each OU should complete in order to meet SDS and COP planning requirements in 2015.

Each PEPFAR OU is encouraged to be innovative in their approach to program design and planning, as this helps us collectively develop new insights. There are, however, specific activities/analyses that OUs are expected to complete, at minimum, to satisfy the requirements for enhanced strategic planning. These include core, near-core and non-core classification of program activities; civil society engagement and method documentation; site yield/volume analysis for HTC, PMTCT, and ART (where site-level data available); efficiency analysis of enhanced program focus; outlier analysis using EA results; and resource projections. The approach to completing these analyses are described in the methods portion of this section (3.3) and are essential to COP/ROP planning.

Wherever possible, the detailed descriptions for activities required to complete each planning step have been indexed to the SDS template to indicate where data, findings and decisions should be documented in the COP submission. For ease of reference, linkages to the SDS template are highlighted in grey.

### 3.1.1 Planning Step 1: Understand the Program Context

To determine how PEPFAR should optimally invest to maximize impact, PEPFAR teams must:

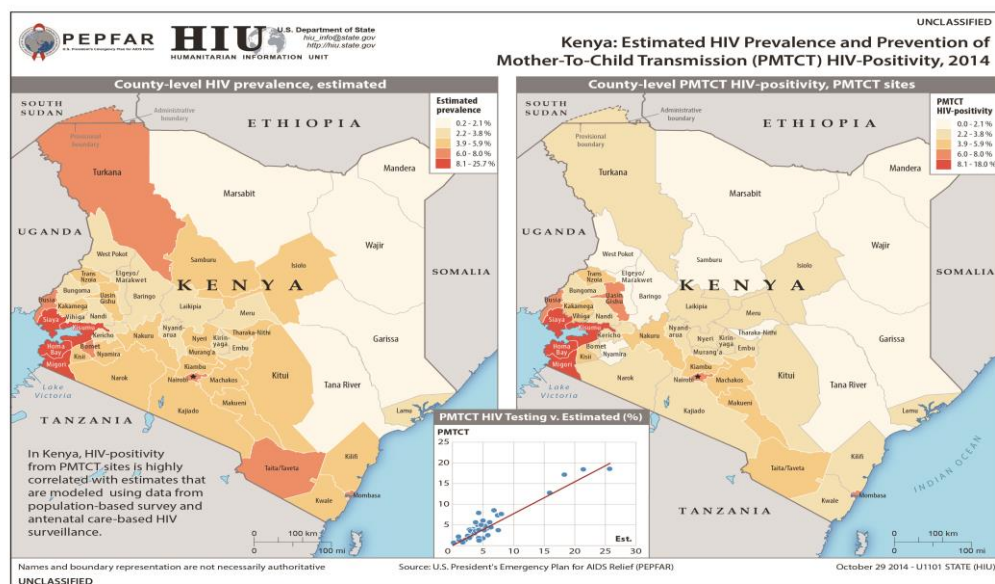
- Review demographic, epidemiologic and national/regional program data to the lowest sub-national unit (SNU) possible.
- Demonstrate a clear understanding of how the response is funded and implemented, including the Global Fund Principal Recipient(s) and host country government.
- Identify critical gaps, bottlenecks and structural or cultural barriers that may impede scale-up to achieve the stated goal for epidemic control.

The results of these assessments should be described in the SDS, [Sections 1.1-1.3](#). Additional detail on each critical element in this step is described below.

#### *Review of Demographic, Epidemiological and Program Data*

PEPFAR teams are asked to gather, review and present key data describing the HIV burden of disease in the national/regional context, including percent HIV positives (# HIV positive and # tested for HIV) at sites and current program performance. We have seen excellent correlation between PMTCT site level results and modeled county-level estimates in Kenya (see figure below).

**Figure 3.1.1: Correlation of Estimated HIV Prevalence and PMTCT HIV-Positivity, 2015**



The purpose of this activity is to better understand the magnitude of the epidemic and current progress towards achieving adequate coverage of **combination prevention** to achieve epidemic control. Two standard tables in the SDS should be populated with key data to provide context for planning decisions.

Standard Table 1.1.1 outlines demographic and epidemiologic data for the national/regional context in which each PEPFAR OU operates. The table is organized to capture the key data points that should, at minimum, be reviewed prior to making program decisions. The data are disaggregated by age and sex (*note that data on female sex workers do not require age disaggregation*). This disaggregation is increasingly critical as evidence mounts regarding the importance of focusing HIV activities on the populations with the highest HIV burden and unmet need, and therefore those most likely to transmit and acquire HIV.<sup>11</sup> Further, these populations will vary by country and region, and PEPFAR field teams should make every effort to populate this table in its entirety using any data available of reasonable quality. Cells indicated in grey do not require information to be entered. ***It is understood that not all countries will be able to populate every cell in the table; however, this exercise is also designed to highlight the areas where significant data gaps exist and where PEPFAR may need to invest to fill these gaps to better measure progress towards epidemic control.***

Every PEPFAR OU should, to the extent it is safe, collect data on prevalence within key populations and estimate the size of those populations. Data for three groups are required for all PEPFAR OUs: men who have sex with men (MSM), female sex workers (FSW), and people who inject drugs (PWID). Weaknesses in these data should be noted and addressed in planning.

Field teams are also asked to identify specific priority populations on which they will focus in the coming cycle, and include an additional row for total size estimate *and* an additional row for HIV prevalence within each population listed.

**NOTE:** For each priority population selected for targeting in the coming cycle and identified in Section 4.1 of the SDS, an associated size estimate and HIV prevalence value is expected in Table 1.1.1.

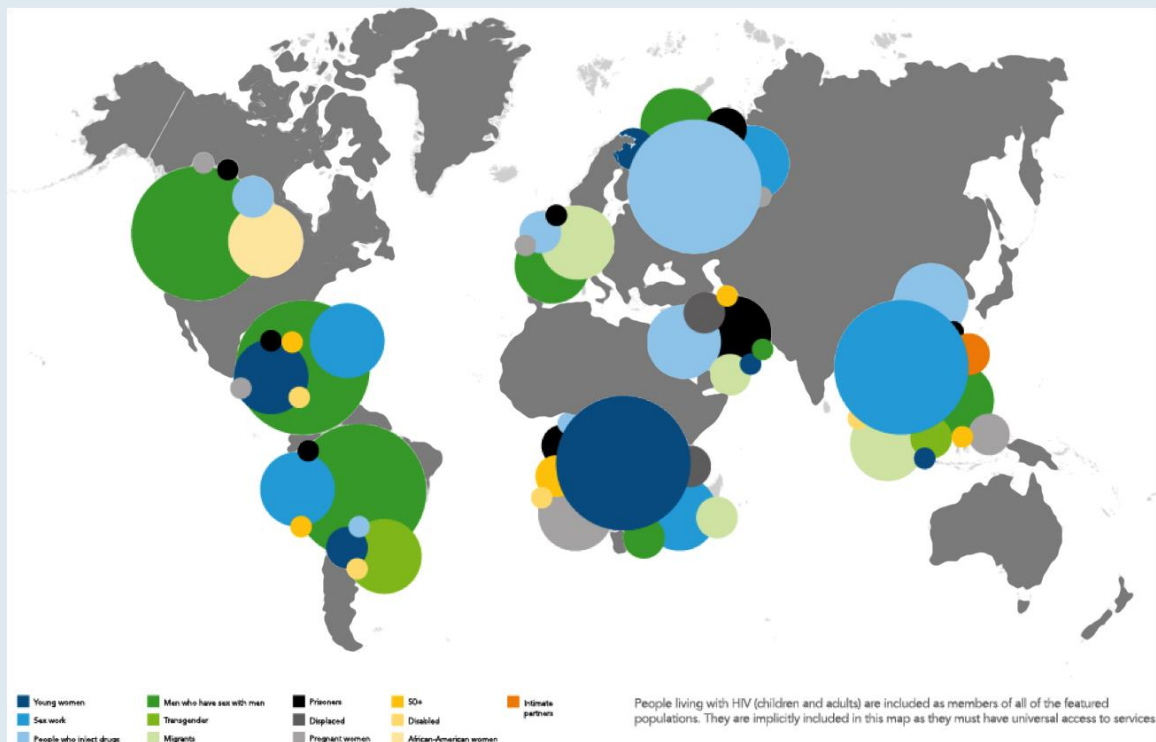
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<sup>11</sup> UNAIDS. (2014, September). *The Gap Report*. Retrieved from <http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport>

## What is the difference between priority and key populations?

UNAIDS defines key populations as men who have sex with men, transgender women, sex workers, and people who inject drugs (UNAIDS guidance for partnerships with civil society, including people living with HIV and key populations, 2011). PEPFAR follows this guidance and also recognizes that other populations may need to be prioritized for HIV prevention, care and treatment, based on local epidemiology. For example, in many sub-Saharan African countries, females 15-24 are at substantially higher risk of acquiring HIV than males of the same age. These girls and women should be a priority population for PEPFAR programs. Likewise, in countries where the HIV epidemic is concentrated among people who inject drugs (PWID), the sexual partners of these PWID might be a priority population, given their substantially higher risk of acquiring HIV. Priority populations should be chosen not just by risk behaviors, but by prevalence data. These populations should be targeted with comprehensive packages of HIV prevention interventions, and with ART for those living with HIV.

The figure below demonstrates the heterogeneity of key and priority populations by location. This will also be relevant for geographic areas within a country.



For every entry cell in **Table 1.1.1** (except for those colored grey), PEPFAR teams should enter a numerical value or one of three letter codes:

1. **NA**: “not available”—indicates no data are available from any source
2. **IQ**: “insufficient quality”—indicates data are available, but the quality does not meet reasonable standards
3. **LG**: “limited generalizability”

Key Data Elements and Potential Sources for <b>Standard Tables 1.1.1 and 1.1.2</b>	
Data Inputs	Potential Source
Demographic data (national and subnational)	Central Statistics Agency, U.S. Bureau of Census, Demographic and Health Surveys
HIV Epidemiological data (national and subnational)	Ministry of Health surveillance, Estimates from UNAIDS Spectrum and Subnational Estimates of HIV Prevalence Report, Surveillance Studies supported by PEPFAR
National Program Statistics	Ministry of Health, UNAIDS, WHO
Estimates for Program Services (ART, Orphans, TB/HIV)	UNAIDS, WHO
Key Populations, HIV and size estimates (MSM, FSW, PWID)	Ministry of Health, UNAIDS, Surveillance Studies supported by PEPFAR and other surveillance reports
Priority Populations, HIV and size estimates	Ministry of Health, UNAIDS, Surveillance Studies supported by PEPFAR and other surveillance reports
Data Inputs	Potential Source
HIV Epidemiological data (national and subnational)	Ministry of Health surveillance, Estimates from UNAIDS Spectrum and Subnational Estimates of HIV Prevalence Report, Surveillance Studies supported by PEPFAR, Demographic and Health Surveys



National Program Statistics	Ministry of Health, UNAIDS, WHO
Estimates for Program Services (ART, Orphans, TB/HIV)	UNAIDS, WHO
Key Populations, HIV and size estimates (MSM, FSW, PWID)	Ministry of Health, UNAIDS, Surveillance Studies supported by PEPFAR and other surveillance reports
Priority Populations, HIV and size estimates	Ministry of Health, UNAIDS, Surveillance Studies supported by PEPFAR and other surveillance reports

Standard Table 1.1.2 provides data on the cascade for HIV prevention, diagnosis, care and treatment for the most recent 12-month period available. The purpose of this information is to better understand in a standardized fashion how effectively different populations are reached with combination prevention services, diagnosed, linked and retained in ART, and ultimately, achieve and maintain virologic suppression. Identifying critical gaps in the clinical cascade can help PEPFAR and national/regional programs tailor activities to more effectively respond to unmet need and implementation realities. Monitoring these data over time establishes a critical feedback loop informing planners if program choices are moving the country or region closer to the goal of 90-90-90 by 2020 or if course corrections are needed.

Cascade data in Standard Table 1.1.2 are disaggregated by population, necessary to effectively target based on burden of disease. The first row, "Total Population," should be inclusive of all subsequent rows and represents summary national cascade information across all populations. The second row, "Population less than 15 years," and third row, "Pregnant Women," are both required and a subset of total population. Sex workers are a key population in every epidemic and data on prevalence and population size should be included by every OU. Where data on MSM are available and can be safely presented, it should also be included. In all countries where prevalence is over 1 percent in the general population, data on pregnant women should be presented. In countries and regions where it is known that the epidemic is concentrated in PWID, data on this population should be presented. In addition, country teams should include a row and associated data for each priority population selected for PEPFAR program focus in the implementation cycle. The priority populations listed should match those described in Standard Tables 1.1.1 and 4.1.4. With respect to care, treatment, retention and viral suppression, teams should include these data for key and priority populations when available and when it is safe to do so.

For every entry cell in **Table 1.1.2**, PEPFAR teams should enter a numerical value or one of three letter codes:

1. **NA**: “not available”—indicates no data are available from any source
2. **IQ**: “insufficient quality”—indicates data are available, but the quality does not meet reasonable standards
3. **LG**: “limited generalizability”

**Standard Tables 1.1.1 and 1.1.2** are intended to present national data. PEPFAR-specific data may be substituted where national data are not available; however, this distinction should be clearly indicated with a footnote.

### TA/TC Considerations

Countries working in concentrated epidemic settings need not complete portions of **Standard Table 1.1.1** related to PMTCT, OVC or Male Circumcision.

### ROP Considerations for Standard Tables 1.1.1 and 1.1.2

Regional programs are expected to know the epidemiology and gaps in all countries where they work. However, they are not expected to submit **Standard Tables 1.1.1 and 1.1.2** for each country in their region. Instead, regional programs should select the top 2-3 countries within their region, with both the largest PEPFAR investment, and the largest HIV burden.

The following is a recommended list of countries for each program to feature in **Standard Tables 1.1.1 and 1.1.2**. If the PEPFAR field team feels they should feature different, or additional countries, they should discuss their proposal with their CL.

**Asia Regional:** Thailand, China

**Caribbean Regional:** Jamaica, Trinidad and Tobago, Suriname

**Central America:** Guatemala, El Salvador, Honduras

**Central Asia Regional:** Tajikistan, Kyrgyz Republic

**Milestone:** Complete **Standard Tables 1.1.1 and 1.1.2** in the SDS template and adequately address guiding questions in Sections 1.1 of the SDS template.

## *Outline the Program Investment Profile*

Regardless of program type or size of investment, the success of PEPFAR programs are dependent on the resources, management, and support contributed by the host country government and other key stakeholders in the HIV response (e.g., the Global Fund). In order to minimize duplication across funders/implementers, increase allocative and technical efficiency, and maximize impact on the epidemic, PEPFAR must have a clear understanding of how the current program is being funded and potential dependencies on other partners for success in achieving the stated goal for epidemic control. This includes, at minimum, data describing total investment by key program area and source of support, as well as data describing how critical commodities are procured. Two tables are provided in the SDS template to assist field teams with presenting these data (which are also a key input into the Sustainability Index) and are described in more detail below.

**Standard Table 1.2.1** is required of all PEPFAR OUs and outlines the investment profile of the national/regional HIV response.

<b>Key Data Elements and Potential Sources</b>	
<b>Data element(s)</b>	<b>Potential Sources</b>
Total Expenditure by Program Area and Funder	<p>National AIDS Spending Assessment (NASA)</p> <p>National Health Accounts (NHA)</p> <p>Other formal national resource tracking activities (e.g., Resource Mapping)</p> <p>Meeting proceedings and joint planning/analysis activities across funders (e.g., Investment Approach, Global Fund Concept Note Development, etc.)</p> <p>Global Fund Annual Financial Reporting (AFR)</p>

Data should be disaggregated by the program areas listed in the first column and by funder in each subsequent column. Columns for the following funders are required at minimum:

- **PEPFAR**
- **Global Fund Principal Recipient(s) (GF)**
- **Host national government (acronym acceptable)**
- **Other**

Additional columns by funder may be included if data are available. The total investment by program area and overall should be listed in the column titled, “Total Expenditure.” In each funder column, the percentage contribution of the total expenditure should be recorded, both by program area and overall.

Potential sources of data are listed above. Many PEPFAR OUs operate in countries that recently completed a NASA or NHA. Though the results of these data are likely unpublished at current, teams are encouraged to reach out to their UNAIDS, World Health Organization (WHO), and host country counterparts to determine if these results can be accessed to improve joint, strategic planning. Similarly, many host countries are in the process of completing a Global Fund Concept Note and/or developing a framework for investment planning bridging multiple donors and stakeholders (see Appendix 8 outlining the Investment Approach). Many of the inputs to these processes will require similar data that should be accessed whenever possible to successfully complete this planning step.

Some additional guiding principles teams should consider when gathering and reviewing investment and expenditure data:

1. To the extent possible, all data should be derived from the same source to improve comparability
2. Data across funders should be presented in the same currency for the same discreet time period and clearly indicated (e.g., 2012 USD)
3. Data should be from the most recent period available

For every entry cell in Table 1.2.1, PEPFAR teams should enter a numerical value or one of two letter codes:

1. **NA:** “not available”—indicates no data are available from any source
2. **IQ:** “insufficient quality”—indicates data are available, but the quality does not meet reasonable standards

Standard Table 1.2.2 is required of all PEPFAR OUs and outlines the procurement profile for key commodities. The purpose of this table is to highlight current procurement arrangements for commodities required to sustain the HIV response and continue to increase scale.

<b>Key Data Elements and Potential Sources</b>	
<b>Data element(s)</b>	<b>Potential Sources</b>
Total Expenditure by Commodity Category and Funder	<p>National AIDS Spending Assessment (NASA)</p> <p>National Health Accounts (NHA)</p> <p>Other formal national resource tracking activities (e.g., Resource Mapping)</p> <p>Meeting proceedings and joint planning/analysis activities across funders (e.g., Investment Approach, Global Fund Concept Note Development, etc.)</p> <p>Quantification and forecasting data from commodity procurement agents (e.g., SCMS, national medical stores, etc.)</p>

Data should be disaggregated by the commodity categories listed in the first column and by funder in each subsequent column. Columns for the following funders are required at minimum:

- **PEPFAR**
- **Global Fund (GF)**
- **Host national government (acronym acceptable)**
- **Other**

Additional columns by funder may be included if data are available. The total investment by commodity category and overall should be listed in the column titled, "Total Expenditure." In each funder column, the percentage contribution of the total expenditure should be recorded, both by commodity category and overall.

Achieving the stated goal for epidemic control may require program shifts that impact other USG (non-PEPFAR) or external platforms in country. As such, PEPFAR teams are asked to complete **Standard**

Table 1.2.3 in the SDS. The purpose of this table is to show the total non-PEPFAR health investments, how much of those investments are co-funding PEPFAR activities, and outline PEPFAR central initiatives contributing to program achievements. ***The USG programs and platforms listed in the sample table in the SDS are for illustrative purposes only. The actual list of non-PEPFAR USG activities will depend on OU context and should be comprehensive of all USG funding streams.***

Guiding principles for completing Standard Table 1.2.3:

Standard Table 1.2.3 should include:

- All USG non-PEPFAR health funding;
- All non-COP PEPFAR funding (e.g. central mechanisms); and
- All private sector investments specifically tied to PEPFAR funds
- PEPFAR central initiative funding

Standard Table 1.2.3 should not include:

- Other donor resources (e.g. DFID, Global Fund); and
- Private sector resources not specifically tied to PEPFAR resources

Column definitions and instructions:

1. Funding Sources – List all relevant funding sources (within the parameters described above)
2. Total Non-COP Resources – This is the total investment in country from each source, regardless of whether or not the activities are integrated with PEPFAR
3. Non-COP Resources Co-Funding PEPFAR IMs – Of the total non-PEPFAR investment (column 2), how much is invested in IMs that are also funded with PEPFAR COP resources
4. # of Co-Funded IMs – How many implementing mechanisms is the funding in columns 3 & 5 spread across?
5. PEPFAR COP Co-Funding Contribution – How much PEPFAR resources are being invested in the IMs being co-funded by PEPFAR and non-PEPFAR resources?
6. Objectives - What is the objective of the integrated/co-funded activities?

Once Standard Tables 1.2.2 and 1.2.3 have been populated, the PEPFAR team should concisely communicate key findings in the narrative portion of the SDS, Section 1.2. Given these data represent

a static point in time, teams should use the narrative to contextualize the information provided and identify any potential changes or risks that may need to be addressed in the planning process. Specifically, teams should report in the narrative the year of the commodity expenditure data reported, any changes that have occurred in the country since these data were collected, and any planned changes in which funder will be supplying each commodity in the next 1-3 years. This is particularly important for commodities, as a stable supply of ARVs and other drugs and supplies for combination prevention is necessary to sustain existing programs and a pre-requisite for any planned expansion.

**Milestone:** Complete Standard Tables 1.2.1, 1.2.2, and 1.2.3 and adequately address guiding questions in Section 1.2 of the SDS template.

**TTFs:** The *Supplementary Data Pack* provides a place to organize data for Standard Tables 1.2.1, 1.2.2 and 1.2.3 on the “Investment Profile” worksheet.

### ***Assess the Sustainability of the Current Program***

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As an emergency response to the AIDS pandemic, PEPFAR has made immense achievements in the past ten years. Moving forward, PEPFAR 3.0 is solidly focused on ensuring that progress towards epidemic control is accelerated, and that the program’s achievements and gains are consolidated and sustained.

To ensure that PEPFAR is on track in supporting sustained epidemic control, PEPFAR’s new business model and platform is elevating sustainability as a key dimension for PEPFAR teams and in-country stakeholders’ (government and civil society) agendas for reaching epidemic control within each country context. By elevating the focus on sustainability, PEPFAR can influence technical gains in country, and foster greater accountability, transparency and use of evidence to accelerate country progress towards epidemic control. In 2015, COP countries are expected to analyze the sustainability of the national response at both the national level and within specific technical areas.

#### ***National Level Sustainability Analysis***

To support a dialogue on sustainability, a new tool—the Sustainability Index and Dashboard (SID)—will be implemented by country teams through an informed, consultative, evidenced-based process. The SID, developed through a USG interagency consultation process, is a tool to measure and track progress over time in five domains and fifteen elements of sustainability for the national HIV/AIDS response in PEPFAR countries (see SID guidance emailed to the field the week of December 15 and located online at <https://www.pepfar.net/Project-Pages/collab-47/SitePages/Home.aspx>). As PEPFAR continues to increase coverage of essential HIV/AIDS prevention, care and treatment interventions, it is important to continue to foster a sustainable national HIV/AIDS response through: availability of epidemiological, health and economic data; use of local institutions as the main vehicles of HIV/AIDS service and program delivery; increased domestic health financing and strategic investments through domestic resource mobilization, allocative efficiency, and technical efficiency; accountability and transparency of results and spending; and an enabling environment characterized by appropriate policies, laws, and regulations as well as effective planning and coordination.. Sustainability can be achieved by integrating essential elements into existing prevention, care and treatment programs; by strengthening health systems, local institutions and health workforce capabilities; and by implementing activities that are directly targeted at improving specific domains and elements of sustainability.

The SID serves multiple important functions in this COP cycle, including:

- Creating an opportunity for dialogue on key issues for achieving sustained epidemic control, particularly for Chiefs of Mission (COMs) to discuss at the highest levels of government areas where progress needs to occur and areas where progress has been made in partner countries.
- Identifying areas of concern that PEPFAR could address, either within a particular domain or a sub-element which is heavily impacted by weaknesses. Conversely, the SID may indicate that investments are no longer needed in a particular domain or sub-element and can be moved elsewhere if the country has made strong achievements.
- Serving as a means to better understand and develop approaches that contribute to sustainability within technical areas, e.g. is local technical and organizational capacity being built to sustain quality of services over time; are PEPFAR investments accelerating expanded service delivery while also ensuring that government is aware of costs going forward and is developing a plan to ensure resources are sustained either domestically or through other means (e.g., public private partnerships).



- Providing an important foundation for identifying core areas for mutual commitments under Country Health Partnerships (CHPS), especially those areas with the potential for transforming our business relationships with partner countries and accelerating implementation of needed changes.

The SID also provides a deliberate mechanism around which teams can identify, measure, invest in and advocate for sustainability to ensure progress and transformative change in achieving epidemic control and an AIDS-free Generation. For COP 2015, with request from Chief of Missions, the SID will be initially a USG tool and only after substantive discussions with the host country government will the tool be placed on the public website. Ultimately, full transparency—all USG collected and analyzed data—is a core principle, but we want Chief of Missions to have adequate in-country discussions prior to posting.

After completing the tool using SID guidance, PEPFAR teams should briefly describe the major findings of the diagnostic that shaped sustainability investments for the coming implementation year in **Section 1.3** of the SDS. At a minimum, the following questions should be addressed:

- Which elements of the response were assessed as unsustainable?
- Of these, which areas are most urgently in need of attention in order to maintain progress towards sustained epidemic control?
- To date, have PEPFAR and/or other donors (i.e. Global Fund) been invested in these areas?

Finally, HSS activities may provide an important contribution to addressing certain unsustainable elements, as demonstrated on the SID, and inform other planned cross-cutting activities (i.e., lab and SI) as well as those from programmatic areas. To the extent that HSS activities relate to addressing sustainability gaps (either identified in SID findings or program-level sustainability issues identified through the Gap Analysis described in the following section), countries are expected to reference those specific sustainability gaps in Tables 6.1-3. Countries are not expected to limit HSS activities to ONLY those identified through the SID or Gap Analysis, nor are countries expected to address all of the gaps identified on the SID.

### ***Technical Level Sustainability Analysis***

Across all technical areas, the process for using sustainability gap findings to inform programmatic planning will be similar. Each technical area should both review elements scored in the SID and conduct the Gaps/Bottlenecks/Barriers Analysis described below to understand:

- If/how current investments and programming are supporting SID elements scored as unsustainable and/or critical sustainability-related gaps/bottlenecks/barriers;
- If/how planned investments and programming can be either continued or modified to better support SID elements scored as unsustainable and/or critical sustainability-related gaps/bottlenecks/barriers; and
- How planned investments and programming to support SID elements scored as unsustainable and/or critical sustainability-related gaps/bottlenecks/barriers will be implemented and monitored.

Based on all of this analysis, Sections 4.2-4.10 of the SDS should articulate which sustainability weaknesses (if any) will be addressed in that particular technical area (and why) to move along the sustainability continuum (i.e., from lesser to greater sustainability); and which data streams will be used to monitor how related investments support movement along the sustainability continuum.

### **TTFs: *Sustainability Index, Investment Approach***

#### ***Define Gaps and Bottlenecks, Structural and Cultural Barriers***

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To achieve epidemic control with limited resources, PEPFAR, host country governments, the Global Fund, and other stakeholders will need to systematically identify the gaps and impediments to reaching combination prevention targets and work together to strategically fill gaps and address barriers as quickly and efficiently as possible. Not all program challenges can be fixed with additional resources, nor will there be a watershed of additional funding in the near term. For this COP planning cycle, PEPFAR teams should systematically characterize the major gaps and impediments to achieving epidemic control using data to quantify these challenges whenever possible. Common types of gaps and barriers are listed below as well as key questions to consider, which are distilled from the Sustainability Index.

Recognizing that PEPFAR will not be able to fill all program gaps or address all barriers, it is insufficient to simply describe challenges to achieving sustained epidemic control. A crucial part of this

exercise is to understand the relative importance of each issue and prioritize which should be addressed in the coming implementation year. It is equally important to determine which should be addressed by PEPFAR based on program context and comparative advantage. This is described in greater detail in Section 3.1.4.

PEPFAR teams are asked to highlight major gaps or barriers that PEPFAR will address in the coming cycle in a number of places in the SDS, including Section 2.0 to explain core, near-core and non-core activity choices; throughout Section 4.0 to explain how program context was considered in determining program activities for priority locations and populations; and especially in Section 6.0 to explain the rationale for investments in program support and system-level interventions.

### ***Resource Gaps***

Currently there are not enough resources committed to the global HIV response to realize the goal of 90-90-90 by 2020 or achieve adequate coverage of other combination prevention interventions (e.g., VMMC) to achieve saturation. Resource gaps may be human (e.g., available health workers) or capital (e.g., infrastructure) in nature. It's necessary that resource gaps are identified with sufficient specificity to be actionable. For example, stating there are not enough resources to achieve 80 percent coverage of ART in 2 years is not sufficient, specifically the prioritization of services. Instead, identifying that the major impediment to ART scale-up is the inability of the host country government to pay for additional ARVs and quantifying this gap provides enough information to begin an informed discussion about PEPFAR's role in achieving desired scale.

This type of information is available through gap analysis techniques or financial/economic modeling (see Appendix 8 on the UNAIDS investment approach). PEPFAR teams are not expected to conduct primary analysis to define resources gaps for the national or regional context. Teams are encouraged, however, to access the most recently available data on resource gaps available through national planning processes (e.g., development of the Global Fund Concept Note), consider this information in program planning, and reference, where appropriate, in the SDS. Key questions to consider include:

- Is there a domestic government budget for HIV and/or specific technical areas independent of external financing, e.g., Global Fund?
- Has there been an increase in domestic public sector budget for health, HIV and/or a specific technical area between 2013 and 2014? What is projected for 2015, 2016 and 2017?
- If there are areas of weakness in health financing for your technical area, what activities is PEPFAR investing in to increase domestic spending?

- Human Resources for Health (HRH):
  - Who is currently paying salary compensation for HRH working in your technical area, i.e. government, PEPFAR, other donor? Is there a transition plan for the host government to assume these costs?
  - Are there sufficient, competent health workers who can provide services in your technical area?
  - Has pre-service curricula content in your technical area been updated in the last three years?
  - What efforts are being made to ensure that health workers trained in your technical area are retained in service?
  - What is the plan and progress in transitioning staff from PEPFAR to local financing/compensation?
- Commodity security and supply chain:
  - Who is financing the drugs and commodities required for your technical area?
  - Is there a secure, reliable and adequate supply of required drugs and commodities for your technical area?

### **Quality Gaps**

Achieving sustained epidemic control not only requires increasing coverage of combination prevention interventions, but also ensuring programs are implemented according to quality standards. Key questions to consider include:

- Are services related to your technical area based on up to date national and or global (i.e., WHO) guidelines?
- Does the government monitor services and review service delivery data in your technical area?
- Does the government use data and findings from monitoring to make mid-course (timely) corrections to improve services in your technical area?

See the *PEPFAR Quality Strategy* available on PEPFAR.net for a framework that can help assess program quality.

### **Data Gaps**

As stated in Section 2.2 above, without quality, routine program data and epidemiologic markers countries and regional programs lack the information needed to quantify gaps and barriers, as well as the critical feedback necessary to monitor expected performance and desired impact of planned activities. This gap hinders PEPFAR and other stakeholders' ability to strategically plan and ensure resources are employed to full potential. In completing the SDS and required planning steps, PEPFAR teams will likely be able to identify with precision which key data elements are lacking and at what levels in their country/regional context. PEPFAR teams should highlight these gaps in the SDS and determine if and how PEPFAR should invest in the coming cycle to strengthen the generation and use of critical data points. Key questions to consider include:

- Are epidemiologic and health data, especially on prevalence, incidence, morbidity and mortality that were collected within the last 3 years available for each technical area? Is the data being used to determine investment decisions in the relevant technical area?
- Are expenditure and financial data available for each technical area? Have expenditures been estimated to the site level? Do government partners analyze trends for the technical area, i.e., unit costs? Based on these and other health economic data, has there been discussion on how to improve efficiency and cost-effectiveness?
- Are performance data from the last 12 months available for each technical area, i.e., coverage, achievement of targets, and the cascade?
- If these data do not exist, what are the plans for building capacity of the partner government and local institutions to collect, analyze and share such data.

### ***Efficiency Gaps***

In a budget constrained environment, increasing efficiency is essential to achieving epidemic control. Efficiency is often used to measure performance of a system or program. An HIV/AIDS program that uses few resources to achieve its goals is efficient while the one that uses more resources to achieve the same outcome is less efficient. Improving the efficiency of the HIV response requires using combinations of inputs wisely and spending resources on the right interventions in the right place for the right populations that will deliver the greatest health benefit in terms of HIV epidemic control. Efficiency gaps may be technical, allocative or productive. PEPFAR teams are expected to routinely use data from the PEPFAR Expenditure Analysis, national expenditure tracking activities, and other sources to define these gaps and monitor improvements in efficiency over time. Additional detail on PEPFAR's definition for program efficiency and tools available to assess are discussed in the 2015 Technical Considerations. Additionally, teams should be able to quantify the financial impact of

enhanced program focus to accelerate epidemic control. This is discussed in section 3.3.4 of this guidance. Key questions to consider include:

*Allocative Efficiency:*

- What proportion of the funding for your technical area is financed through domestic public expenditures?
- What proportion of the key populations or other vulnerable population spending in your technical area is from domestic public expenditures?
- Does the government use data to drive decisions about funding allocation and geographic allocation of services for your technical area?

*Technical Efficiency:*

- Does government use expenditure data or cost analysis to estimate unit costs of services for your technical area?
- What actions are being taken to improve technical efficiency in your technical area?
- Have average unit costs for service in your technical area reduced in the last two years? By how much?

***Structural and Cultural Barriers***

In describing the environment needed to successfully achieve the 90-90-90 by 2020, Michel Sidibé, UNAIDS Executive Director states, “The only way to achieve this ambitious target is through approaches grounded in principles of human rights, mutual respect and inclusion. Coercive approaches not only violate fundamental human rights norms, but they will also hamper hopes for ending the AIDS epidemic.”<sup>12</sup> PEPFAR teams should consider barriers extending beyond the health system that may impact the ability of the host country to successfully achieve epidemic control. Key questions to consider in this area include:

- Are there laws, regulations or policies that present obstacles to progress in each technical area?

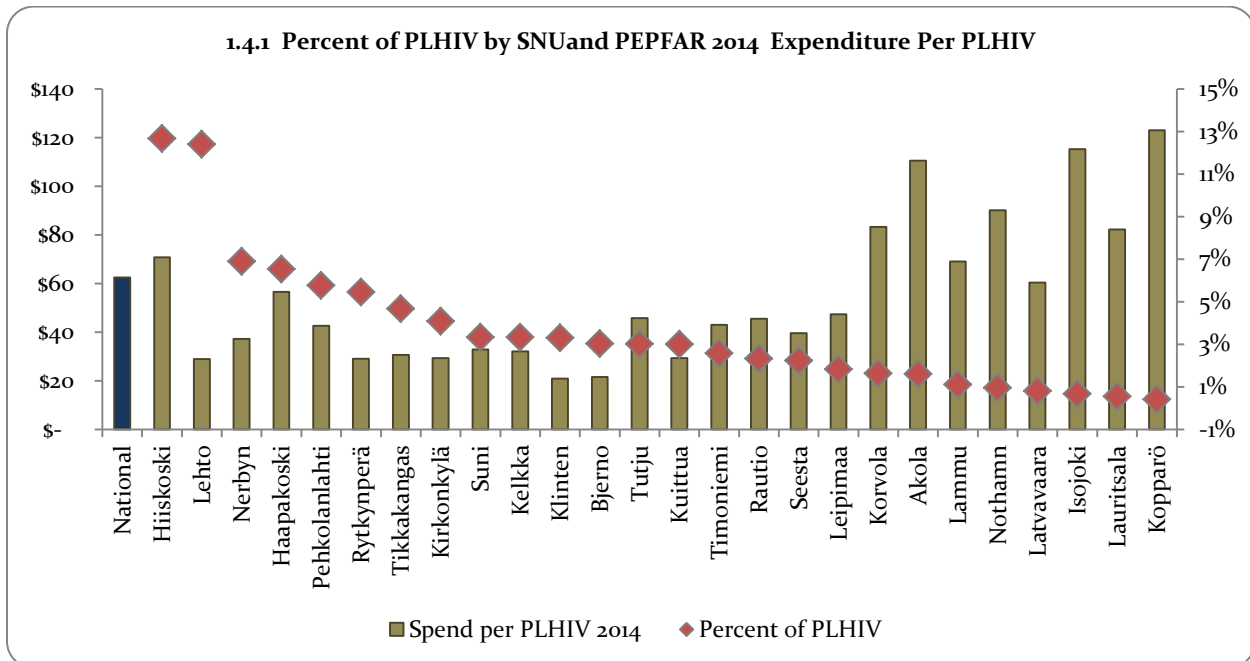
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<sup>12</sup> Luxembourg to champion the 90–90–90 treatment target. (2014, December 9). Retrieved from [http://www.unaids.org/en/resources/presscentre/featurestories/2014/december/20141209\\_luxembourg](http://www.unaids.org/en/resources/presscentre/featurestories/2014/december/20141209_luxembourg)

- Are there laws, regulations or policies that protect the rights and ensure access to non-discriminatory services for each technical area?
- Does the partner government coordinate activities and services for all technical areas and the national response in an open, transparent and participatory manner?
- Does the partner government fund civil society to implement services and programs?
- Does civil society advocate in support of improved policies, programs/services and funding?
- If there are weaknesses in this domain, what is PEPFAR doing to strengthen the enabling environment and address structural, cultural and legal barriers?
- Does the government conduct program and or financial audits related to your technical area?  
Are the findings from such audits made available to the general public?
- Does the partner government have formal channels and opportunities for civil society to engage and provide feedback for your technical area?
- If there are weaknesses in this domain, what is PEPFAR doing to improve accountability and transparency in your technical area?

### 3.1.2 Planning Step 2: Assess Alignment of Current PEPFAR Investments to Epidemic Profile

In order to define priority locations and populations for epidemic control, PEPFAR teams must understand how current investments are aligned to the epidemic profile. This task involves comparing the most recent PEPFAR expenditure data by lowest SNU available to burden of disease, as measured by total PLHIV. In the SDS, PEPFAR teams are asked to include **Standard Figure 1.4.1** to depict this relationship in an easy-to-reference format. The purpose of this analysis and standard graphic is to help teams determine if the existing PEPFAR program (as of the most recent fiscal year) is most effectively aligned to reach the areas and populations with the highest number of HIV infections. An example of this graph is displayed below.



**TTFs:** The **EA-Epi Comparison Tool** is provided to PEPFAR teams to generate this graphic. The tool will be pre-populated with expenditure data from 2014. Teams may need to insert data on total PLHIV and by SNU if not included in the version received.

In addition to comparing the PEPFAR investment to total PLHIV by SNU, the **EA-Epi Comparison Tool** allows teams to compare the PEPFAR investment for key and priority populations across SNUs when data are available. Population groups available for this analysis are pregnant women, MSM, FSW and PWID. Total expenditure for prevention programs devoted to these groups is taken from EA



results. For these graphs to populate, PEPFAR teams should enter an estimate of the total size of each population group by SNU. The tool will calculate the PEPFAR spend per population by SNU for comparison. *Note: the total size estimate is different than the total number reached by PEPFAR as measured by MER reporting.* This analysis is optional, but may be useful for TAVTC programs and those with a heavier focus on key populations.

Guiding principles for generating Standard Figure 1.4.1:

1. Data by SNU are required
2. PEPFAR expenditure per PLHIV by location should be represented by the primary vertical axis
3. Percent of total PLHIV by location should be represented on the secondary vertical axis
4. Data should be rank ordered by percent of PLHIV by SNU, except for the PEPFAR national column which should be placed at the front and highlighted in a different color for easy reference
5. All data and axes should be labeled

Considerations for interpretation:

PEPFAR expenditure per PLHIV is another way to display the relative share of total PEPFAR resources that have been allocated to each geographical unit based on the relative share of HIV burden. We expect some variability in spend per PLHIV given support is likely adjusted to the needs and gaps for each SNU.

Field teams should consider the range of values for expenditure per PLHIV in the program context and determine if this range is acceptable or how it can be explained by other factors, like investments from the host country government and other donors and/or variance in program scope or intensity. These factors should be investigated and assumptions validated internally using empirical data wherever possible. Teams should consider if the historical distribution of PEPFAR resources and intensity of spend per PLHIV is best aligned to achieve epidemic control in highest-burden areas in the near term. The relative share of HIV burden, as measured by PLHIV, is plotted on the secondary access (red diamonds in the figure above) provides additional context for this interpretation. After decisions have been made about program prioritization in the coming cycle, teams should think about how they would expect this graphic to look in the future. Specific questions to consider include:

- Where should PEPFAR increase spending because it is an SNU with high burden and few other funders?
- In which high burden SNUs will PEPFAR spending per PLHIV continue to be low due to economies of scale (i.e., the ability of the existing service delivery platform to accommodate more patients with minimal additional cost)?
- In which high burden SNUs will PEPFAR spending per PLHIV continue to be low due to complementary funding from other sources?
- In which low burden SNUs will PEPFAR be decreasing support in order to align better with epidemic control needs?
- In which SNUs do you anticipate continued high PEPFAR spending per PLHIV because the SNU is important to epidemic control and PEPFAR is the major funder (i.e., there are no other sources of support)?

Teams should communicate key findings from this analysis in the narrative of **Section 1.4** in the SDS as a way to frame program priorities and decisions in COP 2015.

#### **ROP Considerations for Table 1.4.1**

Regional programs should create Figure 1.4.1 for 2 – 3 select countries with the largest PEPFAR investment and the largest HIV burden in the region. PEPFAR teams should be familiar with the coverage and investment profiles in all countries in their region, but are not expected to submit figures for each country. Please see the suggested list of countries to include on page 37.

#### **Milestone:**

- (1) Complete Figure 1.4.1 and insert in SDS
- (2) Adequately address guiding questions in Sections 1.4 of the SDS template

### 3.1.3 Planning Step 3: Determine Priority Locations and Populations for Epidemic Control and Set Targets

PEPFAR teams are asked to design programs that accelerate progress toward epidemic control. This requires setting targets to achieve accelerated coverage of combination prevention interventions in a subset of high-burden locations and populations by the end of USG fiscal year 2017 (country teams should assume flat funding at FY15 levels or other trajectory based on communications from S/GAC for this calculation.) Targets should represent at least 80 percent coverage of ART for geographically bounded areas and defined populations. Given current coverage levels and budget constraints, achieving this goal will require field teams to make decisions about which **locations** (sub-nationally) will be selected for scale-up and which **populations** within those locations will be targeted. These decisions should be data-driven, focused on HIV disease burden and unmet need, and grounded in program cost. This planning step is both the most important and most dependent on other steps in the process. Decisions will likely need to be revisited and validated as targets are set, service packages determined, and costs calculated.

**Note:** *The targets submitted as part of the SDS and site, mechanism and technical level target requirements are for FY16 only. The Data pack will provide an opportunity to set calculate FY16 and FY17 targets to achieve 80 percent coverage.*

There are several critical elements to completing planning Step 3, including describing/mapping the HIV epidemic and unmet need sub-nationally/regionally and by population; selecting locations and populations for program focus; and setting targets to achieve epidemic control. Each element is described in greater detail below.

#### ***Describing/mapping the HIV epidemic sub-nationally and by population***

**TTFs:** The **Supplementary Data Pack** is available to assist teams with importing and organizing their epidemiologic and national/regional program data using the methods described below.

As a first step in prioritizing locations and populations, teams should gather the following data elements to the lowest SNU available.

### **Key Data Elements and Potential Sources**

Data element(s)	Potential Sources
Total population HIV prevalence Total number of PLHIV	Ministry of Health surveillance, Estimates from UNAIDS Spectrum and Subnational Estimates of HIV Prevalence Report, Surveillance Studies supported by PEPFAR Central Statistics Agency, U.S. Bureau of Census

Once key data elements have been organized, the teams should rank SNUs by completing the following steps:

1. Sort SNUs largest to smallest by total number of PLHIV
2. Calculate percentage of total (national/regional) PLHIV in each SNU
3. Calculate the cumulative burden by SNU by summing and recording the percent of total PLHIV for each SNU entry

*If using the **Supplementary Data Pack**, steps 2-3 will be calculated automatically on the “Epi Summary” worksheet.*

Next, teams should include current national/regional coverage data to calculate unmet need for combination prevention interventions, including ART, PMTCT, comprehensive prevention packages for key and priority populations, and VMMC.

For ART, coverage should be represented as a percent for each SNU. Unmet need should be calculated using *total PLHIV* as the denominator, not currently eligible based on national guidelines. Though the number currently eligible is an important factor to consider in operationalizing plans for scale-up, initial estimates of unmet need and program focus for epidemic control should be based on total burden, as measured by number of PLHIV.

*If using the **Supplementary Data Pack**, unmet need will be calculated automatically on the “ART Cascade for Epi Control” worksheet.*

Teams should calculate the **net new patient slots** required to achieve 80 percent coverage of ART for PLHIV by SNU by end of USG 2017. In determining the required targets to achieve 80 percent

coverage in select SNUs, PEPFAR teams will need to adjust for scale-rate (target in year 1 versus year 2) and expected loss to follow-up (LTFU).

*If using the **Supplementary Data Pack**, teams can calculate automatically the required net new patient slots on the “ART Cascade for Epi Control” worksheet by entering percent achievement in year 1, percent coverage goal for saturation, and projected loss to follow-up.*

As background to prioritization decisions, teams should describe these data in Figure 1.4.2 in the SDS. This figure is not required to be in standard format, but does require key elements to be displayed. Minimum elements for display include: **HIV prevalence by SNU, total PLHIV by SNU, and coverage of total PLHIV with ART.**

Teams should also calculate unmet need for PMTCT and VMMC. The **Supplementary Data Pack** provides space for these calculations on the associated worksheets.

### ROP Considerations for Table 1.3.2

Regional programs should create Figure 1.3.2 for 2 – 3 select countries with the largest PEPFAR investment and the largest HIV burden in the region. PEPFAR teams should be familiar with the coverage and investment profiles in all countries in their region, but are not expected to submit tables for each country. Please see the suggested list of countries to include on page 37.

### Selecting locations and populations for program focus

Multiple data sources and a number of program/contextual factors must be considered when PEPFAR teams select areas and populations for focus in COP 2015. **The goal of this analysis is to program resources where the host country has the highest probability of attaining epidemic control.** This will require focusing on specific areas and targeting specific population groups where the most new HIV infections are likely to originate.

With currently available data, it is not always apparent which information should take precedence, what thresholds should be applied, and what weight should be given to each individual criterion. Due to a general lack of data and poor geographic specificity in the data available, we have to use a combination of the following proxies to develop a more focused operational plan: HIV prevalence, population, total number of PLHIV, coverage of combination prevention services, and key and priority population size/location estimates.

Each country context will be different and one method or standard selection criteria should not be applied across the board; however, there are some guiding principles PEPFAR teams should follow when selecting locations and populations for scale-up:

1. High-burden areas and populations take precedence.

Epidemic control is not attainable until areas and populations with the highest density of PLHIV are saturated with combination prevention services (HTC, PMTCT, ART, VMMC, condoms, and other targeted prevention for key and priority populations). Total number of PLHIV should be the first criterion applied, followed by current coverage of combination prevention interventions.

Below is a 2x2 table for country teams to help conceptualize how to prioritize SNU considering HIV disease burden and HIV prevalence,

HIV Prevalence	HIV Disease Burden		
		High	Low
	High	Yes prioritize for epidemic control, if other data indicate	Is the geographic area too large for targeting, i.e. the unit of analysis is higher than the district or equivalent?
	Low	Is the geographic area too large for targeting, i.e. the unit of analysis is higher than the district or equivalent?	No, do not prioritize for epidemic control

2. Program scale-up of combination prevention should be in areas with high HIV transmission and acquisition, not necessarily entire SNUs

Percent coverage should be applied within a specific bounded area—i.e., sub-national administrative unit (state, province, region, district, ward, etc.) or city/township. In selecting areas and populations for epidemic control in the near term, teams should use data to the lowest SNU available. Typically, epidemiologic data are available at the first SNU—e.g. state, region, province—which means prioritization decisions should start with these areas based on the above criteria. Additional context/information, however, will need to be taken into account prior to making resource allocation decisions. For example, prevalence and HIV burden of an SNU may be driven entirely by a limited number of smaller bounded areas (e.g., counties, districts, cities, townships) or by specific populations. Similarly, a province with a relatively low burden of HIV (as measured by total PLHIV) may have areas with high HIV transmission pockets, or **micro-epidemics**. In the event trade-offs need to be made within or between focus SNUs (and more granular epidemiologic data are not available) efforts should focus on high density locations, such as urban and peri-urban centers.

Likewise, populations should be prioritized within high-burden SNUs. Often, available epidemiological information will not be sufficient to guide effective and focused programmatic responses. For example, while Demographic and Health Surveys (DHS) data may indicate that females 15-24 have substantially higher prevalence than male peers, it will not be efficient to target all females in that age range with comprehensive services. PEPFAR teams should use program data, published literature and ANC surveillance data to narrow broader populations and drive focused programming.

This level of focus should apply to both prevention and treatment programs. ART programs should set targets for the general population and for those populations at greatest risk of transmitting HIV. Where data on key populations cannot be collected safely (e.g. for MSM), programs should still work intentionally to make services friendly and accessible to those populations, and to develop proxy measures of success.

3. **Saturation** equates to 80 percent coverage of those in need of combination prevention services.

In accordance with the UNAIDS 90-90-90 goal, PEPFAR teams are asked to design programs and set targets to achieve 80 percent coverage of total PLHIV on ART *in geographic focus areas and priority populations*.

In addition, teams will need to assess current coverage of other combination prevention interventions in these areas/populations and consider how these programs complement efforts to achieve ART coverage goals. With respect to targeted prevention interventions for key and priority populations, targets should be set based on population size estimates, when available, and represent realistic coverage goals. Given the typical size of target prevention populations and the complexity in reaching them, coverage of 80 percent may not be attainable. However, teams should be able to describe how prevention investments in the coming cycle will translate to increases in coverage of key and priority populations with core services (see Section 3.3.1 on defining core, near-core and non-core interventions within program areas).

To complement the UNAIDS 90-90-90 targets for HIV-positive individuals, UNAIDS will soon release global HIV prevention targets through 2020 that contribute to epidemic impact goals by 2030. The target for VMMC is likely to be 80 percent circumcision prevalence among males 15-29 years of age by 2020, with sustained coverage at that level through 2030. PEPFAR will continue to support the UNAIDS strategy, as we have in the past. While VMMC is a priority intervention, it may not be possible to achieve the stated 80 percent coverage target specified within five years in all OUs with PEPFAR resources alone, if doing so diverts funding away from the 80 percent ART coverage target that takes primacy. In such instances of resource limitation, the VMMC coverage gap should be defined, by SNU, age group, and FY (2016-2020), so that different funding sources can be determined.

There are two additional considerations for ART saturation for PMTCT/pediatric populations. To harmonize the 90-90-90 targets with the “Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive”, ART saturation is 90 percent ART coverage of total HIV positive pregnant women (95 percent of HIV positive pregnant women know their status x 95 percent of known HIV positive pregnant women on ART = 90 percent ART coverage of HIV positive pregnant women). In addition, ART saturation explicitly includes children. For those programs that set ACT targets these should not be adjusted but should be counted as a proportion of the 80 percent coverage of PLHIV. In those programs not participating in ACT, pediatric ART saturation should be calculated using the same threshold as adults (80 percent of PLHIV<15 on ART).



**Milestone:** Describe the choices made for program focus in the implementation year by location and population group and address all guiding question in Section 3.0 of the SDS.

### ***Setting targets for accelerated epidemic control in priority locations and populations***

PEPFAR field teams are asked to set targets for combination prevention interventions that assist host country governments achieve accelerated epidemic control in a subset of high-burden locations and populations in the near term. Generally, targets should:

- Be in accordance with the OUs stated goal for epidemic control and teams should specify how PEPFAR investments will translate to expected increases in coverage in the COP 2015 implementation period, FY 2016 and beyond<sup>13</sup>.
- Facilitate saturation of combination prevention interventions.
- Be prioritized by location, population and intervention should be data-driven and grounded in program context, program cost, and implementation realities.

*This section is **not** comprehensive guidance on how to set targets for every indicator measured by PEPFAR. Rather, the guiding principles and instructions below pertain to targets highlighted in the SDS that provide a snapshot of how field teams have prioritized locations, populations, and interventions for epidemic control.*

PEPFAR teams should use this guidance to inform program choices and subsequently document targeting decisions in **Section 4.1** of the SDS, which includes five standard tables (4.1.1-4.1.5). Each table is described below in the context of the related combination prevention or support intervention.

In setting targets to accelerate epidemic control and completing the relevant section in the SDS, teams should keep several guiding principles in mind:

1. Targets for epidemic control are distinct and mutually exclusive of expected volume to maintain support in other locations and populations.

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<sup>13</sup> For example, these targets will achieve XX% coverage in the 20 highest burden communities

In **Section 4.1** of the SDS, PEPFAR teams will present targets outlined in the five standard tables *for priority locations and populations only*. In many OUs, we expect PEPFAR resources dedicated to scale-up to shift to prioritized areas and interventions; however, PEPFAR teams will need to budget for continued support to existing ART and PMTCT patients and OVC beneficiaries in other locations as programs are transitioned. To determine the required resources to support sites in other locations, PEPFAR teams should use program data to calculate the expected volume of beneficiaries in those areas. Expected volume should be recorded in **Standard Table 5.1.1** in the SDS, not **Standard Table 4.1.1**. Methods for this analysis are described in section 3.1.5 below.

*The sum of targets included in both **Sections 4.1 and 5.1** of the SDS should equal the technical area target<sup>14</sup> for each indicator.* For example, a PEPFAR team has determined the program can support 300,000 current on ART by APR 2016 in selected priority areas. This figure should be recorded in **Standard Table 4.1.1**. The team has also calculated there would be an expected volume of 200,000 current on ART by APR 2016 in other areas as programs are transitioned. This figure would be entered in **Standard Table 5.1.1**. The total current on ART expected for APR 2016 would then equal the current on ART in priority areas (300,000), *plus* the current on ART in other areas (200,000). In this example, the summary technical area target for APR 2016 is 500,000.

2. Target timeframe should be framed by goals beyond implementation in COP 2015.

Strategic planning requires PEPFAR teams to think beyond the implementation year associated with COP 2015 (FY 2016). However, teams are *not* expected to set targets beyond what will be reported in APR 2016.

For ART coverage specifically, teams are requested to select priority locations and populations in which coverage of 80 percent is possible in *two years*, i.e., by the end of FY 2017. This timeframe is intended to provide a near-term goal post for PEPFAR teams to guide decisions as they set targets to accelerate ART coverage in priority areas. Targets recorded in **Standard Table 4.1.1**, however, will only outline targets for achievement in 2016 towards this forward-looking goal.

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<sup>14</sup> See section 5.4 on target definitions.

For other combination prevention and support targets defined in Section 4.1 of the SDS, teams must estimate coverage by APR 2016 in the Standard Tables, but are not expected to set targets that result in 80 percent coverage of the target population if not achievable during this time frame.

3. Program costs and trade-offs should be taken into account when setting targets for priority locations and populations.

Achieving targets outlined in Section 4.1 represents a cost to PEPFAR programs. In determining targets for ART, other combination prevention activities, and OVC, teams should use empirical cost data to assess what is feasible within the current funding envelope (see section 3.3.6 on resource projections). Teams should also keep in mind that achieving targets in one technical area (e.g., ART) has an impact on funding available to achieve targets in another technical area (e.g., VMMC). There is not specific guidance applicable to all PEPFAR OUs on the most appropriate percentage allocation of funds between combination prevention and support activities; however, teams are expected to meet legislated budget code earmarks (see section 7.3), should consider any central funding that may be available to assist with achieving targets in specific technical areas, and consider the type and magnitude of support provided by the host country government and other stakeholders. The ultimate goal is to achieve epidemic control in selected areas and populations in the shortest timeframe possible. The optimal mix of combination prevention interventions will vary by context and teams should use any data or modeling available that can inform these decisions.

### ***Setting Targets for ART in Priority Locations and Populations***

PEPFAR teams are requested to set targets for ART that will assist the host country government achieve 80 percent coverage of PLHIV on ART by the end of USG fiscal year 2017 (September 30, 2017) in high-burden areas and/or populations. Given available USG resources and taking into account contribution of PEPFAR to the national treatment program, PEPFAR teams will likely need to prioritize specific areas where the attainment of 80 percent ART coverage is possible in two years. Teams should record proposed ART targets for priority locations and populations in Standard Table 4.1.1 in the SDS.

#### Guiding principles for completing Standard Table 4.1.1:

1. Populations should be assigned to geographic locations with the exception of military.

Data to the lowest SNU available should be used to determine where PEPFAR will focus geographically. Because current epidemiologic data are typically not available to most efficiently target and program resources, other contextual information must be taken into account. Selection of an SNU for program focus does not mean the PEPFAR team will focus in all sub-areas or on all populations within the SNU. Even within SNUs, priority for scale-up of combination prevention should be assigned to areas and populations where the most new HIV infections are likely to occur. Site-level PMTCT prevalence data will be essential for this analysis.

Recognizing the data limitations and that population focus may be more granular than the SNU level, in Standard Table 4.1.1 PEPFAR teams are required to assign targets to a specific SNU. The SNU level chosen in column 1 should be the lowest SNU level where data on HIV burden (as measured by total PLHIV) are available. For each SNU chosen for focus, teams should demonstrate that PEPFAR targets will contribute to achieving 80 percent coverage of all PLHIV estimated for that SNU within 2 years, or qualify in the narrative which sub-areas or populations within the SNU have been targeted to achieve the 80 percent coverage goal.

Military populations are the one exception to this rule. Due to the migratory nature of military populations and potential sensitivities associated with identifying their location, PEPFAR teams are permitted to include a row for “Military” in Standard Table 4.1.1 that is not tied to a specific SNU. If this option is chosen, teams should be able to quantify the estimated number of PLHIV and how coverage of ART will change with PEPFAR investments.

2. Eligibility criteria based on national guidelines should be taken into account when setting ART targets.

As countries adopt WHO guidelines for early initiation of ART it is expected there will not be a conflict between targeting based on total PLHIV and the ability of PEPFAR and the host country government to achieve targets based on national ART guidelines. However, in this COP cycle teams should use any clinical data available to determine if the current national guidelines would prevent achieving 80 percent ART coverage goals in focus SNUs identified. Any foreseen challenges in scale-up pertaining to national ART guidelines should be described in the narrative.

3. Commodities and other inputs required for effective provision of ART should be taken into account.

As described in planning Step 1 above, part of understanding the program context is determining any dependencies on other sources of support as PEPFAR plans activities and scale-up. This is particularly true for ART. In setting targets, PEPFAR teams should consider what inputs are required that are currently not funded by PEPFAR. Commodities, specifically, are often funded by the Global Fund or other entities. Teams should assess the ability of other stakeholders to scale support at a pace commensurate with PEPFAR in determining targets for priority SNUs and the program as a whole.

Column definitions and instructions for Standard Table 4.1.1:

1. Sub-national Unit –List all sub-national units *selected for focus in COP 2015*. A row is permitted for “Military” is applicable. A “Total” row is required.
2. Total PLHIV –Enter the number of total PLHIV estimated for each SNU chosen and the total for *all SNUs chosen for focus*.
3. Expected current on ART (2015) –National program data should be entered in this column, *not* PEPFAR results only. Enter the expected number of current on ART at the end of USG fiscal year 2015 (September 30, 2015) for each SNU chosen and the total across selected SNUs.
4. Additional patients required for 80 percent coverage –Calculate and enter the required additional patients needed to achieve 80 percent ART coverage of PLHIV for each SNU chosen and the total across selected SNUs.
5. Target current on ART (APR 2016) –Enter the proposed *PEPFAR* target for current on ART to be achieved by APR 2016 for each SNU chosen and the total across selected SNUs.

**Note:** *The total current on ART for selected SNUs is not the same as the total current on ART target for the PEPFAR technical area in APR 2016. The sum of current on ART for priority locations and population (Table 4.1.1) and the expected volume in other locations and populations (Table 5.1.1) should equal the PEPFAR technical area target for APR 2016.*

6. Newly initiated in FY 2016 –Enter the expected number of patients that will be newly initiated in USG fiscal year 2016. To accurately calculate this number, teams will need to adjust for LTFU over the implementation year.

**TTFs:** The **Supplementary Data Pack** is available to assist teams complete Standard Table 4.1.1. In the workbook, users are able to designate SNUs to be chosen for focus. These selections will be displayed on the worksheet labeled “Targets for Priority Areas.” If all data inputs have been populated correctly in the workbook, columns 2-6 will populate automatically. Adjustments to the target for focus below SNU (i.e., achieving 80 percent coverage of sub-areas and/or specific populations and not the SNU as a whole) are possible and should be calculated in the Data Pack in new entry columns for consistency.

### TA/TC Considerations for Target Tables 4.1.1-4.1.5

TA/TC programs may have pilot/demonstration projects that include setting direct targets; however, these teams are not expected to set PEPFAR targets for epidemic control in the same way as LTS programs. TA/TC programs are encouraged to include national data, where possible, in target tables outlining the selected areas and populations the PEPFAR team has chosen for program focus to further contextualize coverage of combination prevention interventions and gaps that may still remain by APR 2016.

In addition to setting targets for current on ART and ART enrollment (newly initiated) by SNU, PEPFAR teams should outline in **Standard Table 4.1.2** how they will meet the enrollment target proposed by entry stream for ART. At minimum, 4 entry streams should be considered and included as rows in **Standard Table 4.1.2**:

1. Clinical care patients not on ART

The most efficient way to increase enrollment of ART programs is to transition PLHIV currently receiving clinical care (or pre-ART) to ART. Of course, this will depend on national guidelines and other structural constraints or resource gaps. PEPFAR teams are asked to estimate the number of clinical care patients expected to become eligible and initiate ART in USG fiscal year 2016 and 2017 using data on CD4 declines per year.

2. TB-HIV patients not on ART

Another entry stream for ART enrollment that should be included is the cohort of PLHIV co-infected with TB. This stream has two arms:

First, PEPFAR teams should determine how many newly initiating ART patients will be the result of TB testing at PEPFAR-supported ART sites. To the extent possible, this number should not overlap with the number of clinical care patients estimated to transition to ART discussed above.

Second, PEPFAR teams should estimate how many individuals currently receiving TB treatment and prophylaxis at TB sites will receive HIV testing and be linked effectively to ART sites as newly initiating ART patients.

### 3. HIV-positive pregnant women

HIV-positive pregnant women receiving care and support through PMTCT outlets will initiate ART over the period. Teams should estimate the number of women newly initiated on ART through PMTCT programs as a key entry stream for ART enrollment targets.

### 4. Other priority and key populations

Outside of transitioning current clinical care patients, enrolling co-infected TB patients, and initiating HIV-positive pregnant women, most PLHIV are initiated through HTC programs linked to prevention platforms. PEPFAR teams should be able to describe with data how many newly initiating ART patients can be expected from entry streams 1-3 above. The remaining treatment slots necessary to achieve the enrollment target will need to come from PEPFAR HTC and prevention program activities.

### Column definitions and instructions for Standard Table 4.1.2:

1. Entry streams for ART enrollment –List all entry streams expected to contribute to ART enrollment. At minimum, the 4 streams described above should be included. A “Total” row is required.
2. Tested for HIV –Enter the total number receiving HTC for each entry stream and the total across all streams identified.



**TTFs:** The **Supplementary Data Pack** should be used to calculate the required number receiving HTC for “Other priority and key populations” using a cascade analysis approach.

**Note:** *The number tested for HIV for the “TB-HIV patients not on ART” stream should include only those tested in TB sites. TB-HIV patients newly initiated on ART currently receiving clinical care through ART sites should already be identified HIV positive.*

3. Identified positive –Enter the expected number identified HIV positive as a subset of column 2 for each stream and the total across all streams identified.

Note: The number identified positive for HIV for the “TB-HIV patients not on ART” stream should include only those tested in TB sites.

4. Newly initiated on ART –Enter the number of patients expected to be enrolled on ART for each stream and total across all streams identified. The total number newly initiating across all entry streams should equal the total number newly initiated in FY 16 in column 6 of [Standard Table 4.1.1](#).

### **Setting Targets for VMMC in Priority Locations and Populations**

New modeling tools are available to assist countries in identifying age groups of males at higher risk of acquiring HIV for VMMC to maximize the immediacy and magnitude of epidemic impact by 2030. In most countries, this is achieved by prioritizing VMMC coverage among males 15-29 yrs. Countries should articulate strategies to reach 80 percent circumcision prevalence: first, among males in the high burden SNUs/micro-epidemics; and, second, within those SNUs, among males in the highest priority age bands. Geographic areas and age groups with higher current levels of unmet need should be prioritized within the overall strategy, i.e., between SNUs of equivalent HIV burden, the SNU with lower circumcision prevalence should be prioritized (similar for age bands). PEPFAR teams are asked to present targeting decisions by priority population in [Standard Table 4.1.3](#) of the SDS.

**Note:** *PEPFAR teams are not required to outline VMMC targets by SNU in the SDS. However, the targets for VMMC should fall primarily within locations prioritized for epidemic control. If targets have been set for areas outside of those selected for program focus, teams will need to explicitly state their rationale in the narrative portion of [Section 4.1](#).*

Column definitions and instructions for [Standard Table 4.1.3](#):



1. Target populations –List each target population for VMMC focus in COP 2015 by age band.
2. Population size estimate (priority SNUs) –Enter the size estimate for each target population identified and the total across all target populations. *Size estimates and targets in this table should be restricted to priority locations selected to accelerate epidemic control.*
3. Current coverage –Enter the estimated current percentage of males circumcised in each identified target population within priority SNUs.
4. APR 16 target –Enter the proposed targets for VMMC as intended to report in APR 2016.
5. Expected coverage APR 16 –Enter the expected percent of males circumcised in each identified target population as of the end of USG fiscal year 2016 (September 30, 2016).

**TTFs:** The **Supplementary Data Pack** should be used to calculate the current coverage of VMMC by age band, set targets, and estimate coverage as of APR 16.

### ***Setting Targets for Prevention Interventions in Priority Locations and Populations***

Once teams have identified priority and key populations for focus in the selected SNUs, they should develop best-possible estimations of population size. See the FY 2015 Technical Considerations, the reference sheet for PP\_Prev in the 2015 MER Guidance and 2011 Guidance for Prevention of Sexually Transmitted HIV Infections for more information on size estimation. Teams should then develop a basic package of interventions for each population based on existing guidance from the above documents, and set coverage targets for each population based on an evidence-based hypothesis about the levels of coverage necessary to achieve population-wide reductions in incidence. For guidance on prevention for females 15-24, please see the PEPFAR DREAMS Guidance for Preventing HIV in Adolescent Girls and Young Women (forthcoming).

In 2015, UNAIDS will release targets for HIV prevention. These are likely to focus on key populations and females 15-24, with a target of a 75 percent reduction in new infections in each group globally by 2020. Interventions prioritized will likely include pre-exposure prophylaxis (PrEP) for both MSM and young females, cash transfers for vulnerable females, and VMMC for their sexual partners. PEPFAR will again not be able to fund the gap between current coverage of these interventions and the UN targets, but teams should begin quantifying the gaps in interventions we currently support.

Column definitions and instructions for **Standard Table 4.1.4:**

1. Target populations –List each population for program focus in SNUs prioritized for accelerated epidemic control in COP 2015. PEPFAR teams may add as many rows as needed to accommodate selected populations; however, *three populations are required to be included in the table: MSM, FSW, PWID*. A “Total” row is required.
2. Population size estimate (priority SNUs) –Enter the estimated population size of each populations selected for focus. *Estimates of population size should only be inclusive of priority SNUs*. If data for selected SNUs are unavailable, PEPFAR teams should include one of two letter codes:  
  

**NA:** “not available”—indicates no data are available from any source

**IQ:** “insufficient quality”—indicates data are available, but the quality does not meet reasonable standards
3. Coverage goal –Enter the percent of the selected populations for focus PEPFAR intends to reach in USG fiscal year 2016. This percentage to correspond to the value in column 4.
4. APR 16 target –Enter the proposed target for beneficiaries reached for each selected population. This value should correspond to the percentage in column 3.

### **Setting Targets for OVC**

PEPFAR teams should describe/map the OVC situation, select locations and populations for program focus; and set targets. Teams should provide a brief description of the data sources used and assumption made.

**Milestone:** Complete Standard Tables 4.1.1-4.1.5 in the SDS template and adequately address guiding questions in Section 4.1.

### **3.1.4 Planning Step 4: Determine Program Support and System-Level Interventions in which PEPFAR will invest to Achieve Epidemic Control**

Based on systematic review of the gaps and bottlenecks and structural and cultural barriers to achieving epidemic control described in Planning Step 1, PEPFAR teams should determine where and how PEPFAR should invest to address these obstacles in COP 2015. Typically, activities will occur above the site or at system-level. The primary measure for determining the value of these investments should be the effect the increase of support will have on the ability of countries to achieve stated goals for saturation of combination prevention and epidemic control. Therefore, PEPFAR teams will need to describe in **Section 6.0** of the SDS how each program support or system-level activity relates to the clinical and prevention cascade. Details about this logical framework are described below. In addition, several other criteria should be taken into account when determining where and how to invest in system-level interventions, including:

1. Comparative advantage

Based on existing mechanisms, special skills and/or expertise of implementing partners, capacity and resources of host country government and other stakeholders, and goals for sustainability of the HIV response, PEPFAR teams should assess if gaps should be filled or barriers addressed by PEPFAR or other entities. If it is determined PEPFAR has a comparative advantage, teams will need to describe how these investments have been considered in terms of medium- and long-term sustainability in the narrative portions of **Sections 6.1-6.3** of the SDS.

Similarly, teams should consider comparative advantage of USG agencies and partners when determining who will be responsible for implementing laboratory strengthening, strategic information (SI), health systems strengthening (HSS) and system-level activities. As with direct service provision, efficiency is paramount and utilizing or modifying the scope of existing mechanisms that house the appropriate skillsets will free up resources consumed by program start-up and administration. Finally, teams should take note of HQ agency additive programs, for example, USAID's work in domestic resource mobilization and CDC's work with HIV Impact Assessments.

2. Geographic and population focus

PEPFAR teams should consider how the program will shift given COP 2015 focus by location and population and assess if current laboratory strengthening, SI and HSS interventions are suited to directly impact the ability of the host country to achieve epidemic control for those high-burden areas/groups. Impact on the ability to saturate in these areas should not be diffuse, but logically linked and clearly articulated.

3. Core, near-core, non-core

Investments in system-level activities should be consistent with *interagency consensus* on what interventions are core, near-core, and non-core. *Non-core activities should not be funded in COP 2015.* Near-core activities should include transition plans in **Appendix A** of the SDS.

4. Limited resources require program trade-offs

Investments in laboratory strengthening, SI, HSS and other system-level activities should have a clear relationship to increase in uptake of combination prevention service and/or adherence, retention, and quality of services delivered.

5. Measurable deliverables are required

Though standard output and outcome metrics collected through PEPFAR reporting cycles are typically not directly attributable to system-level activities, in COP 2015 PEPFAR teams will be required to outline custom deliverables for each of these activities that can be monitored throughout the implementation year. Implementing mechanisms and agencies will be accountable for successfully completing each deliverable as outlined in **Section 6.0** of the SDS. Deliverables should be measurable and clearly linked to the stated goal for epidemic control.

PEPFAR teams are asked to describe their program strategy for filling critical gaps and mitigating barriers in **Sections 6.1-6.3** of the SDS. In the narrative portion for each section, teams should concisely describe the major activities that will be funded, link them to gaps and barriers identified in **Sections 1.0 and 2.0** of the SDS, and explain the rationale for how these activities will assist the host country government achieve epidemic control in locations and populations selected for program focus described in **Section 3.0**. In addition, teams are asked to complete a standard logical framework (log frame) table within each program activity for sustained epidemic control: laboratory strengthening, SI,

and HSS. The required format for this table can be found in the relevant sections in the SDS template.

Column definitions:

1. Program Activity – List all activities in laboratory strengthening, SI, and HSS that will be funded in COP 2015.
2. Deliverables – This column is divided into two parts: deliverables for USG fiscal year 2015 and USG fiscal year 2016. Deliverables for 2015 should describe in 250 characters or less **intended achievements** as of September 30, 2015. These deliverables should be accomplished with COP 14 or prior-year resources. 2016 deliverables should describe in 250 characters or less **planned achievements** as of September 30, 2016. Planned achievements should characterize the anticipated direct results of COP 2015 program funds. Deliverables should be quantitatively or qualitatively measurable by field staff and reviewers from headquarters (HQ).
3. Budget codes and allocation – This column is divided into two parts: historical and planned budgets. PEPFAR teams are required to specify the budget code and estimated U.S. dollar amount allocated to each activity for 2015 and 2016. 2015 is **historical** information and should be derived from COP 14. 2016 is **planned** information and should be consistent with agency, mechanism and budget code allocations.

**Note:** *PEPFAR recognizes field teams may not be able to determine with exact precision how much of planned resources are devoted to each activity, especially when the activity is funded through multiple budget codes. However, this information is crucial for assessing value and efficiency in these investments and teams should work with agreement/contract managers and implementing partners to develop defensible estimates.*

4. Associated implementing mechanism(s) – PEPFAR teams should identify which IMs will be responsible for the deliverables outlined in column 2. Please reference the HQ mechanism ID from FACTS Info.
5. Relevant Sustainability Index score – PEPFAR teams should identify which elements of the SID each activity will address and the associated score in the most recently completed SID. Not all activities will be directly linked to a SID score. If the activity does not have an impact on sustainability, teams should record “**NA**” in this column.

6. Impact on epidemic control – Laboratory strengthening, SI, and HSS activities should be linked to the clinical and prevention cascade for saturation of combination prevention interventions. PEPFAR teams are asked to indicate which elements of epidemic control will be impacted by each activity. Elements are as follows: HIV testing and counseling (HTC), linkage to care (LTC), ART uptake, other combination prevention, and viral suppression.

**Note:** *“Other combination prevention” includes one of the following program activity areas: VMMC, condoms, and prevention targeted to key and priority populations.*

Teams should indicate which elements of epidemic control are impacted by recording “X” in the relevant cell. In addition, teams may use the cell to succinctly describe the type of impact in 30 characters or less.

**Note:** *Planned evaluations should also be identified in this accompanying table. Only key information consistent with the table requirements should be included. More detailed and additional information (detailed in the Evaluation Standards of Practice document) regarding planned, ongoing, and completed evaluations will be collected in conjunction with the APR.*

**Milestone:** Complete Sections 6.1 – 6.3 of the SDS. Describe how program support and system-level interventions are linked to epidemic control and addressing sustainability issues identified in the Sustainability Index. Quantitative attribution not required.

**3.1.5 Planning Step 5:  
Determine the Maintenance Package of Services and Support in Other Locations and Populations and Expected Volume**

PEPFAR is obligated to ensure standards of care are upheld for the patients we support with life-saving care, treatment and support services. In the current environment there is an urgent need to shift program resources on the locations and populations where most new HIV infections are likely to occur. However, redirecting resources to enhance program focus must be accomplished through responsible financial and program planning with the host country government or other sources of support. In COP 2015, PEPFAR teams are expected to define a maintenance package of services

needed to maintain support for locations and populations not prioritized for accelerated epidemic control; outline transition plans for current programs that will be phased out and sites that will no longer receive PEPFAR support or how support will be consolidated to a district hospital or higher-level facility to increase efficiency; and determine an expected volume of beneficiaries that will receive the maintenance package of services defined.

Guiding principles:

1. PEPFAR should no longer support sites with HTC services where an adequate number of HIV positives are not identified.

In addition to discontinuation of PEPFAR-supported HIV testing at sites with less than four positives identified in the last 12 months, PEPFAR teams with site-level indicator data are expected to complete a full site yield analysis for HTC, including testing conducted at PMTCT sites. The purpose of this analysis is to determine where the majority of positives are identified and quantify potential cost savings or increases in yield that result from enhanced program focus on high-burden areas and populations. A full description of methods to conduct a site yield analysis can be found in section 3.3.3.

**TTFs:** The ***Supplementary Data Pack*** has been provided to PEPFAR teams to more easily conduct site yield analyses for HTC and PMTCT. This tool is linked to the ***Site Expenditure Allocation Tool (SEAT)*** to assist teams with quantifying the estimated cost savings or increases in yield that may result from redirecting resources to focus sites.

2. PEPFAR should work with the host country government and other stakeholders to transition support for low-volume ART sites or refer current patients to higher volume sites to improve quality of care.

PEPFAR-supported ART sites that provide services to a low volume of ART patients may not be able to provide the same quality of care as sites with higher volume and greater capacity. If resources for scale-up are to be focused in high-burden locations and populations, PEPFAR teams will need to determine which treatment sites in other

locations PEPFAR will continue to support with a core package of services (see next subsection) and which sites will be selected for transition.

PEPFAR teams with site-level indicator data are expected to conduct a site volume analysis for ART. The purpose of this analysis is to identify low-volume sites and determine the cost savings or additional patient slots that could be supported if PEPFAR resources are redirected to higher volume sites. A full description of methods to conduct a site volume analysis can be found in section 3.3.3.

**TTFs:** The ***Supplementary Data Pack*** will help PEPFAR teams more easily conduct site volume analysis for ART. This tool is linked to the ***Site Expenditure Allocation Tool (SEAT)*** to assist teams with quantifying the estimated cost savings or increases in volume that may result from redirecting resources to focus sites.

3. Program costs and trade-offs should be taken into account when determining maintenance support for other locations and populations.

Continuation of support to sites in areas not selected for prioritization in COP 2015 represents a cost to PEPFAR. After the site yield and volume analysis are conducted and interagency decisions are made about which sites will continue to receive PEPFAR support in the coming cycle, teams will need to estimate the required resources necessary to support the maintenance program (i.e., sites/program activities outside of the selected priority locations). To the extent possible, this should be driven by program data, expenditure data, and the expected volume of beneficiaries. For PEPFAR-supported ART sites, teams should factor in an estimate of passive enrollment and continuation of care for current patients supported with clinical care and ART. These calculations are described in more detail in section 3.1.5.

Resources needed to support the current volume of beneficiaries in *priority areas*, plus the resources needed to support the current volume of beneficiaries in *other locations* that will be maintained in COP 2015, represent the total dollars required to sustain the current



program, or the 'carrying costs.' Given a finite budget, this carrying cost will affect the resources available for other program activities and the magnitude of scale-up that can be achieved in priority locations. Section 3.3.6 describes methods for resource projections that can be applied to assist with estimating this resource requirement.

**TTFs:** The ***PEPFAR Budget Allocation Calculator (PBAC)*** is a resource projection tool that PEPFAR teams may use to estimate the required resources to fund program activities based on historical expenditure data.

### ***Define a maintenance package of services to maintain support for other locations and populations***

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Country teams should develop a package of services provided at PEPFAR-supported facilities and service outlets in other location sand for populations not prioritized for scale-up. The components of this package should be based on the host country's minimum/standard package of services for PLHIV but focused on essential HIV-related services and commodities. The components of this package will not be the same in every country and will depend on services provided by the host country government and other stakeholders. Essential components to be considered for a minimum package of services for other locations and populations include:

- HIV testing and counseling on request by a presenting client or as indicated by clinical symptomology or identified risk behaviors.
- Care services for PLHIV, including provision of cotrimoxazole, screening for TB and other opportunistic infections, provision of fluconazole or INH prophylaxis, condoms, PHDP package, etc. depending on the country context.
- Treatment services including routine clinic visits, ARVs, and care package.
- Essential laboratory services for PLHIV – capacity for HIV testing, EID, viral load and CD4 testing.

Teams should consider how implementing a *maintenance package* affects all parts of program support within a site where one or more program components would need to be transitioned to other stakeholders (e.g., MOH). Programs may transition at different rates, and there is expected to be a transition period for some program activities including OVC, VMMC, gender based violence, routine testing for pregnant women, key population outreach etcetera, and some above site-level support.

While PEPFAR programs phase out of active counseling and testing and new ART enrolment, PEPFAR service or technical support for other programs must be done as well through careful transition planning to ensure that harmful consequences are avoided. PEPFAR teams should communicate early and comprehensively with other USG health programs, the Global Fund and government to identify a clear transition plan that may include: uptake of services by the government or referral of clients to service delivery points in prioritized locations.

The maintenance package of services and transition activities will have an impact on the resources required to support programs in areas outside of those selected for prioritization in COP 2015. This package should be taken into account in estimating the budget needed to maintain support in other locations and populations (see planning Step 6 below). As concisely as possible, PEPFAR teams should describe the maintenance package of services provided outside of priority areas in the narrative of Section 5.1 in the SDS.

### ***Outline transition plans for sites and programs that will not continue to receive PEPFAR support***

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After teams successfully complete the site yield and volume analyses, define a core package of services, and interagency decisions are made about which sites will be supported with the core package in the coming cycle, plans for sites or other PEPFAR supported programs to transition to other stakeholders should be documented in **Appendix A, Table A.3** of the SDS. Additionally, teams are requested to concisely describe these transition plans in the narrative of **Section 5.2** in the SDS.

### ***Determine expected volume of beneficiaries***

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Teams must specify in **Standard Table 5.1.1** of the SDS the volume of beneficiaries expected to be reached with the core package of services outside of priority locations. In calculating these figures, teams should consider the following:

- Expected sites that will be supported *after* site yield and volume analysis (see Section XX.)
- Impact of transition plans on volume of beneficiaries supported by PEPFAR.
- Differences in HTC yield in areas not prioritized for epidemic control compared with scale-up (priority) areas.
- Differences in HIV testing positivity yield associated with passive testing (i.e., PITC) versus yield associated with all HTC activities.
- Differences in retention and LTFU in maintenance sites compared with scale-up sites.

Column definitions and instructions:

1. Maintenance volume by group – Five activity groups, each representing one row in the table, are required:
  - HIV testing in PMTCT sites
  - HTC (only maintenance ART sites in FY 16)
  - Current on care (not yet initiated on ART)
  - Current on ART
  - OVC

In the SDS template, the MER indicator code is listed next to each group.

2. Expected result APR 15 – Enter the expected result as of APR 2015 (September 30, 2015) *only for areas not prioritized in COP 2015*.
3. Expected result APR 16 – Enter the expected volume for each group in the implementation cycle. This should correspond to the expected APR result in 2016 (September 30, 2016) *only for areas not prioritized in COP 2015*.
4. Percent increase (decrease) – Enter the percentage increase or decrease in volume of beneficiaries for each group *only for areas not prioritized in COP 2015*. This can be calculated with the following formula:

$$(\text{Expected APR 16 result} - \text{Expected APR 15 result}) \div \text{Expected APR 15 result}$$

**TTFs:** The **Supplementary Data Pack** has been provided to assist teams with calculating the expected volume of beneficiaries in each of the groups listed in **Standard Table 5.1.1**. Use the “Maintenance” and “OVC” worksheets to determine the total targets for each group.

### TA/TC Consideration

TA/TC programs where there has not been any historical PEPFAR direct service delivery investments outside of priority geographic areas or key populations are not required to complete **Standard Table 5.1.1**; however, they will be expected to discuss transition plans for activities no longer prioritized in COP 2015 in the narrative of **Section 5.2** in the SDS.

**Milestone:** Complete Sections 5.1 and 5.2 of the SDS, including table 5.1.1.

### **3.1.6 Planning Step 6: Project Total PEPFAR Resources Required to Implement Strategic Plan and Reconcile with Planned Funding Level**

PEPFAR teams are expected to determine the cost to PEPFAR of activities planned for COP 2015. This “resource projection” should be based on the actual cost of services and support provided in the past with necessary adjustments for how activities and costs will change in the future. *The actual cost is not the same as the amount budgeted.* Teams should use cost and/or expenditure data to determine the resources required to achieve desired targets and program deliverables in the next fiscal year and verify this amount *does not exceed the planned funding level for COP 2015*. Resource projections should also be used to guide program decisions regarding priority locations and populations chosen for scale-up; core, near-core, and non-core activities; selection of core and maintenance packages for service delivery; and proposed targets.

Generally, there is paucity of cost data at the field level that can be utilized to better inform program decisions and feed into budget projections. In response to this critical data gap, PEPFAR institutionalized the Expenditure Analysis (EA) Initiative in 2012 and expanded to all PEPFAR OUs in 2014. Through EA, PEPFAR teams have data on the unit expenditure (UE) observed for achieving program results in the last, full implementation cycle. PEPFAR teams should use this information as a starting point for calculating the expected cost to PEPFAR of the program in the future. For a full description of EA, and use of financial and economic data in program planning more generally, please see the PEPFAR Technical Considerations 2015.

A strategic approach to empirically-based budgeting is described in detail in the methods portion of this section (3.3.6). When implementing this approach during COP planning, there are several guiding principles teams should consider:

1. Carrying costs to PEPFAR of current program activities should be calculated first.

As described in the section on maintenance above, PEPFAR will continue to support current PLHIV receiving clinical care and ART services in all sites until referral, consolidation or transition of site support to other stakeholders can be accomplished without compromising patients’ health. For maintenance sites (i.e., in areas not prioritized for epidemic control), PEPFAR teams should allocate sufficient funds to support the current cohort of patients enrolled in care and treatment, consistent with the maintenance package of clinical services defined. For low-volume and transition sites, the expected volume of beneficiaries should be

adjusted to account for transition of patients to support by other stakeholders. In addition, teams should determine the expected number of new patients will be enrolled in the implementation year in maintenance sites as a result of PITC and diagnosis. Calculating this carrying cost provides a sense of how much of the COP 2015 budget should be set aside prior to planning for any other activities or scale-up to meet PEPFAR obligations and maintain clinical standards of care.

2. Length of time enrolled should be taken into account when setting targets and projecting resources for care and treatment.

With the required congressional directive of 50% across the entire bilateral program care and treatment expenditures are not insignificant. Minor adjustments can have a large impact on the total cost of the clinical program and the number of patients that can be supported. One essential adjustment in any resource projection is the length of time a patient is receiving care over the implementation year—i.e., the cost-per-patient of a person initiated on ART in January will be different than the cost-per-patient of a person initiated on ART in July. Using the USG fiscal year as the discreet time period, the first patient would receive nine months of ART, whereas the second patient would receive three months, resulting in very different annual costs for each. When this principle is applied to the aggregate program, the enrollment rate matters and has an impact on the total estimated cost. Budgeting by multiplying the annual, average cost of ART by the total current on ART at APR 16 will substantially *overstate* the required resources needed to support the cohort since not all will be on treatment for a full year.

To correct for this time component, teams should use simple patient year calculations to determine the *equivalent number of patient-years* that would be expected given the number of patients enrolled at the start of the period, scale-up rate during the cycle, and the expected LTFU. This applies to both clinical services and commodities. This method is described in detail in section 3.3.6 below. EA results for pre-ART and ART unit expenditures are already adjusted using patient-year calculations.

3. Unit expenditures and unit costs used for resource projections need to be adjusted to reflect program activities and expected costs in the future.

At minimum, there are two adjustments that all teams should make prior to calculating resource projections:

- *Adjustments for program focus*

Based on the results of the site yield and volume analysis and selection of scale-up, maintenance and transition sites, teams should adjust the expected future UE based on the implementing mechanisms and sites that will be responsible for achieving targets in the implementation year. Costs vary across sites, geographic areas and implementing partners, which will impact the total cost of the program in the next cycle as the program shifts focus to higher-burden locations and populations. Data on the historical UEs for implementing partners at the geographic- level can be used to make these adjustments.

- *Adjustments for expected changes to program components or costs*

The UE from the last cycle may include expenditures that will not be expected in the coming cycle (e.g., purchase of a fleet of vehicles). Conversely, the UE may not include investments that are expected in the coming cycle (e.g., improvements to retention through enhanced provider training programs). These differences can be quantified and should be used to adjust inputs to resource projections. The same principle applies to adjustments based on expected changes in contribution of other sources of support (e.g., Global Fund).

**TTFs:** The ***PEPFAR Budget Allocation Calculator (PBAC)*** is a resource projection tool that PEPFAR teams may use to estimate the required resources to fund program activities based on historical expenditure data.

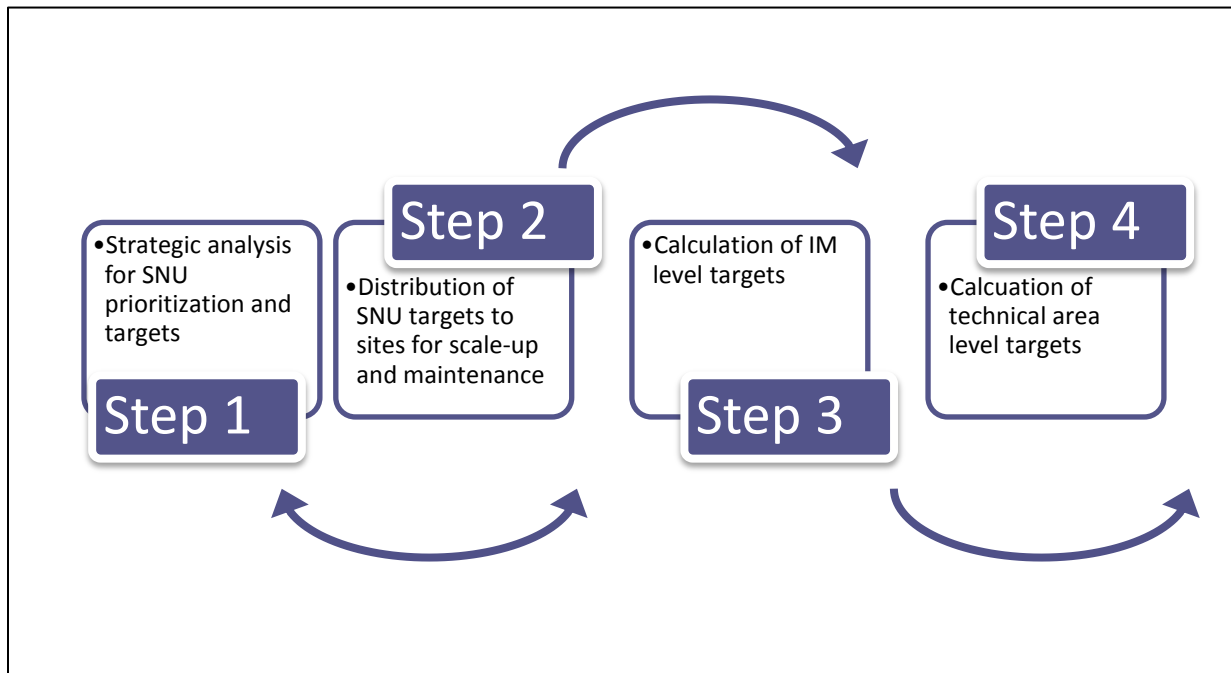
### **3.1.7 Planning Step 7: Set Site, Geographic and Mechanism Targets and Budgets**

COP15 will include five types of targets, all of which will be set for FY 16 results. FY 15 targets will not be restated in COP15.

1. **Site Level Targets** – Site level target setting allows for implementing partners to clearly articulate and set expectations for achievements at each PEPFAR-supported site based on supported activities and in alignment with geographic, population, and intervention-based prioritization efforts for scale-up or maintenance.
2. **Sub-national (ie. District) Level Targets** – Sub-national level target setting strategically demonstrates geographic prioritization of efforts towards the 90:90:90 by 2020 UNAIDS target in alignment with the distribution of the burden of disease in a country.
3. **Implementing Mechanism Level Targets** – Implementing Mechanism (IM) targets represent expected accomplishments for the implementing partner based on available funding and agreed upon activities. Target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements.
4. **Technical Area Summary Level Targets** – The PEPFAR Technical Area Summary Targets are an aggregated reflection of total expected achievements in a country based on the collective work of all PEPFAR partners, and should represent PEPFAR's contributions to the national program. These targets should reflect scale up for epidemic control in high disease burden areas and maintenance of programs in other areas.
5. **National Targets** – National data represent the collective achievements of all contributors to a program area, including PEPFAR (i.e., partner country government, donors, or civil society organizations).



## Target Setting Overview



### Recommended Process for Establishing and Entering Targets

- Country teams notify partners of priority areas and targets by SNU and work with partners to set relevant site-level targets
- Partners enter site-level targets into DATIM or other identified format
- Activity managers and project officers review and approve partner targets at the agency-level and confirm budgets
- Interagency PEPFAR team reviews and approves site, mechanism, and geographic targets

After teams have completed the geographic and efficiency analysis and set programmatic targets for priority areas and populations, these will need to be distributed to sites (facility and community). The strategic analysis conducted in Steps 1 -6 now need to be operationalized by assigning site-level targets, and calculating mechanism level targets and budgets.

## *Distribution of SNU targets to sites for scale-up and maintenance*

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In Step 3, scale-up and maintenance targets by SNU for all indicators were determined. These targets need to be distributed to sites.

### *Distribution of scale-up targets by SNU to sites*

1. Distribution of SNU targets across sites need to take into account the following considerations:
  - Past performance of partners at sites and capacity to expand site volume (including changing the monitoring time intervals)
  - Site yield for testing and volume for other services
  - The need to establish additional sites in catchment areas within a geographic region to meet the target
2. If additional sites are needed, then look at current partner's capacity to expand to additional sites.
3. Relevant site support should be determined by assessing site needs for commodities, human resources, or relevant technical support for expansion of services. This will determine the appropriate categorization of targets by DSD or TA-SDI support to the site.
4. If several partners are working across the continuum at facility and community sites, it is imperative that the partners coordinate to ensure no patients are lost across the continuum.

### *Distribution of maintenance targets by SNU to sites*

1. Resources need to be allocated to sites to maintain patients on ART, taking into consideration other critical programmatic areas of support such as OVC.
2. As described in Step 6, PEPFAR will continue to support current PLHIV receiving clinical care and ART services in all sites until referral or transition of site support to other stakeholders can be accomplished without compromising patients' health. For maintenance sites (i.e., in areas not prioritized for epidemic control), PEPFAR teams should allocate sufficient funds to support the current cohort of patients enrolled in care and treatment, consistent with the maintenance package of clinical services defined. For low-volume and transition sites, the expected volume of beneficiaries should be adjusted to account for transition of patients to support by other stakeholders. In addition, teams should determine the expected number of new patients will be enrolled in the implementation year in

maintenance sites as a result of passive HIV testing and diagnosis. A similar approach should be taken with OVC programs.

3. Relevant site support should be determined by assessing site needs for commodities, human resources, or relevant technical support for expansion of services. This will determine the appropriate categorization of targets by DSD or TA-SDI support to the site.

### *Implementing Mechanism Level Targets*

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Implementing mechanism targets should be calculated based on the site-level targets. Where more than one partner may reach the same individuals at a given site, country teams should take the opportunity to rationalize partners for increased efficiency. Implementing mechanism targets should not be determined prior to conducting Steps 1-6.

### *Technical Area Summary Targets*

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Technical area summary targets are a de-duplicated sum of the implementing mechanism targets. Given the programmatic pivots expected in COP15, targets may not follow the same trajectory as previous years. Furthermore, cascade analysis of targets will need to occur at a subnational level as opposed to the technical area level.

**Milestone:** As an Interagency team, you should be able determine technical area, mechanism, geographic and site-level targets. Targets should be entered in DTAIM (or approved substitute) and mechanism budgets and other required details should be entered into FACTS Info.

**3.1.8 Planning Step 8:  
Determine monitoring strategy for planned activities in accordance with  
requirements and assess staff capacity**

PEPFAR must continue to enhance oversight of and accountability for programs and ensure that PEPFAR-supported beneficiaries are receiving quality services and accounting for US tax payer dollars. Teams should consider how information from all data streams available to country teams will be used routinely throughout the year to monitor progress, ensure compliance with strategic plans outlined in the SDS, and course-correct where needed. PEPFAR teams should assess the current skills and time commitments of program staff to ensure sufficient capacity is available to meet monitoring requirements. Methods and tools to assess current staff time allocation and cost of doing business (CODB) can be found in section 8.1 of this guidance. In addition, new site monitoring requirements for all PEPFAR OUs need to be specifically addressed in COP 2015 development.

The Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of services and technical assistance, (2) ensure accountability of USG investments, and (3) maximize impact of the HIV epidemic.

Consistent with these goals, SIMS will promote compliance with global and national service delivery standards, and facilitate program improvement. SIMS data will be used to: (1) demonstrate the quality of services and TA at each site, (2) demonstrate accountability of USG investments by showing that quality is being monitored and improved where needed, and (3) prioritize quality improvement of core interventions where most important for epidemic control and impact.

SIMS assesses and scores PEPFAR programs at the facility, community, and above-site levels, measuring adherence to standards of care and service delivery and those entities supporting it. SIMS results confirm adequate compliance to standards and identify areas where improvements in PEPFAR-supported programs can be made. More recent and routine analysis will help to foster stronger public health monitoring and more timely and effective response.

The initial roll-out of SIMS is intended to demonstrate accountability of USG investment by systematically monitoring quality across all PEPFAR implementing agencies and partners. During the fourth quarter of FY 2014 and first quarter of FY 2015, teams operationalized SIMS and began to use the data to facilitate improvement. The remainder of FY 2015 (Q2-Q4) will focus on increased coverage and scale of SIMS in-country. Access to PEPFAR resources for COP 2015 will be contingent upon successful deployment of SIMS.



COP 2015 will be used to plan how PEPFAR posts will operationalize the SIMS Requirements post-FY2015 as described in the SIMS cable (see Appendix 10). In order to assist field teams plan and budget for the SIMS assessments, the ***SIMS Action Planner*** is available on the COP 2015 page on PEPFAR.net. This is a tool that may be used to plan the COP 2015 SIMS related site visits and should be based on sites in which PEPFAR partners will be active in the implementation cycle. PEPFAR teams are required to provide a summary of their COP 2015 site visit plan that includes information noted in the SIMS Action Planner *Summary* tab only.

As part of the development of the COP 2015 site visit plan, teams should carefully review the costs associated with conducting site visits, utilizing existing human resources and vehicles to conduct site visits. Should planning show that additional M&O needs are required, teams must rationalize (with data) any new SIMS related M&O requests.

## 3.2 Order of Planning Steps and Activities

The recommended planning steps described in section 3.1 are modular, meaning teams may complete each step in whatever order they choose depending on the PEPFAR program context and/or availability of staff time. Some steps can be done concurrently; other steps are dependent on the outcomes of prior activities and should be completed in sequence accordingly. Similarly, some steps may need to be revisited after further analysis and decision making. Finally, there are analyses/activities found in the methods section (3.3) that inform multiple steps and should be completed at specific points in the process to be most useful. PEPFAR field teams are encouraged to be innovative in their approach; however, some guiding principles are provided below. For ease of reference, the planning steps are as follows:

1. Understand the current program context
2. Assess alignment of current PEPFAR investments and program focus
3. Determine priority locations and populations and set targets to achieve goal for accelerated epidemic control
4. Document gaps and barriers to achieve goal for accelerated epidemic control and outline program support and system-level activities in which PEPFAR will invest
5. Determine core package of services and support, expected volume of services, and expected investment for other locations and populations
6. Project total PEPFAR resources required to implement program plans and reconcile with planned spending level
7. Set site, geographic and mechanism targets and budgets in accordance with strategic direction
8. Determine monitoring strategy for planned activities in accordance with requirements and assess staffing pattern to achieve goals and accountability of results

Guiding principles for order of planning steps and key analyses/activities:

1. The civil society engagement plan should be developed and implemented at the beginning of the planning process.

The intent of the civil society engagement plan is to engage early and often with organizations that offer valuable, on-the-ground information about the effectiveness of the current HIV response and viability of future plans. Teams should develop the plan and

begin implementation concurrent to all initial planning steps and activities (see sections 2.3.3 and 3.3.1).

2. Initiate strategic communication with external partners.

PEPFAR teams should consult with host country governments and external partners to signal potential changes in direction to program implementation and work with key stakeholders to share critical data elements and jointly plan for program shifts in focus to achieve sustained epidemic control (see section 2.3). Effective engagement and joint planning should result in increased allocative and technical efficiency and program impact.

3. Steps 1 and 2 should be completed prior to other planning steps and can be completed concurrently.

Understanding the program context and assessing the alignment of program investments is requisite to informed decisions about how PEPFAR will fill critical gaps and design programs to maximize the impact of investments in the pursuit of sustained epidemic control. There is no dependency between Steps 1 and 2 and they may be completed concurrently to use time efficiently.

4. Initial site yield and volume analyses should be completed prior to Steps 3-8.

The results of the initial site yield and volume analyses (see Section 3.3.3) should inform decisions about geographic and population prioritization; targets at the site, mechanism, and SNU levels; establishment of maintenance package; transition plans; resource projections; and the monitoring plan and Management and Operations (M&O) activities, especially the implementation of SIMS. The site yield/volume analyses can be completed concurrent to Steps 1 and 2 to use time efficiently; however, it is likely the analyses will need to be revisited from time to time as other steps are completed and decisions made.

5. Quantification of cost savings and productivity gains should always accompany site yield and volume analysis.

As teams complete the site yield/volume analysis, it is recommended the results of each scenario are linked to resources freed up by redirection of PEPFAR resources or increases in productivity that result from enhanced program focus (see Section 3.3.4).

Used in tandem, these analyses will inform program decisions made in completing future steps.

6. Initial core, near-core and non-core program activities should be established after completing Steps 1 and 2.

The results of planning Steps 1 and 2 should form the backdrop for initial, interagency decisions about which program activities will be classified as core, near-core, or non-core in the implementation period (see Section 3.3.1). It is likely this activity will be iterative and decisions will need to be revisited as other planning steps are completed.

7. Steps 3-5 are dependent and should be completed concurrently.

As teams make decisions regarding geographic and population focus (Step 3), set targets for epidemic control (Step 3), and determine activities that will fill critical program gaps (Step 4), they must also determine what the minimum package will look like in other areas and the expected volume of beneficiaries that will receive the minimum package (Step 5). Given a fixed funding level, trade-offs will need to be made that affect the ability of the program to scale and invest in laboratory strengthening, SI and HSS activities. These steps are dependent on each other and each will likely need to be revisited as different scenarios are considered.

8. Steps 6 and 7 are dependent and should be completed concurrently.

Teams are required to project the required resources needed to implement the planned program and verify the program cost is within the planned spending envelope (Step 6). This will require estimating the total program cost, which will partially be determined by decisions made in Steps 3-5. Additionally, accurate resource projections will require adjustments to cost inputs resulting from shifts in program focus and partners selected to increase scale (see section 3.3.6). As such, teams should iteratively complete steps 6 and 7 and make adjustments to each as needed. Completion of Steps 6 and 7 may also require teams to revisit decisions made in Steps 3-5.

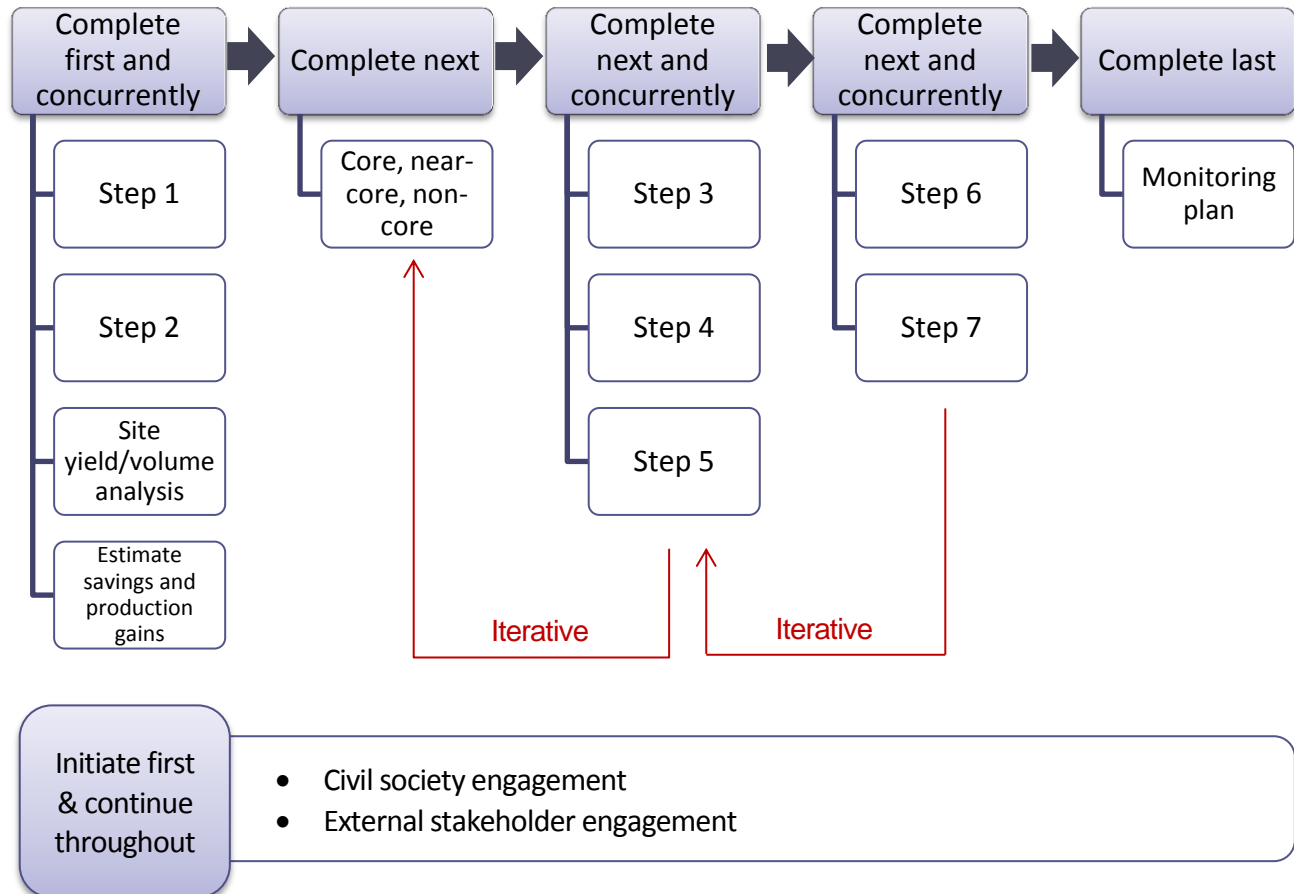
9. Step 8 should be completed last.

Teams should wait to determine the monitoring plan and assess staff capacity after Steps 1-7 and all other required analyses and activities have been completed. This is particularly true for defining the SIMS implementation plan and the impact on cost of doing business.



Figure 3.2.1 below summarizes these guiding principles.

### 3.2.1 Recommended Order of Planning Steps and Key Activities/Analyses



## 3.3 Methods

The sections below provide guidelines for completing activities and analyses necessary to successfully implement the modular planning steps in section 3.2 and generate a comprehensive SDS.

### 3.3.1 Core, Near-core, and Non-core Program Decisions

PEPFAR's success will be measured by how effectively we target and tailor our efforts, together with our partners, towards controlling the epidemic. In this third phase, PEPFAR has three guiding pillars:

- **Accountability** – Cost-effective programming that maximizes every dollar
- **Transparency** – Sharing program data
- **Impact** – Sustained control of the epidemic through saving lives and averting new infections

Moreover, PEPFAR is focused on delivering ***the right thing, in the right place, at the right time.*** What we do and where we do it matter, but when we do it is also vital to maximize our impact. Specifically:

- The **right thing** means focusing on the highest impact interventions. When we focus on these interventions and bring them to scale, we see tremendous results. When we fail to focus and/or to reach scale, progress is slow or stalls.
- The **right place** means focusing our resources in key geographic areas, including at the sub-national level, and reaching the most vulnerable populations.
- The **right time** means getting ahead of and ultimately controlling the epidemic. Continually fighting an expanding epidemic is not programmatically or financially sustainable.

With the globe and PEPFAR focused on controlling the epidemic in each country to achieve a sustainable response, how we approach our work in PEPFAR is changing. We have a role in supporting countries to reach their 90-90-90 and saturation goals and we can be counted on to:

- Deliberately focus on core combination prevention interventions
- Assess which investments are core, near-core and non-core to PEPFAR within each country context and make budgetary decisions accordingly
- Evaluate each site's performance and focus geographically and by site for all care, treatment and prevention interventions
- Ensure transparency and the use of real-time data for performance-based decision-making and to ensure maximum impact

- Identify and support strategic approaches to ensure sustainable epidemic control where appropriate.

Whether a PEPFAR country program is classified as long term strategy (LTS), targeted assistance (TA), technical collaboration (TC), co-finance (LTS/TA), or served from a regional platform, greater integrated data analysis and interpretation will underpin team decision-making in the third phase of PEPFAR. Moreover, programs will continue to take strategic action to focus resources geographically and programmatically to save lives and prevent the spread of HIV. This will require PEPFAR teams to examine epidemic, programmatic, financial, and expenditure data in a more sophisticated and integrated manner. Teams will also be required to assess where PEPFAR fits within a national response to accelerate scale-up of the highest impact interventions.

Based on scientific evidence in June 2014, Ambassador Deborah Birx described the following core activities as the **“right things”** to maximize efforts to reach sustainable epidemic control:

- Combination Prevention (PMTCT, ART, Condoms, VMMC)
- Prevention (effective/targeted)
- OVC –services for families that have been specifically shown to impact children
- Neglected & Hard to Reach Populations
  - Pediatrics
  - Young women
  - Key populations – MSM & transgender persons, sex workers, people who inject drugs
- Strengthening Health Systems as specifically required to support the core activities
  - Human resources for health, procurement & supply chain, laboratory, and strategic information

### ***Defining a PEPFAR Country Team’s Core, Near-Core, & Non-Core Activities:***

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The purpose of this exercise is to ensure that the core activities described above are being scaled within the national response at a rate, coverage level and in a quality manner to achieve sustainable epidemic control. It is designed to ensure that PEPFAR country programs are supporting the scale-up, quality, and where appropriate, sustainability of these core activities within the national response. However, it does not mean that PEPFAR has to directly support or engage in all of these areas.

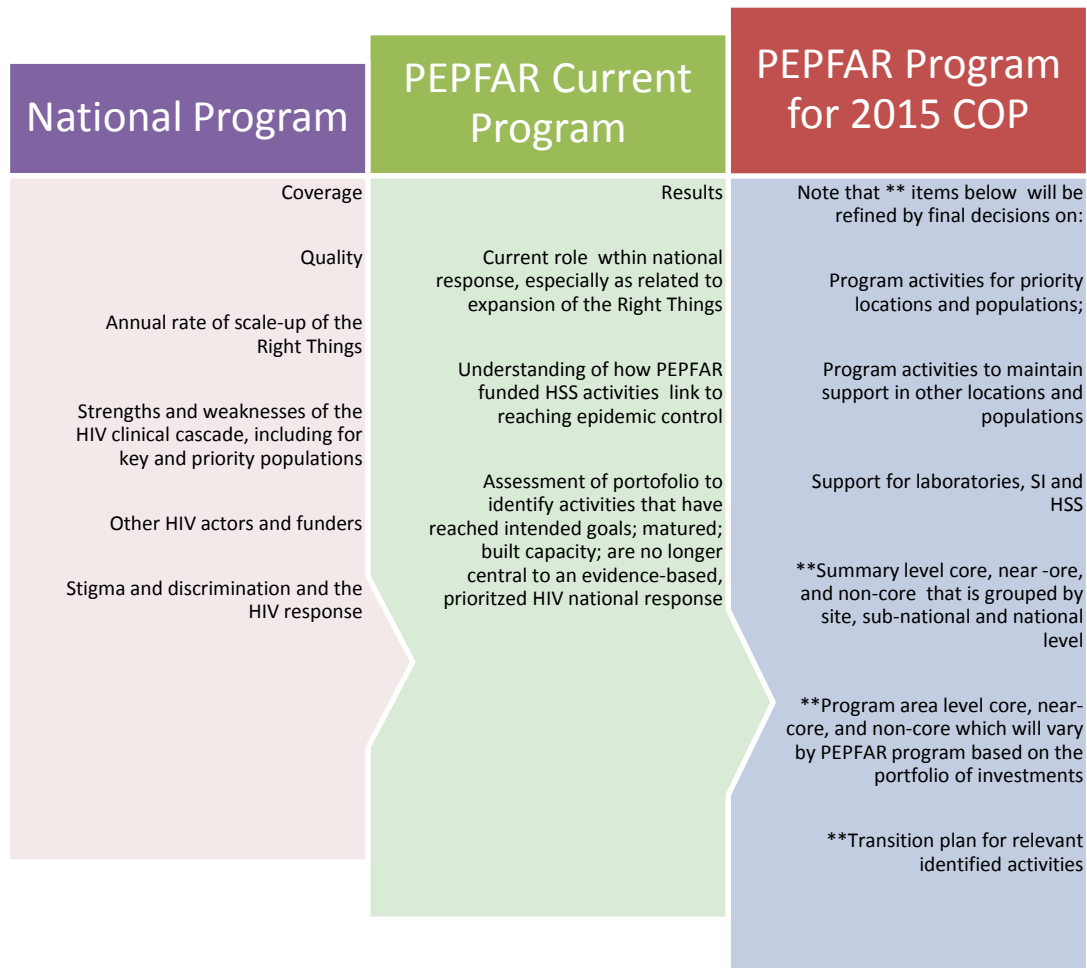
For a team to set and/or validate its role in the national response, each PEPFAR team needs to have a clear understanding of the progress of the national response in coverage and quality of the “right things”; any gaps and/or challenges that exist and/or are anticipated; and how other actors contribute

in these areas. PEPFAR teams should examine the HIV clinical cascade for strengths and weaknesses as well as how PEPFAR-funded health systems strengthening activities support reaching sustained HIV epidemic control. Also, PEPFAR teams will need to critically review their current portfolio to assess if there are activities or components of activities that can be transitioned away from PEPFAR funding for any of the following reasons: capacity has been built and can be transferred, including when the country is able to sustain activities with limited or no PEPFAR support; the activity is being addressed by another resource stream; the activity has matured and/or reached its intended outcome; and/or the activity is no longer central to an evidence-based, prioritized national HIV response. Teams may choose to define their core, near-core and non-core activities in three steps:

1. Review of PEPFAR's role at the national, sub-national, site level
2. Review of PEPFAR-funded activities by program area
3. Re-review of initial core, near-core and non-core findings (at national and program area(s) level) once program activities for priority/other locations and populations have been determined

Because each national planning process is at a different stage, PEPFAR teams will design their approach to this exercise in a way that takes into account their national context and builds on and leverages national processes and information.

Finally, for this exercise, it is important to recognize that epidemic control is the primary goal of PEPFAR programs. To the extent that this goal is reached, PEPFAR teams will need to consider the sustainability of these gains in partnership with local governments, civil society, and other multilaterals including UNAIDS and the Global Fund.



Previously released definitions for core, near-core and non-core activities apply in the development of the 2015 COP. They are listed below for your reference. Also, note for PEPFAR country-teams with existing COP commitments to the Pink Ribbon, Red Ribbon partnership, these will be classified as near-core. Expansion of these commitments can be classified by relevant teams as core, near-core or non-core. Teams will reflect decisions in SDS Table A.1 and A.2.

### ***Core, Near-Core, Non-Core Definitions:***

Long Term Strategy Countries: These are countries in need of external support for HIV/AIDS programs for the long term, based on prevalence, resource need, Global Fund financing, unmet service needs, capacity gaps, and U.S. geopolitical interest.

- **Core** - Activities critical to saving lives, preventing new infections, and those which PEPFAR is uniquely positioned to undertake.

- **Near-Core** - Activities that are critical to and/or directly support achieving core activities and that cannot yet be done well by other partners or the host government.
- **Non-Core** - Activities that do not directly serve our HIV/AIDS goals and/or can be taken on by other partners.

Targeted Assistance Countries and those supported through Regional Programs: These are countries receiving specific support for key populations or priority technical areas. USG activities largely support capacity building and technical assistance. May provide direct services for key populations.

- **Core** - Activities critical to saving lives, preventing new infections - and which USG is uniquely qualified. *Primarily focused on key populations – MSM, TG, FSW, PWID – and stigma and discrimination.*
- **Near-Core** - Short term/time-limited investments/activities that are critical and/or directly support achieving core activities and cannot yet be done well by other partners or the host government.
- **Non-Core** - Activities that do not directly serve our HIV/AIDS goals and/or can be taken on by other partners.

### ***Non-Core Transitions:***

It is the expectation that those activities designated by a PEPFAR teams as non-core will be transitioned within in a 12-month timeframe and the transition plan summarized in SDS [Table A.3](#).

PEPFAR teams should document interagency decisions on core, near-core, and non-core activities and support in [Appendix A](#) of the SDS, [Standard Tables A.1 and A.2](#). In addition, teams should describe, as concisely as possible, major decisions in COP 2015 development regarding program focus by activity area in [Section 2.0](#) of the SDS.

In [Standard Table A.1](#), all major program activities should be recorded and assigned to the columns indicating core, near-core, or non-core. In addition, teams are asked to classify the activity by row as *primarily* implemented at the site-level, sub-national level, or national level. Regional programs may add a row marked “regional” to describe activities above country-level.

In [Standard Table A.2](#), teams are asked to classify *components* of major activity areas as core, near-core, and non-core. The following rows are required in this table:

- HTC



- Care and treatment
- Prevention
- OVC
- Laboratory strengthening, SI and HSS

### 3.3.1 Civil Society Engagement Checklist and Documentation Process

PEPFAR teams are expected to engage with civil society during the development of COP 2015 (see section 2.3.3 above).

#### *Civil Society Engagement Checklist*

##### *Preparation*

- ☐ Develop a strategy and timeline specific to the country for engaging civil society based on the principles put forth in the Technical Considerations.
- ☐ Consult with country partners (UNAIDS, Global Fund, Other Bilateral Donors, Country Governments) for a list of potential civil society partners to engage.
- ☐ Disseminate a Request for Participation to various stakeholders through mail, email or other outreach methods.

##### *Engagement*

- ☐ Hold initial meetings with civil society introducing the PEPFAR planning process, potential avenues of engagement with civil society, and the overall timeline of the PEPFAR COP and other relevant processes.
- ☐ Set a time for the initial PEPFAR COP civil society engagement meeting.

**Note:** *This may need to be over the course of several meetings depending on the size/areas of discussion in the PEPFAR COP process.*

- ☐ Prepare background information for civil society Members and disseminate it at least two weeks before the meeting, allowing for time for any questions to be asked before the formal meeting. Background Information should include:
  - Previous COP
  - Overview (e.g., PowerPoint slide deck) of current COP 2015 priorities, shifts, considerations, etc.
  - Evidence supporting the policy and programming decisions of the current COP
- ☐ Host the meeting and ensure that civil society provides written recommendations to PEPFAR
- ☐ Host a meeting with civil society and provide written feedback to civil society on PEPFAR perspectives on civil society recommendations.

**Note:** *Other avenues of civil society engagement (technical working groups, community advisory boards) can follow the basic format of the COP process.*

##### *On COP Approval: Follow Up/Evaluation Survey*

- ☐ Upon final COP approval, PEPFAR country teams should provide written feedback, on why civil society comments were included or excluded in the COP planning process.



- ☐ Upon final COP Approval SGAC will provide a standard survey to civil society organizations to document and assess how the civil society engagement process was conducted, what strategies were most effective in leveraging improvements in the COP planning decisions, and what other avenues they would like to be engaged in PEPFAR planning, and what can be improved for next year.

**Note:** OGAC will provide a standard evaluation survey tool for teams to use or adapt/adopt later in 2015.

### *Follow Up/Evaluation Survey*

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- ☐ Provide written feedback, on why civil society comments were included or excluded in the COP planning process.
- ☐ Provide an evaluation survey to civil society organizations to document how the process went, what other avenues they would like to be engaged in PEPFAR planning, and what can be improved for next year. Note: OGAC will provide a standard evaluation survey tool for teams to use or adapt/adopt in early 2015.

### *Documentation Requirements for COP 2015*

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A supplemental document (no more than two pages) is required to describe the process and results of the civil society engagement strategy. **The Civil Society Engagement Process Documentation should be uploaded to FACTS Info as a supplemental document at the time of COP submission.** To complete this requirement, PEPFAR teams should respond to the following:

- A- Please describe the process used to fulfill the requirement to consult civil society, incorporate feedback, and brief civil society on the final COP 2015 submitted to headquarters. Name the organizations or networks that were consulted, the process used to determine which organizations were invited to the consultation, as well as the constituencies each represented. If there were any key constituencies not represented or groups who sought involvement who were not included explain the efforts made to engage them.
- B- Answer Yes or No to the questions below:
  1. Did civil society have an opportunity to provide suggestions on goals, priorities, targets, budgets to PEPFAR team ahead of COP 2015 plans being developed?
  2. Was a basic overview of the COP process given, as well as guidance on how and when organizations could provide input?

3. Were any capacity development services provided, including helping civil society members understand how to make use of available data on epidemiology and PEPFAR programming?
4. Did the team work with the U.S. Embassy, UNAIDS and other technical partners to engage civil society?
5. Was ongoing contact established or maintained with a diverse group of civil society organizations and what are the plans for ongoing contact?
6. Were draft goals, objectives, budgets and targets for COP 2015 by program area discussed?
7. Were changes highlighted from prior year programs and their expected impact?
8. Were SAPR/APR and other performance data shared?
9. Was impact modeling utilized?
10. Were changes in PEPFAR targets and strategies over time included?
11. Were discussions held on the role of local civil society in the response?
12. Was information shared about USG funding available to civil society?
13. Were local civil society advocacy efforts discussed such as:
  - a. Increasing government transparency and accountability
  - b. Increasing quality and uptake of services
  - c. Decreasing stigma and discrimination
  - d. Promoting sustainability of efforts to achieve epidemic control

Please provide a brief written response to each question below:

- A- What were the major issues or suggestions made by civil society about specific COP goals and targets?
- B- What was the impact of these conversations and/or how were comments provided by local civil society incorporated into the COP 2015?
- C- What method was used to provide feedback to civil society groups regarding the impact of their participation, including an explanation of why suggestions were or were not incorporated into the final COP?
- D- Please provide the following information from the COP planning budget process.
  - What percentage of new FY 2015 program funding (minus the M&O budget) will be received by Prime Partners who are local civil society organizations? *This should be available as a MER auto-generated indicator.*

- If feasible, estimate the percentage of new FY 2015 program funding received by local civil society organizations as sub-recipients?

E- Include the Civil Society Engagement plan as an annex to the supplemental report.

1. What are the key engagement activities the PEPFAR team will conduct in FY2015?
2. What civil society organizations will your team continue to engage with throughout FY2015?

F-Include as Annexes the Written Recommendations from Civil Society and the feedback from PEPFAR Country Teams.

### 3.3.3 Site Yield and Volume Analysis

Given a fixed resource envelope smaller than the resource gap, tough decisions will need to be made in most countries about where PEPFAR provides services or support. Sites with low-volume, and particularly, low-yield should be critically assessed to determine if operations resources could be directed towards other sites or interventions to get a higher net program output and/or epidemic impact. To answer this critical question, operational definitions must be established for 'low-volume' and 'low-yield.' There is not a single definition that can be applied across countries and PEPFAR program areas and the threshold used to define low volume and yield should be driven by historical data.

*All PEPFAR teams **with site-level results** are expected to complete a yield analysis for HTC sites, including testing for pregnant women through PMTCT sites and a volume analysis for ART sites.*

#### TA/TC Consideration

Given the types of support provided, TA/TC programs typically do not have the same volume of PEPFAR site-level results as LTS programs. TA/TC programs are required to complete site-level yield and volume analyses on any PEPFAR data available, but are also encouraged to access national site-level results, whenever possible, to complete a similar yield and volume analysis. This exercise will likely provide deeper insights into country program focus and resource alignment to assist with PEPFAR program planning and provides an additional tool for stakeholder engagement.

**TTF:** The **Supplemental Data Pack** is provided to field teams to assist with data organization and completing yield and volume analyses (see descriptions in text below).

#### *HIV Testing and Counseling Yield Analysis (HTC and PMTCT sites)*

The purpose of this exercise is to quantify the number and percentage of sites where the most HIV positive individuals are identified, and conversely, the number and percentage of sites where the fewest number of HIV positive individuals are identified relative to others. The results of this analysis

should guide program decisions about where PEPFAR will invest to maximize program output. To effectively complete this analysis, the following three data elements are critical to review:

1. The absolute number of positives by site
2. The positivity rate by site
3. The cumulative number and cumulative percent of positives at any specific point in the distribution

PEPFAR teams are expected to summarize their findings in the corresponding sections in the SDS—[Section 4.5](#) (HTC) and [Section 4.4](#) (PMTCT). In the **Supplementary Data Pack**, worksheets “HTC yield” and “PMTCT yield” are provided to assist field teams organize site-level data and summarize their results in standard figures that can be inserted directly into the SDS.

The organization of data in the **Supplementary Data Pack** and the presentation of results in [Standard Figures 4.4.1](#) and [4.5.1](#) in the SDS is the first step in conducting a site yield analysis. Field teams are also expected to summarize the results in terms of high and low yield classification. As stated above, ‘high’ and ‘low’ yield must be operationally defined by the PEPFAR team and the threshold used to classify sites should be reflective of the distribution. For example, identifying sites as ‘low yield’ where fewer than 10 HIV positive individuals are identified in the last year may not be reflective of the distribution if 95 percent of all supported sites identified more than 10 positive individuals. As a starting point for this investigation and identifying appropriate thresholds, teams may use one of the methods described below. This exercise will likely be iterative as the results are tied to resources (see section 3.3.4 below) and considered in decision making.

#### **Method 1: “80/20 rule”**

Country teams can use the **Supplementary Data Pack** to classify sites as low-volume or low-yield using the “80/20 split test” to focus attention on sites with relatively lower performance (as measured by yield.) Specifically, the question to answer is: *What percentage of sites account for 80 percent of program yield?* Once the data are sorted largest to smallest by number of positive individuals identified at each site, the point in the distribution where the cumulative percentage of positive individuals equals 80 percent will indicate the percentage of sites that account for those positive individuals. This method will also allow users to identify the number of HIV positive individuals per year, per site that would establish the threshold for being classified ‘low yield.’

#### **Method 2: “(X) times greater UE”**

The EA results can be a useful resource in identifying sites with relatively low performance and may help identify a threshold number of positives per year, per site used to classify sites as ‘low’ and ‘high’ yield. Though site-specific data are not currently available, unit expenditures (UEs) have been calculated for each partner working in each SNU (one level below national). Often “outliers”—those observations with higher than expected UEs—are driven by lower relative volume or yield or less efficient models of service delivery. To focus attention on sites with relatively lower performance (as measured by UE), country teams can set an acceptable range for UE and review outliers using the **EA Data Navigation Tool** (see Outlier Analysis in section 3.3.5 below). The outer bound of this range would be defined as (X) times greater than the average across all partner and SNUs for a specific UE. This allows teams to focus on partners, SNUs or sites where resources may not be utilized as efficiently as possible, resulting in lower relative yield and impact than could otherwise be achieved.

Other methods may be considered, but teams should complete an analysis that identifies low-yield sites using objective criteria. Identifying a site as low-yield does not necessarily result in discontinuation of services/support, especially if the site operates in a geographical focus area; however, the analysis will highlight areas where a performance improvement plan may be needed and help determine if additional investments in the site are sensible.

### **ART Site Volume Analysis**

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In addition to the yield analysis described above, PEPFAR teams with site-level ART data are expected to conduct a site volume analysis for ART. Two data elements are critical to effectively complete this analysis:

1. The absolute number of current on ART by site
2. The cumulative number and cumulative percent of current on ART at any specific point in the distribution

PEPFAR teams are expected to summarize their findings in the corresponding section in the SDS—**Section 4.8** (Adult ART). In the **Supplementary Data Pack**, worksheets “HTC yield” and “PMTCT yield” are provided to assist field teams organize site-level data and summarize their results in standard figures that can be inserted directly into the SDS. In addition to this analysis, teams are expected to classify sites as ‘low’ and ‘high’ volume as described in the yield section above. Both the *80/20 split* method and *(X) times greater* method are useful as starting points for the site volume analysis.

## *Using the Results of Yield and Volume Analysis*

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The HIV testing site yield analysis and ART site volume analysis should be used in conjunction with the efficiency analysis results; geographic and population prioritization; and core, near-core, and non-core determination to make decisions about which PEPFAR-supported sites will be prioritized for scale-up and which sites will be maintained or transitioned in the implementation year. *These decisions should be succinctly described in the SDS in the corresponding sections for HTC, PMTCT and ART.*

*Teams are also required to include in the **Goal Statement** narrative of the SDS the **total number of sites that are assigned to each of the following categories:***

- 1. Scale-up** (prioritized in implementation period)
- 2. Maintenance** (supported with maintenance package of services)
- 3. Transition** (PEPFAR support discontinued in implementation period)

Sites prioritized for scale-up should generally be 'high' yield/volume per the operational definitions assigned by the country team. Additionally, sites defined as 'low' yield should generally be classified as 'maintenance' or 'transition' and not prioritized for scale-up. Further, analysis results across HTC, PMTCT and ART sites should be triangulated prior to making decisions about site classification. There is no step by step guide to how to accomplish this task, and the process will be iterative, likely requiring multiple rounds of data review and interpretation. Additionally, this information will need to be considered within the local context; for example, epidemiologic data describing the size, location and HIV burden in key and priority populations, the current status of the national B/B+ implementation plan and the current HRH and HSS challenges will all be important to consider.

For each program area, (ART, HTC, and PMTCT) there are three broad categories of information that should be used to decide which group to place a PEPFAR supported site within:

1. Estimate of unmet need within the sub-national unit should be used to inform programs where additional support is needed and be consistent with geographic and population prioritization decisions
2. Location of sites in relation to each other (ie. are ART, HTC and/or PMTCT sites co-located in the same facility and/or located in the same sub-national unit) should be used to ensure that prioritization decisions are consistent and integrated across all program areas.

3. Location and size of key and priority populations and the services targeted to these populations should be used to ensure hot spots are prioritized.

Further, there are a number of guiding principles teams should consider prior to making decisions about which sites will be prioritized for increased resources and program scale-up:

1. PEPFAR should no longer support sites where four or fewer HIV positives have been identified in the last 12 months.

Consistent with the country cable distributed on September 17, 2014 (see Appendix 12), PEPFAR programs should stop supporting HIV testing at HTC and PMTCT sites that have identified two or fewer HIV-positive individuals during the last six-month SAPR period or four or fewer HIV-positives during the last 12-month APR reporting period. For PMTCT, teams should also consider if these sites provide ART to pregnant women. If so, the results of the volume analysis of ART sites should be triangulated prior to making decisions regarding discontinuation of PEPFAR support.

2. Analysis should be completed first on the entire data set, and then adjusted for geographic focus.

Teams should conduct the site yield and volume analyses described above on the full data set—i.e., including all sites with data over the last reporting cycle—and present/describe summary results for HTC, PMTCT, and ART using the total sites reporting in APR 2014 as the denominator. Once the yield/volume in each of these program areas has been characterized for the existing program, the team should determine how the sites classified as 'low' and 'high' yield align with geographic and population prioritization decisions.

3. Analysis should be based on empirical data, not what is "expected."

Consistent with guiding principle two above, actual results should be used to conduct site yield and volume analyses. Teams should not impute what the expected positivity rate would be in the future as a basis for decision making, unless there is strong empirical evidence that suggests otherwise. If any data are imputed, it must be clearly stated in the SDS in the relevant sub-sections of **Section 4.0** (HTC, PMTCT, and Adult ART).

4. Low-yield sites in focus areas require additional scrutiny.



Sites classified as 'low' yield that operate in areas prioritized for scale-up should be highly scrutinized to determine if support to these sites can be discontinued without interrupting services for priority populations, and/or if quality issues are impeding the ability of the sites to scale at a pace required for attaining the stated goal for epidemic control.

5. The number of maintenance or transition sites should be de-duplicated when counting sites PEPFAR will no longer support in the future.

It is likely the site yield and volume analysis across HTC, PMTCT and ART programs will produce overlapping results—i.e., the same sites will be identified as 'low' yield in each program area analysis. Teams should look across platforms to consider co-location of services and how this impacts the total number of sites the team is reporting that will enter a maintenance state, and the total number of sites PEPFAR will no longer support and will be transitioned in the implementation period. In reporting the total number of sites classified as scale-up, maintenance or transition in the **Goal Statement**, teams should not count the same sites more than once.

### **Milestones:**

- Complete yield analysis for HIV testing in HTC and PMTCT sites and volume analysis for ART sites.
- Insert yield and volume analysis graphics from Supplemental Data Pack directly into the relevant sections in the SDS—HTC (Section 4.5), PMTCT (Section 4.4) and Adult ART (Section 4.8)—and succinctly describe findings in the narratives.
- For each program area, classify sites as prioritized for scale-up, maintenance, or transition; de-duplicate sites repeated more than once in each category; calculate the total number of sites for each category and report in the Goal Statement of the SDS.

### 3.3.4 Quantifying Cost Savings and Productivity Gains from Site Analysis

In addition to completing the site yield and volume analyses described in section 3.3.3, PEPFAR teams are expected to estimate the cost savings and/or increases in productivity that result from enhanced program focus. Cost savings may result from discontinuation of support to sites classified as 'low' yield and 'transition' as the resources that would be consumed by supporting these sites in the coming year would be available to use in sites prioritized for scale-up or in other program interventions. Productivity gains, in this context, refer to increases in program output that would result from re-investment of cost savings in higher-yield or higher-volume sites. For HIV testing in HTC and PMTCT sites, productivity gains would be represented by increases to the yield—i.e., percent of HIV positives identified—with the same total resources allocated to these programs. For ART, productivity increases would be characterized by the percentage increase in the number of PLHIV served with care and treatment given the same total resources allocated to these programs.

Quantifying cost savings and productivity gains can be accomplished with the following steps:

1. Determine sites that will no longer receive PEPFAR support in the implementation year (transition) for each program area (HTC, PMTCT, and ART.)
2. Estimate the resources required to support these sites in the most recent annual period using empirical expenditure data.
3. Determine how cost savings would be reinvested, both by program area and location (SNU.)
4. Calculate the potential increases in yield and volume that result from reinvented resources.

In practice, this analysis can be quite complex. For example, site-level expenditure data is not currently available; however, EA data are available at the level of mechanism and SNU and can be mapped to sites identified for transition. Similarly, to accurately calculate increases in productivity, empirical data on positivity rates by site in focus areas must be used.

To assist field teams with this analysis, the **Site Expenditure Allocation Tool (SEAT)** is provided and pre-populated with country specific data. This tool allows for rapid calculation of cost savings and productivity gains and can be used iteratively in scenario analysis as teams define 'low' and 'high' yield/volume thresholds and sites that will be targeted for transition.

There are several caveats to this type of analysis that should be considered:

1. The **SEAT** establishes a modeled counterfactual (2013) to help focus program refinement and does not model future impact

2. The results assume the infected population in areas where resources are reinvested are large enough that additional testing/volume of that magnitude is possible
3. The results assume 'high yield/volume' partners can produced at same rate with the additional volume
4. The results assume funding can and should be redirected (e.g., obligations, contracts, etc.)
5. The analysis does not account for sustainability concerns of future investments
6. The results estimate site-level expenditures using mechanism and sub-national unit EA results

### **TA/TC Consideration**

TA/TC programs that are able to access and use national data to complete site yield and volume analysis will likely not have the necessary cost data to complete an efficiency analysis as described above and will not be expected to quantify cost savings and productivity gains from site focus. TA/TC programs should, however, think about how the results of these analyses would impact shifts in program support and what the expected difference in cost to PEPFAR might be.

### 3.3.5 Outlier Analysis

There are a number of ways that analyzing outliers can assist with COP development, including identifying key cost-drivers and highlighting areas to focus attention for maximizing efficiency gains and program output. For the purposes of EA, an “outlier” is used to describe a unit expenditure (UE) that is a certain amount above or below the average UE for all observations in a distribution. An “observation” is a UE representing a combination of mechanism and location. For example, if 10 PEPFAR implementing partners provide ART to adults in two provinces each, and have reported *both* expenditures and indicators for the same time period, there would be 20 (10X2) unique unit expenditure observations in the distribution for adult ART. The average (weighted by patient volume) would then be calculated for the distribution to determine the average mechanism unit expenditure.

**Note:** *The average mechanism UE will be different (lower) than the PEPFAR national UE for the same indicator. This is expected and due to the restriction in the analysis to only partners reporting both indicators and expenditures.*

The threshold for identifying an outlier is not prescribed and should be tailored to the indicator and program context. In the **EA Data Navigation** tool provided, the threshold for analyzing outliers can be set to any desired level. We recognize that partners have different models of service delivery, reach different populations or may be providing different types of support even though they count the same indicator. Some variation in the mechanism UEs is expected given these realities; however, this method will allow teams to conduct quantitative analysis of these differences in support, and look for efficiency gains across partners and regions where similar expenditures and outputs are expected. This analysis may also call attention to data quality problems that need immediate remediation. It is important to remember that the calculated UE is a combination of expenditure and result data. Often outliers are identified because the volume is disproportionate to the expenditure (i.e., incredibly low or high). In this respect, the outlier analysis can help identify low performing or high cost sites and quantify efficiency gains from enhanced program focus.

**TTFs:** The **EA Data Navigation** tool has been provided to assist country easily analyze outliers.

In the context of COP refinement, we recommend country teams use the **EA Data Navigation** tool to address the following questions:

- What’s an acceptable outlier threshold for each distribution?

- Which indicators/program areas have the greatest number of outliers?
- Which SNU has the greatest number of outliers?
- Which partners/mechanisms have the greatest number of outliers?
- For extreme outliers (very top and bottom of distribution), does the volume or expenditure appear to be driving the UE? Is there reason to believe these data aren't accurate, and is it worth getting clarification from the reporting IP?
- What percentage of total expenditures for a specific intervention do the outliers account for? What percentage of total volume of beneficiaries do the outliers account for? Is this acceptable when compared?
- Given your knowledge of the program context and partner activities, can the outlier be explained *using quantitative data*? For example, if it's thought a partner has a higher UE due to serving a hard to reach population, can you demonstrate the partner spends more on travel/transport, vehicles, etc. than the average across all partners? Is this acceptable and in alignment with program prioritization?

This type of investigation may help teams identify common themes that will have broader implications for program output and efficiency, such as specific models of service delivery or geographic areas that are clear cost drivers and may need adjustment. It is important to note that UEs do not consider quality of the support provided. Other data, such as retention information and SIMS results, should be considered in tandem to assessing acceptability of outliers based on quality considerations.

### 3.3.6 Resource Projections to Estimate the Cost of Program

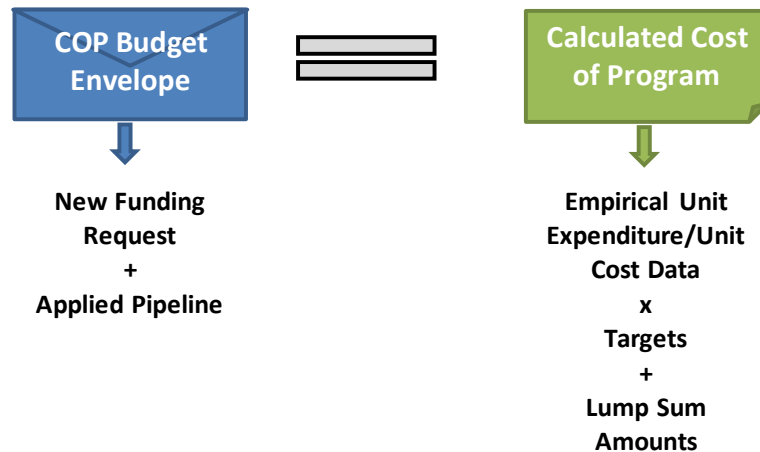
Using empirical cost data<sup>15</sup> is a critical element in determining the expected cost to PEPFAR of the planned program. Some unit costs may be available and widely understood (e.g., cost/expenditure per person receiving HIV testing and counseling), whereas some unit costs may need to be outlined at the country level (e.g., cost of training one health worker on minimum package of voluntary medical male circumcision services). There are some activities where assigning a “unit” may be more difficult or less clear. For example, supportive supervision for clinical services is typically thought of as technical assistance, and traditional units of output – in terms of number of individuals reached – may not be an appropriate metric. These types of activities may be more difficult to accommodate in the budget; however, assigning some unit of output is still a useful method to determine how many resources will be needed to support the intended program in the next year. In the case above, a potential solution might be to use EA and other program data to determine, on average, how much was spent to provide supportive supervision to each site. Using the site as the unit allows for some standardization of costs to PEPFAR. Budgeting for such activities per site would then provide a proxy to ensure the program is adequately resourced in next year’s budget. The above example is only one possible metric and country teams will need to explore all options that make sense for their program context and activities. Further, some activities may not need to be assigned a unit, but will still need to be included in the budget (e.g. a special study intended to be completed in the next fiscal year.)

The following flow diagram provides a conceptual framework for systematic use of empirical cost data to develop a COP budget. Each step is described below.

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<sup>15</sup> PEPFAR Unit Expenditures are not the full unit cost of delivering a program; however, it is the unit cost to PEPFAR. Unless the level of PEPFAR support or the intervention is expected to change dramatically, it is appropriate to use the unit expenditure from the Expenditure Analysis results to apply during the PEPFAR budgeting process.

**Basic Premise:**



There are costs to PEPFAR of implementing a program (“calculated cost of program”) and a total “COP budget envelope,” which defines the financial ceiling that constrains program output. Once a budget is completed, these two major elements need to be reconciled. The financial ceiling, or budget envelope, is the total available resources that can be applied to the next fiscal year. In theory, this envelope will consist of money in the pipeline that will be applied to next year’s program, plus new money provided by PEPFAR. The calculated cost of the program should be where EA and other cost/expenditure information are applied.

As discussed above, the cost of the program to PEPFAR should be determined by multiplying unit cost/expenditure information by proposed targets and adding in any additional lump sum amounts to cover activities without clear output metrics. The following steps describe how to use available data to calculate the cost of the program.

**Step 1: Outline all indicators for the program**

**Ex:**

No. Pregnant Women Tested and Received Results

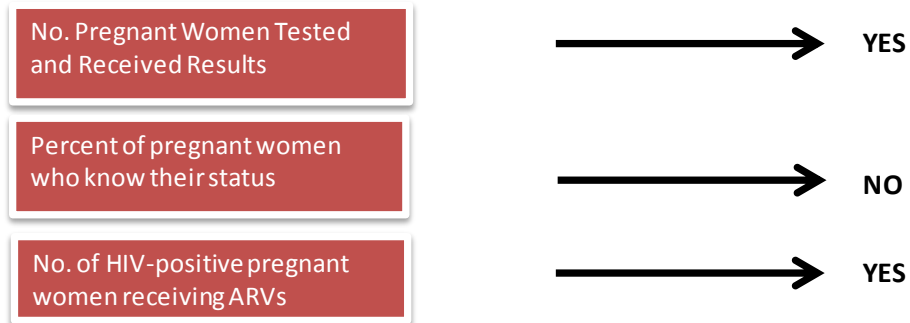
Percent of pregnant women who know their status

No. of HIV-positive pregnant women receiving ARVs

The first step is to outline all output/outcome metrics used to measure program performance. These will include those indicators that are essential, required, and reported to OGAC, as well as any indicators used for monitoring at the country level.

## Step 2: Identify which indicators will carry cost to PEPFAR

**Ex:**



Next, teams should identify which of the indicators identified in Step 1 will incur a cost to PEPFAR. In the above example, the first indicator (number of pregnant women tested) will result in a cost to the program. The second indicator listed, however, will not incur a cost, because the costs of this activity (determining the percent of pregnant women who know their status) will be carried by the first indicator since it is a subset of testing (or caring for) pregnant women through PMTCT. Therefore, there is no need to assign a unit cost/expenditure to this metric. Representatives of the Finance and Economics Working Group (FEWG) are available to assist country teams with identifying indicators that carry costs and need to be included in budget projections.

## Step 3: Map indicators to empirical cost data (where available)

**Sources:**



After determining which indicators will carry a cost to PEPFAR, teams should locate sources of empirical cost data that can be used to assign a unit cost/expenditure to these outputs. In many countries, EA results will be the only source of information for specific indicators. In some cases, there



will be other sources of data, such as published cost studies or grey literature. In the absence of EA results or other cost data, teams should use their prior knowledge of activities and/or interact with implementing partners and service providers to derive an informed estimate. Teams are encouraged to determine which sources are most appropriate and relevant. EA Advisors are available to assist upon request.

#### **Step 4: Adjust empirical cost data to reflect program in coming year**

**Exs:** Remove construction and renovation from EA unit expenditure estimate  
Adjust ART cost per patient from external study to account for PEPFAR-only share

Next, teams should adjust empirical cost data to reflect the program's actual costs in the coming year. For example, some teams will need to adjust EA UE to account for one time investments made in the previous fiscal year. In this scenario, assume the UE for one patient year of adult ART was \$200 (USD) using EA from FY 2013 in country X. The country team knows the \$200 per patient includes the renovation of several health clinics. This cost will not need to be incurred in the next year, so budgeting \$200 per patient for adult ART is not necessary. The team reviews the EA data with their EA Advisor and determines \$20 per patient of the \$200 accounts for the renovation cost. The team elects to reduce the unit expenditure from \$200 to \$180 to more accurately estimate what the program will cost PEPFAR next year.

Adjustments may also be required when using external cost data. If in country X there was a cost study on ART last year that concluded the yearly cost per patient-year of adult ART was \$400 (USD), the country team could use this information to calculate the budget; however, the figure would need to be adjusted. Most HIV cost studies focus on total cost of service delivery without discerning the source of funding. If the team knows that PEPFAR does not pay for ARVs in country X, the \$400 would need to be adjusted downward to account for only the portion of the total cost per patient-year that PEPFAR will support.

Adjusting unit cost estimates can be very detailed and challenging. OGAC and agency headquarters encourage country teams to work with their EA Advisors to think through these adaptations and impact on the budget.

#### **Step 5: Add lump sum amounts, required for program but not carried by indicators**

**Exs:** Agency management and operations

Resources needed for special studies/operations research to be implemented in coming year

Resources needed for program activities that rarely have unit cost/expenditure associated with them (e.g., infection control)

Next, teams should list all activities that are slated for the next fiscal year where no unit cost data are applicable due to the nature of the activity (e.g., policy guideline development, strengthen waste management activities). These activities require imputing a “lump sum” amount (e.g., renovations for a health clinic to improve ventilation and reduce opportunistic infections). It is at the country team’s discretion how these lump sum amounts are determined. As in the supportive supervision example at the beginning of this section, the country team may elect to assign their own unit to an activity (e.g., sites supported). Some activities, however, will not have a natural unit for which to budget. For these, the country team should use their best judgment to determine cost to PEPFAR and evaluate if the investment aligns with program priorities.

**Step 6: Calculate total resource needed by program areas**

<b>Ex:</b>		<b>Unit Expenditure for VMMC:</b>	\$	100
	✖	<b>Proposed target for VMMC</b>		10,000
	<hr/>			
	+	<b>Resources needed for targets</b>	\$	1,000,000
	+	<b>Additional fixed (lump sum)</b>	\$	200,000
	<hr/>			
	■	<b>Total resources needed for VMMC</b>	\$	1,200,000

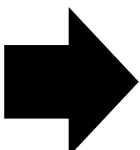


Next, teams should use the information assembled in Steps 1 – 5 to calculate the total program cost to PEPFAR. To do so, teams should multiply the unit cost/expenditure estimates used for each program area by the intended targets for that area and add any lump sum amounts. The total will represent the best estimate for what resources will be required to support the proposed program in the next fiscal year. Summing across program areas and activities will yield the total cost of the PEPFAR program for a given country.

**Note:** For most program areas, targets can simply be multiplied by UEs to estimate the total resource need. However, for ART, pre-ART, and Option B+ (PMTCT) targets, an additional step is necessary. Because the volume of patients receiving ARVs for treatment or PMTCT varies considerably over the course of the year, UEs for these program areas are calculated based on the average number of **patient years** over the given reporting period, as opposed to using the number of beneficiaries at the end of the fiscal year. In order to accurately estimate resource needs for these activities, year-end

targets must first be converted into patient years. For example, if country teams were calculating the target number of patient years for FY15, the formula would be<sup>16</sup>:

$$\text{Target FY15 Patient Years} = (\text{APR 14 result} + \text{SAPR 15 target} + \text{SAPR 15 target} + \text{APR 15 Target}) \div 4$$

For ART and pre-ART activities, this measure provides a more accurate indication of the service volume provided over the course of the fiscal year. Once country teams have calculated the target number of patient years for the given fiscal year, the total resource need can then be estimated by multiplying the unit cost/expenditure by the intended targets for that area and adding in any lump sum amounts, as described above. Note that for countries implementing Option B+ (lifelong ART), patient years will also need to be calculated for PMTCT targets.

<u>1) Calculate Patient Years</u>				<u>2) Multiply Patient Years by UE</u>	
FY14 COP target	10,000			Unit expenditure for adult ART	\$ 200
FY15 SAPR target	15,000			Adult treatment target (in patient years)	15,000
FY15 SAPR target	15,000			Resources needed for targets	\$3,000,000
FY15 APR target	20,000			Additional fixed (lump sum)	\$ 200,000
Sum	60,000			Total resources needed for Adult ART	\$3,200,000
FY15 Patient Years (sum ÷ 4)	15,000				

## Step 7: Map program area (indicator) totals to PEPFAR budget codes

<sup>16</sup> SAPR targets appear twice in this calculation intentionally. Weighting more heavily towards the midpoint is standard in patient-year calculations

	VMMC	<b>OR</b>	Males circumcised	Other program areas/indicators....
<b>Ex:</b>				
MTCT				
HVAB				
HVOP				
IDUP				
HMBL				
HMIN				
CIRC	84%		84%	
HVCT				
HBHC				
PDCS				
HKID				
HTXS				
HTXD				
PDTX				
HVTB				
HLAB				
HVSI				
OHSS	16%		16%	
HVMS				

Once the total cost of the program has been calculated, teams should map the cost data to the standard PEPFAR budget codes to determine how resources will be requested and verify that earmarks are met. This can be accomplished in one of two ways:

- 1) For a given **program area**, determine as a percentage how much of the total calculated cost of the program would be paid for by each PEPFAR budget code
- 2) For **each indicator** assigned a unit cost, determine as a percentage how much of the total calculated cost of the program would be paid for by each PEPFAR budget code

**Note:** *If electing method two lump sum amounts will also need to be mapped and are not rolled into unit cost estimates.*

The total dollar value required in each budget code to support the program can be determined by multiplying the percentage across each program area/indicator by the calculated cost of the program for that area/indicator.

### **Step 8: Reconcile with budget envelope and adjust targets if needed**

Finally, country teams should ensure the total calculated cost of the program does not exceed the pre-determined COP budget envelope. If the cost is higher than the budget envelope, targets or lump

sum amounts must be reduced to meet the financial ceiling. If the cost is lower than the budget envelope, the country team can identify additional program requirements or notify OGAC that they will be able to execute planned COP activities with a smaller budget. The goal is to have the calculated cost of the program be less than or equal to the budget envelope.

**TTFs:** The ***PEPFAR Budget Allocation Calculator (PBAC)*** has been provided to assist country teams with completing the steps associated with calculating estimated program costs. Each country receives a unique copy of the PBAC, pre-populated with EA results (unit expenditures) from the most recent data collection cycle. Unit expenditure estimates can be adjusted to accommodate expected changes to program activities and/or costs as described in Step 3 above.

## **4.0 TEMPLATES, TOOLS, AND SUPPORT FOR COP 2015**

## 4.1 Tools and Templates

***Sustainability Index and Dashboard (SID):*** The SID is an excel-based tool that measures the current state of sustainability of the national HIV/AIDS response and tracks progress over time in PEPFAR countries among five key domains and fifteen elements essential for a sustainable HIV/AIDS response. All PEPFAR teams submitting a COP are required to complete the SID in advance of COP development to inform program planning and decision-making. The results are intended to be used annually to inform PEPFAR investments and steadily advance sustainability across critical areas. Each COP program received a country-specific SID Tool in mid-December along with the SID Guidance.

***PEPFAR Budget Allocation Calculator (PBAC):*** There was considerable feedback from Phases I and II of EA implementation on the difficulty of translating EA results into the PEPFAR budget codes. The PBAC tool will assist country teams with estimating expected program costs using empirical data from EA and other sources. Teams can enter or import key EA data and targets into the tool and it will generate budget allocations that correspond to the traditional PEPFAR budget codes. Note that the budget tool provides an index value to assist teams and provide an objective basis for allocations, but does not provide rigid benchmarks. Budgets should be guided by fiscal data and determined in overall program context. PBAC comes with an additional manual posted on PEPFAR.net.

***EA Data Navigation Tool:*** This tool was designed to assist country teams and HQ support teams review EA data during the COP/ROP planning process. This Excel tool features multiple sheets with dropdown menus that allow users to customize and summarize EA results by program area, sub-national unit, and cost category over multiple fiscal years. The tool also contains information on national UEs and mechanism specific UEs. Pre-populated ***EA Data Navigation Tools*** for 2014 have been posted on each PEPFAR OU page on PEPFAR.net.

***EA-Epi Comparison Tool:*** This tool is designed to align expenditures with epidemiological data at the sub-national level. Epidemiologic data may include prevalence, incidence, ANC prevalence, ART need, testing volume, and testing yield. Expenditures may be presented in total by sub-national unit, or disaggregated by the appropriate program area. Pre-populated ***EA-Epi Comparison Tools*** for 2014 have been posted on each PEPFAR OU page on PEPFAR.net.

***Site Expenditure Allocation Tool (SEAT):*** The SEAT is designed to assist country teams evaluate the impact of concentrating PEPFAR support in FBCTS, PMTCT, and HTC sites with higher yields of

HIV-positive patients receiving services. The tool provides estimates of potential savings that would be attained by withdrawing support from direct service delivery sites and the impact on indicators if the savings are redistributed to sites in other geographic areas. The selection of sites from which to withdraw support is conducted by the country team and not completed within the tool. Country teams can insert a list of sites into the tool to run simulations to assess the magnitude of savings and the potential impact on indicators if resources are reallocated. As EA has not yet collected site-level expenditure data, the SEAT uses the most disaggregated unit expenditure available, typically at the level of an implementing mechanism within a specific sub-national unit (e.g., partner XYZ's contract 123 in province A) to estimate the effect of withdrawing PEPFAR support for specific services at sites under that mechanism in that province. The SEAT provides a range of potential savings intended to reflect the uncertainty around the true site-level UEs. As with the PBAC tool, the SEAT does not provide rigid benchmarks of savings and indicator impacts, rather it assists country teams to evaluate scenarios when a withdrawal of PEPFAR support from sites is warranted. Currently the SEAT is intended for use only by PEPFAR Long-Term Strategy countries.

PEPFAR teams will have access to download country-specific versions of each of the tools above on the designated webpage for their OU in PEPFAR.net.

## **4.2 Technical Considerations**

The Technical Considerations should be used to assist PEPFAR teams and implementing partners apply normative guidelines, as well as the most recent scientific evidence, when planning and implementing programs. The Technical Considerations have been restructured for the 2015 COP to include technical area priorities, updated background and scientific evidence to support these priorities, and other relevant technical information. Additionally, the SIMS Core Essential Elements have been mapped to the corresponding areas of the Technical Considerations to facilitate use of the Technical Considerations in supporting quality program improvement. It is essential that teams read all relevant sections of the Technical Considerations as much of the material on laboratory strengthening, SI and HSS has been consolidated into separate sections. The Technical Considerations can be downloaded on the PEPFAR.net COP 15 website.



## 4.3 Financial Supplement Worksheet

Each country or region must submit a ***Financial Supplemental Worksheet*** at COP/ROP submission, detailing the historic, current and projected financial performance of all mechanisms and CODB categories included within the COP/ROP. Each country or region must submit one document compiling the information for all agencies (see section XX).

The ***Financial Supplemental Worksheet*** can be found on the PEPFAR.net COP15 website.

## 4.4 SIMS Action Planner

***SIMS Action Planner (SAP)***: The SIMS Action Planner is designed to assist country teams to operationalize the SIMS Requirements for COP/ROP 2015 (see Appendix 10). Using the post's existing iPSL, the tool calculates how many and what type of SIMS assessments (i.e., facility, community, above-site, to new sites, to high-volume sites, follow-up remediation) each country is required to complete in FY2016. For planning purposes, the number of follow-up remediation assessments is projected to be 25 percent of required initial assessments. This information allows teams to accurately project costs and resource implications associated with SIMS in FY2016. The SIMS Action Planner is to be routinely updated with the most recent iPSL throughout the fiscal year to continuously monitor progress on achieving the COP/ROP 2015 SIMS Requirements. The tool and instructions on how to use it can be found on the COP 2015 page on PEPFAR.net.

## 4.5 PEPFAR Human Resources for Health (HRH) Strategy

PEPFAR's HRH Strategy will ensure that investments in HRH directly support overall program priorities and country-level core, near-core and non-core activities to achieve sustained epidemic control in priority locations and populations. The Strategy's goal is to ensure an adequate supply and quality of human resources for health to expand HIV/AIDS services in PEPFAR-supported high-volume program sites and/or high-HIV burden areas. At the OU level, implementing the HRH Strategy (i.e., strategy development, programming and monitoring) will require a cross-technical programmatic approach, with all technical areas supporting components of the Strategy's objectives at the Implementing Mechanism level. See forthcoming guidance for a full description.

## 4.6 Public Private Partnership (PPP) Tool-kit

An integral component of driving quality of partnerships within PEPFAR is through sharing of best practices. Field teams are encouraged to make use of the [Community of Practice Toolkit](#) (Table 1), which was developed by OGAC to assist PPP practitioners with engaging with the private sector, opportunity identification, development, management, and reporting of PPPs. The PPP toolkit, in coordination with technical assistance, can support country teams as they work through the various stages of PPP development process within their portfolios.

## 5.0 COP ELEMENTS

## 5.1 Chief of Mission Submission Letter

As in past COP cycles, PEPFAR teams are encouraged to submit a letter from the Chief of Mission (COM) to the Ambassador-At-Large and Coordinator of U.S. Government Activities to Combat HIV/AIDS with the COP submission. The purpose of the letter is to articulate at a high-level major changes that are being proposed, assumptions that the team has made about factors required to successfully meet the 2015 COP goals, objectives and targets, and identified concerns or barriers. If relevant, the letter could also address any technical support needs that the team has identified as necessary for implementation. Finally, recognizing that each operating environment is unique and that there are significant contextual factors that influence the PEPFAR program, the COM letter is a place to articulate these issues and their impact on the team's success and plans.

## 5.2 Strategic Direction Summary

The SDS outlines key data and analysis results, the strategic plan for the coming year, and the monitoring framework that will be used to measure progress. The SDS is submitted in FACTS Info as a supplemental document. Microsoft Word format is recommended and a template has been provided to assist country teams prepare a comprehensive SDS.

PEPFAR teams should use the guiding questions and adhere to the required tables and figures in the SDS template to successfully meet this COP 2015 requirement.

*The SDS should be **no more than 12,500 words**, excluding tables, figures, footnotes and appendices. Submissions with a word count greater than 12,500 will not be accepted without advanced authorization.*

The SDS template may be downloaded on the PEPFAR.net COP 15 website.

**Note:** *All data tables, graphics, figures and language contained in the SDS will be reviewed collaboratively with HQ and field teams to identify any sensitivity prior to being distributed outside of PEPFAR implementing agencies/partners and released into public domain. Elements that may be useful for internal program planning, but not yet cleared by external owners (e.g., unpublished data provided by host country governments) will be redacted if approval is not granted. Data that are likely*

*to put certain populations at risk if published (e.g., geographic data on key populations) will also be redacted.*

## 5.3 Supplemental Data Pack

The Supplemental Data Pack has been provided to country teams in Microsoft Excel format and is intended to be a template and analysis tool to assist PEPFAR field teams meet the requirements for successful preparation of the SDS. The workbook is also intended to assist reviewers to understand the data analysis completed by the country teams and limit the need for extensive verbal or written clarification. The workbook is submitted in FACTS Info as a supplemental document.

The Supplemental Data Pack may be downloaded on the PEPFAR.net COP 15 website.

## 5.4 Indicators and Targets

In COP15, PEPFAR will consider five types of targets that serve different purposes when reviewed at different levels of aggregation.

1. **Site Level Targets** – Site level target setting allows for implementing partners to clearly articulate and set expectations for achievements at each PEPFAR-supported site based on supported activities and in alignment with geographic, population, and intervention-based prioritization efforts for scale-up or maintenance.
2. **Sub-national (ie. District) Level Targets** – Sub-national level target setting strategically demonstrates geographic prioritization of efforts towards the 90:90:90 by 2020 UNAIDS target in alignment with the distribution of the burden of disease in a country.
3. **Implementing Mechanism Level Targets** – Implementing Mechanism (IM) targets represent expected accomplishments for the implementing partner based on available funding and agreed upon activities. Target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements.

4. **Technical Area Summary Level Targets** – The PEPFAR Technical Area Summary Targets are an aggregated reflection of total expected achievements in a country based on the collective work of all PEPFAR partners, and should represent PEPFAR's contributions to the national program. These targets should reflect scale up for epidemic control in high disease burden areas and maintenance of programs in other areas.
5. **National Targets** – National data represent the collective achievements of all contributors to a program area, including PEPFAR (i.e., host country government, donors, or civil society organizations).

Each type of target, starting at the site-level, builds upon the other. In other words, site-level targets should aggregate into sub-national level targets. Together, these should inform implementing mechanism target totals which feed into aggregate technical area summary level totals for each operating unit. Appropriate deduplication of the targets need to be taken into account at each level of aggregation.

PEPFAR teams are required to provide FY 2016 targets (October 1st to September 30th of each fiscal year). FY 2016 targets represent expected accomplishments with COP15 funds by September 30, 2016.

#### **5.4.1 Site and Sub-national Level Targets**

Please reference Section 3 of the COP Guidance for information on the strategic approach for targeting.

#### **5.4.2 Implementing Mechanism Level Indicators and Targets: Required for all IMs**

Implementing Mechanism (IM) target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements. Each Implementing Mechanism's indicator set should represent a comprehensive set of measurements that provide the information needed by the partner and the PEPFAR team to manage the program activities. Minimally, partners will be expected (by the country team) to set targets for all required indicators that are applicable to the work they are doing (reference the MER Guidance for reporting requirements). If there are no applicable indicators, and none otherwise identified by the OU (such as a custom indicator), no IM target submission is necessary.

Target Justification Narratives (2250 characters) should follow the same guidance as provided below (as applicable) for the technical area indicator narratives.

### 5.4.3 PEPFAR Technical Area Summary Indicators and Targets

The PEPFAR Technical Area Summary Targets are based on the collective work of all PEPFAR partners, and should represent PEPFAR's contributions to the national program. These targets should reflect scale up for epidemic control in high disease burden areas and maintenance of programs in other areas.

FY 2016 targets should reflect geographic and population-based prioritization and targeting efforts. Technical area summary are a duplicated sum of site/implementing mechanism level targets.

All teams are expected to report on targets for required indicators that are applicable to the program's funded activities. These targets reflect expected accomplishments that are directly supported by PEPFAR. PEPFAR recognizes that 'direct support' in the form of 'direct service delivery' or 'technical assistance for service delivery improvement' support<sup>17</sup> is provided within the context of partner country national programs, as a contribution to or a share of those programs, which may also receive financial and other support from the host country and other donors such as the Global Fund. As such, these targets should feed into the national program goals set through a strategic planning process led by the partner government and supported by key stakeholders.

Note that Regional Operating Units will be required to provide technical area summary targets at the regional aggregate level as well as by contributing country.

Beyond the required set of indicators, additional country-defined indicators may be submitted as custom indicators in the Technical Area Summary Indicators section of the COP together with corresponding targets (please refer to FACTS Info training and data entry guidance for more information on custom indicators).

#### Target Justification Narratives (2250 characters)

Target justification narratives should be specific to each indicator and should describe:

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<sup>17</sup> Please refer to PEPFAR's *MER Indicator Reference Guide* v2 for more guidance on required indicators and reporting, including detailed information on what constitutes PEPFAR direct service delivery and technical assistance for service delivery improvement.

- the methods used to calculate the indicator
- the strategic focus for implementation in that area and what type of activities are supported by U.S. government
- any changes in the focus of the work and/or in the IP landscape
- related national policies that may influence expected achievements
- any successes or challenges to implementing or monitoring the program (i.e. in a way that the targets are higher/lower than might be expected for the fiscal year)
- any de-duplication methods that were utilized

#### **5.4.3 National-level Indicators and Targets**

All operating units (countries and regions) will report national level data on a small core subset of indicators, where applicable. National targets are the expected national achievements inclusive of all stakeholders in a country, and are based on a reporting timeframe defined by the partner national government. These are required for submission to headquarters for selected indicators. All Operating Unit teams must work with partner governments to set and review the annual targets for 2015 and 2016, at a minimum. As in previous COP cycles, PEPFAR teams should have already identified the timeframe for which the national targets are set (e.g., Jan – Dec or Oct – Sept).

In light of recent legislation extending the authorities of the PEPFAR authorization, national targets will continue as a requirement of all COP submissions for selected program areas. These requirements are consistent with PEPFAR practices throughout the recent phase of the initiative. PEPFAR teams will report national targets for seven national output indicators. For the FY 2015 COP, the required targets are in the areas of treatment, PMTCT, voluntary medical male circumcision, key populations, and country ownership. The MER Indicator Reference Sheets revised for FY15 based on feedback from the last year of implementation, outline the specific indicators that should be used for target setting and the reference sheets that will inform the target setting process. Although these indicator labels and reference sheets primarily describe PEPFAR-supported programming, OUs are being asked to expand the utility of these indicators to the national context.



## 5.5 Implementing Mechanism Information

An implementing mechanism (IM) is a grant, cooperative agreement, or contract in which a discrete dollar amount is passed through a prime partner entity and for which the prime partner is held fiscally accountable for a specific scope of work. Examples of implementing mechanisms are bilateral contracts, bilateral grants, field support (USAID) to a HQ-managed project/entity, cooperative agreements, etc.

Each U.S. government implementing partner will have a separate mechanism. One prime partner will need to have multiple mechanisms only if:

- A partner is funded by more than one agency; or
- A partner has multiple projects that are administered through separate procurement instruments. These will need to be entered as two separate partners and implementing mechanisms.

**Note:** *You do not need a separate “funding mechanism” entry for each funding source that a partner is receiving.*

All costs associated with institutional contractors providing support to the country team should be entered in the M&O section.

### 5.5.1 Mechanism Details

The following information regarding an implementing mechanism will be submitted on the “Mechanism Details” tab of the Implementing Mechanisms section of the COP. In general, these implementing mechanism details should not change from one cycle to the next (i.e., the data remains static over time):

- Prime Partner Name
- G2G ( and Managing Agency)
- Funding Agency
- Procurement Type
- Implementing Mechanism Name
- HQ Mechanism ID (system assigned)
- Legacy Mechanism ID

- Field Tracking Number (optional)
- Agreement Timeframe (may change if there are no-cost extensions)
- Benefitting Country(ies) (only required for Regional OU programs)

The following implementing mechanism details must be reviewed and if necessary updated by country teams for the current FY 2015 COP. While some items may stay the same from cycle to cycle, others must be updated for the current submission in order to respond to revised guidance and/or reflect current data.

- TBD mechanism (a mechanism that was TBD in prior cycles may be named in COP15)
- New Mechanism (A mechanism can only be listed as “new” during its first COP cycle)
- Global Fund/Multilateral Engagement
- Construction/Renovation Projects
- Motor Vehicle data

#### **5.5.2 Prime Partner Name**

The prime partner name for a mechanism, regardless of prime partner type, will be selected from a list of pre-existing partner names that currently exist within the FACTS Info – PEPFAR Module system. If the partner is new, and does not already appear as a prime partner within the FACTS Info system, you will select “New Partner” as the partner name. To request the addition of a new partner, country teams will need to submit a “New Partner Form” to your CL. The New Partner form is posted on the [FY 2015 COP Planning](#) section of the PEPFARii.net site under [HQ > Planning and Reporting Cycles](#).

Once the partner form is received, the new partner name is validated and loaded into FACTS Info. You will be notified that the “New Partner” prime partner entry can be changed in the system to the actual partner name (note, this update will not be possible via templates).

#### ***Partnership for Supply Chain Management***

When preparing to program funds into Supply Chain for Management Systems, teams must select the Partnership for Supply Chain Management (PfSCM) as the Prime Partner, and not MSH or another prime partner within PfSCM. If PfSCM is not chosen, funds will not be deposited into the Working Capital Fund and will not be able to be used for supply chain activities. COP funds for PfSCM (SCMS) must go through the HIV/AIDS Working Capital Fund (WCF) account at USAID. This is an important distinction because it is different from all other COP funds. These funds are sent directly from OGAC to the WCF account and are not allotted to Post like other COP funds.

It is critically important that teams carefully plan the amount budgeted in the COP for SCMS. Unlike other mechanisms, SCMS is not able to receive additional funding through future reprogramming of USAID obligated but unobligated funds, except in emergency circumstances. In addition, due to the nature of a Working Capital Fund, once funding is allocated and transferred to the WCF account, it is fully obligated and cannot be transferred out of this account during future Operation Plan Update cycles. Information on the process for shifting additional funding to SCMS in emergency situations is provided in the Operational Plan Update Guidance.

### 5.5.3 Government to Government Partnerships

The Department of State cable released 05 September 2012 serves as the guidance document to be followed when establishing and executing new government-to-government (G2G) agreements in the FY 2015 COP. The Common Language Protocols document provides guidance for the transfer of funding to the host government agency receiving funding. Both documents are posted on the [FY 2014 COP Planning](#) section of the PEPFARii.net site under [HQ > Planning and Reporting Cycles](#).

G2G funding is defined as **“Funding which is transferred to a Host Government Ministry or Agency (including parastatal organizations and public health institutions) for the obligation and disbursement of those funds by that government entity”**.

The tickbox designating the mechanism as G2G must be checked in FACTS Info if the mechanism represents an intention to provide direct G2G assistance from the U.S. government to any entity as defined above. Teams should **not** check the box if fund transfers to the government will be through a non-governmental implementing partner.

Upon selecting the G2G tickbox, you must also indicate the “Managing Agency” for this mechanism, i.e. which agency will be managing the relationship with the government and the project. This may be the same agency or a different agency from the one listed in the implementing agency box.

If you have any questions about whether a partner falls under the G2G definition (i.e. whether your partner is a parastatal), or regarding the managing agency for a mechanism, please contact your CL.

Upon submission of a G2G request, OGAC will conduct a review process to approve all newly planned G2G agreements under PEPFAR. This includes activities using FY 2015 PEPFAR planned funds, prior-year funds and anticipated out year funds for the life of the project. To fully evaluate the proposed G2G mechanism, country teams need to provide supporting documentation on the government entity that will hold the agreement and execute the activities, the agency-specific risk

assessments conducted or planned, as well as the intended fund transfer mechanism (i.e. Fixed Amount Reimbursement Agreement (FARA), direct transfer, cooperative agreement, etc...).

To initiate the G2G review process the following information is required:

- Proposed grantee name (e.g. specific ministry)
- Annual funding for project
- Life of project funding
- Fiscal year of funds to be used
- Anticipated start and end dates
- Type of risk assessment to be done or already done for each agency

The merit of a G2G request will be evaluated during the technical and programmatic FY 2015 COP reviews. OGAC will conduct a final review and approve which proposals can advance through a G2G agreement.

#### 5.5.4 Funding Agency

It is critical that teams identify the correct USG agency in the Funding Agency field; the agency or Operating Division selected will receive the funding from OGAC.

USG Funding Agencies	
<ul style="list-style-type: none"> <li>• <b>DoD (Department of Defense)</b></li> <li>• <b>DOL (Department of Labor)</b></li> <li>• <b>Department of State</b> <ul style="list-style-type: none"> <li>○ AF (African Affairs)</li> <li>○ EAP (East Asian and Pacific Affairs)</li> <li>○ EUR (European and Eurasian Affairs)</li> <li>○ INR (Intelligence and Research)</li> <li>○ NEA (Near Eastern Affairs)</li> <li>○ OGAC (Office of the U.S. Global AIDS Coordinator)</li> <li>○ PM (Political-Military Affairs)</li> <li>○ PRM (Population, Refugees, and Migration)</li> <li>○ SCA (South and Central Asian Affairs)</li> <li>○ WHA (Western Hemisphere Affairs)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>HHS (Health and Human Services)</b> <ul style="list-style-type: none"> <li>○ CDC (Centers for Disease Control and Prevention)</li> <li>○ HRSA (Health Resources and Services Administration)</li> <li>○ NIH (National Institutes of Health)</li> <li>○ OGA (Office of Global Affairs)</li> <li>○ SAMHSA (Substance Abuse and Mental Health Services Administration)</li> </ul> </li> <li>• <b>Peace Corps</b></li> <li>• <b>USAID (United States Agency for International Development)</b></li> <li>• <b>U.S. Treasury</b></li> </ul>

- **HHS/NIH:** Field teams should ensure that they are familiar with the scope of HIV-related clinical or other research that NIH (and potentially other U.S. government agencies) currently fund in country to determine whether or not there are non-research activities appropriate for inclusion in the COP that may be logically “appended” to these research efforts. If there are opportunities to provide country/regional PEPFAR funding to add a service component to an NIH study, country funding for the additional service component *only* would be put into the COP. The NIH study would NOT be included. You can also include support for training through NIH via Fogarty International Center (FIC) research training grants that support the strengthening of human capacity in strategic information: surveillance, HIS, targeted and public health evaluations, program monitoring and evaluation, modeling, and bioethics. Operating Unit teams should be in contact with the FIC research training program officer or directly with the grantee and their in-country collaborators to discuss capacity building needs (see research training websites at [www.fic.nih.gov](http://www.fic.nih.gov) for contact info for AIDS International Training and Research Program, International Clinical, Operations and Health Services Research Training Award for AIDS and TB, and International Research Ethics Education And Curriculum Development Award). As with all agencies, NIH should be listed as the Funding Agency, and the Prime Partner who will eventually receive the funding should be listed as the Prime Partner.
- **HHS/HRSA:** Please note that although CDC locally manages HRSA partners such as ITECH (the University of Washington), the Twinning Center (American International Health Alliance (AIHA)), New York AIDS Institute (HIVQUAL), Harvard University, Catholic Relief Services, and Columbia University (Nursing Capacity Building), HRSA should be listed as the Funding Agency, as they hold the grants/contracts for these partners and must receive the funds.
- **Peace Corps:** Funding going to the Peace Corps should be identified with Peace Corps as the Funding Agency. Peace Corps should never appear as another USG Agency’s prime partner. The Implementing Mechanism section of the COP should only be used to capture Peace Corps programming outside of Peace Corps Volunteer costs.
- **Department of Labor:** Funding going to the Department of Labor should be identified with Department of Labor as the Funding Agency. Department of Labor should never appear as another U.S. government Agency’s prime partner.

- **State:** Please identify the State Department Bureau for all mechanisms where the Department of State is the Funding Agency. Any project using State's Regional Procurement Support Offices (RPSO) for construction or renovation, must list the relevant State regional bureau as the Funding Agency. For more information on construction or renovation as an implementing mechanism, see Section 5.5.11.
- **Treasury:** Treasury's Office of Technical Assistance (OTA), which provides advisors with expertise in public financial management to government ministries, was included in PEPFAR's most recent authorization. Depending on country context, Operating Unit teams may wish to incorporate this element into their broader health systems strengthening portfolio. For these mechanisms, please identify Treasury as the Funding Agency and as the Prime Partner.

#### 5.5.5 Procurement Type

PEPFAR utilizes the following types of procurement:

- Contract - A mutually binding legal instrument in which the principal purpose is the acquisition by purchase, lease, or barter of property or services for the direct benefit or use of the Federal government or in the case of a host country contract, the partner government agency that is a principal signatory party to the instrument. Note: IQCs should be listed as contracts.
- Cooperative Agreement - A legal instrument used where the principal purpose is the transfer of money, property, services, or anything of value to the recipient in order to accomplish a public purpose of support or stimulation authorized by Federal statute and where substantial involvement by the USG is anticipated. Note: PASAs should be listed as cooperative agreements.
- Grant - A legal instrument where the principal purpose is the transfer of money, property, services or anything of value to the recipient in order to accomplish a public purpose of support or stimulation authorized by Federal statute and where substantial involvement by USG is not anticipated.

- **Umbrella Award** – An umbrella award is a grant or cooperative agreement in which the prime partner does not focus on direct implementation of program activities, but rather acts as a grants-management partner to identify and mentor sub-recipients, which in turn carry out the assistance programs.
- **Inter-agency Agreement (IAA)** - An Inter-Agency Agreement is a mechanism to transfer funding between agencies. This mechanism should only be used in **very rare** occasions and is never permitted for use with GHP-State funding. If the USG team decides that one agency has a comparative advantage and is better placed to implement an activity with either GHP-USAID or CDC GAP funding, the USG team has the option of requesting to transfer money from one agency to another through an IAA. This is not the most efficient way of providing funds from one agency to another. However, one example of an appropriate use of an IAA is agency buy-in for census bureau (BUCEN) services.

### 5.5.6 Implementing Mechanism Name

The mechanism name is a tool to identify unique mechanisms. We have seen the following mechanism naming conventions:

- Partner Acronym: AIHA; CHAZ
- Project Name: Support to RDF; Sun Hotel PPP; GHAIN, If this is a HQ buy-in implementing mechanism then you must put the name of the HQ project in the implementing mechanism name field. For example, if you are using the CTRU Project or UTAP, you should use these names in the implementing mechanism name field. Otherwise, there are no limitations on mechanism name; we recommend that country teams choose unique values for the mechanism name.

The Implementing Mechanism name is not the same as the Prime Partner name, although in some cases the fields may hold the same values. The table below provides several examples of the difference between implementing mechanism name and prime partner name.

Examples of Implementing Mechanism and Prime Partner names are below:

Implementing Mechanism Name	Prime Partner Name
Together We Can	American Red Cross
Twinning	American International Health Alliance
MEASURE/DHS	Macro International
Network RFP	To Be Determined

#### 5.5.7 HQ Mechanism ID, Legacy Mechanism ID, and Field Tracking Number

The **HQ Mechanism ID** will be assigned by the FACTS Info – PEPFAR Module system when the mechanism is saved in the system (either through a template upload or on-screen). New FY 2015 mechanisms will be assigned HQ Mechanism IDs by the FACTS Info – PEPFAR Module system when they are saved to the system.

The **Legacy Mechanism ID** refers to the historical mechanism ID that was used either in COPRS I or Plan B. Country teams should reference the following Legacy Mechanism ID types:

- For mechanisms that existed in the FY 2009 COP in the COPRS I system, Operating Unit teams should use the COPRS I “mechanism system ID.”
- For mechanisms that were created in the FY 2010 or 2011 COP or using the “Plan B” system, country teams should use the mechanism ID from that system. For example, if the file name included “new017” in the name, the mechanism ID would be “17.”

The **Field Tracking Number** is not a required field. It is intended for country use only to assist with internal tracking systems or syncing COP data with country-based “shadow systems.” Examples of possible field tracking numbers include:

- Contract / cooperative agreement number
- Vendor ID
- COPRS shadow system ID

#### 5.5.8 Agreement Timeframe

The Agreement Start Date and Agreement End Date fields are a month-year stamp that field teams use to indicate the agreement timeframe. This time stamp will serve as an indication of where a mechanism is in its lifecycle. An actual time stamp is not required for TBD mechanisms.



### 5.5.9 TBD Mechanisms

If the mechanism prime partner is TBD, the tickbox “TBD Mechanism” must be checked and FACTS Info will automatically populate the Prime Partner field with “TBD.” When using Implementing Mechanism templates, if you indicate that the mechanism is TBD, please ensure the Prime Partner is listed as “TBD” only.

Upon checking the TBD tickbox, or when completing an IM template for a TBD, a new tab will appear in FACTS Info requesting the user to enter details regarding the status and history of the TBD, projected award date, and any other information that would be helpful for a reviewer.

### 5.5.10 New Mechanism

Upon the creation of a new mechanism in FACTS Info, the “New Mechanism” tickbox will be checked automatically.

### 5.5.11 Construction/Renovation

This tick box in FACTS Info is used to identify mechanisms that contain funding for construction and/or renovation projects. Checking this box will then open a separate tab in the IM where country teams should complete required information on the projects.

A Construction/Renovation tab will appear requesting the user to enter each proposed project. All fields on the Construction/Renovation Project Plan form must be completed. There is no minimum or maximum limit on the amount of funds allocated to a construction/renovation project for it to be subject to inclusion in the COP submission i.e., all projects, regardless of amount, need to be submitted for approval. Attributions for construction and renovation for each IM should match the total of all IM project plans. Please see section 5.5.11 for more information.

### 5.5.12 Motor Vehicles

This tickbox is used to identify mechanisms that have purchased and/or leased motor vehicles over the timeframe of the IM/agreement. This tickbox must be used in order to report on the FY 2015 request for the purchase and/or lease of motor vehicles as well as to report on the number of previously PEPFAR purchased or leased that are in use at the time of COP submission. A Motor Vehicle tab is where country teams should enter the data on new FY 2015 funding and provide the current size of the PEPFAR fleet under this mechanism.

- At the top of the tab, enter the total number of motor vehicles previously PEPFAR purchased or leased under this mechanism that are currently in use (i.e. from the start of the mechanism through COP submission).
- The main section of the tab requires OUs to provide specific information on each motor vehicle request. Upon clicking the “add” button, you will be required to provide:
  - The type of vehicle requested (boat, truck, car, ambulance, etc.)
  - The acquisition method for the requested vehicle (leased or purchased)
  - The total number/amount of this particular type of vehicle being requested
  - The new FY 2015 funding being requested for the group of vehicles that are batched in this entry.
    - NOTE: Any vehicles that are being funded out of the applied pipeline should be listed as zero-funded.

Only new FY 2015 funding requested for motor vehicles should be entered in the appropriate attributions (“Motor Vehicle: Purchased” and “Motor Vehicle: Leased.”) The totals for these attributions must equal the new funding requested in the motor vehicles tab. Teams are encouraged to utilize the Motor Vehicles IM Summary Report, found in the Budget Section of FACTS Info to check their planned allocations and requests to ensure accuracy.

Any USG related motor vehicle planned expense must be captured in the appropriate agency and cost category of CODB.

### 5.5.13 Prime Partners

**Definition:** A prime partner is an organization that receives funding directly from, and has a direct legal relationship (contract, cooperative agreement, grant, etc.) with, a USG agency.

There can be only one prime partner per implementing mechanism. When implementing mechanisms are awarded to a joint venture/consortium, the lead partner is the prime, and any other partners in the consortium should be identified as sub-partners. With the exception of the prime partner, you will only need to enter those members of the joint venture/consortium that are active in your country.

As noted above, the prime partner name for a mechanism, regardless of prime partner type, will be selected from a list of pre-existing partner names that currently exist within the FACTS Info – PEPFAR Module system. If the partner is new, and does not already appear as a prime partner within the

FACTS Info system, you will select “New Partner” as the partner name. In order to request the addition of a new partner, country teams will need to submit a “New Partner Form” to your CL. The New Partner form can be found on PEPFARii.net. Once the partner form is received, the new partner name validated, and the partner information loaded into FACTS Info, you will be notified that the “New Partner” prime partner entry can be changed in the system to the actual partner name (note, this update will not be possible via templates).

#### Maximizing Efficiencies:

- 1) **In order to maximize efficiencies in administrative costs, countries should have no shared prime implementing partners with multiple agency agreements, including with partner governments** (see cable entitled: MESSAGE FROM SECRETARY CLINTON ON GOVERNMENT-TO-GOVERNMENT MECHANISMS FOR PEPFAR). If you feel that this is necessary in your country’s context, you will be expected to submit a request for a waiver of this requirement.
- 2) In order to avoid duplication in program implementation by partner, agency, program area and geography, country teams are not allowed to fund different partners that are working in the same program area in the same facilities or geographic locale – independent of whether or not they are currently funded by one agency or different agencies. The following is allowed however:
  - Different partners; same program area; same agency; distinct geographic locales
  - Different partners; same program area; different agency; different locale
  - Different partners; different program area; different agency
  - Partners working in multiple geographic areas on technical assistance only

As above, if you feel that funding multiple partners is necessary in your country’s context, you will be expected to submit a request for a waiver of this requirement.

**Do not** name a partner as a prime or sub under an implementing mechanism until it has been formally selected through normal Acquisition & Assistance processes, such as Annual Program Statements, Requests for Application, Funding Opportunity Announcement, or Requests for Proposals. If a partner has not been formally selected, list the prime partner for the implementing mechanism as TBD.

For all direct programming to be implemented by a USG, the agency should have an implementing mechanism with itself named as the prime partner. Note that all of the costs associated with a USG

agency's footprint in country, i.e., costs of doing PEPFAR business or "Management and Operations" costs (including staffing to support TA), will be entered in the M&O section. Technical staff salaries will be attributed to the applicable budget code through the M&O section, not through implementing mechanisms.

#### 5.5.14 Sub-Partners

For FY 2015, sub-partner names need to be provided for each implementing mechanism proposed in the COP. If sub-partners are unknown for an implementing mechanism, nothing need be entered in the mechanism at this time; however, sub-partner lists must be updated throughout the year during the COP/ROP update process. If the sub-partner is known you should choose it from the pre-existing list of partner names.

As noted above for prime partners, the sub partner name for a mechanism, regardless of partner type, will be selected from a list of pre-existing partner names that currently exist within the FACTS Info – PEPFAR Module system. If the partner is new, and does not already appear as a prime partner within the FACTS Info system, you will select "New Partner" as the partner name. In order to request the addition of a new partner, country teams will need to submit a "New Partner Form" to your CL. The New Partner form can be found at: [www.pepfar.net](http://www.pepfar.net).

#### 5.5.15 Definitions

**Sub-Partner:** An entity that receives a sub-award from a prime partner or another sub-partner under an award of financial assistance or contract and is accountable to the prime partner or other sub-partner for the use of the Federal funds provided by the sub-award or sub-contract.

**Sub-Award:** Financial assistance in the form of money, or property in lieu of money, provided under an award by a recipient to an eligible sub-partner (or by an eligible sub-partner to a lower-tier sub-partner). The term includes financial assistance when provided by any legal agreement, even if the agreement is called a contract but does not include either procurement of goods or services or, for purposes of this policy statement, any form of assistance other than grants and cooperative agreements. The term includes consortium agreements.

**Note:** *Information is only to be submitted on Prime Partners and Sub-Partners, not on "Subs of Subs."*

### **5.5.16 No Sub-Partners When a U.S. government Agency is the Prime Partner**

For those occasions where a USG Agency is the prime partner, you may not have sub-partners under that funding mechanism. A sub-partner under a USG Agency is the same as a prime partner, and the entity should be entered as a separate funding mechanism. For instance, CDC should only be listed as a prime partner for technical programming that CDC provides directly in-country. (Costs of staff time, including the provision of technical assistance, should be entered as costs of doing PEPFAR business in the M&O section, not as a funding mechanism.) If funding will eventually be obligated to another organization, then CDC should NOT be the prime partner. For more assistance with this issue, please contact Heather Pumphrey ([hbp7@cdc.gov](mailto:hbp7@cdc.gov)).

### **5.5.17 Subdivisions of an Organization**

If an organization has one or more subdivisions or sub-offices that are receiving funding, you should not enter each subdivision or sub-office as a sub-partner of the parent organization. You would only enter the subdivision or sub-office if it is receiving the funding directly from a USG agency prime partner, independently of the parent organization.

*Examples:*

1. If you are funding the national Red Cross in your country, you would not list each subdivision of the Red Cross as a sub-partner if it is receiving its funding from the national headquarters office. You should only list local chapters of the Red Cross as sub-partners if they are receiving funds directly without it first going through the national headquarters office.
2. If you are funding the national MOH in your country, you should only list the district level health ministries as sub-partners if they are receiving funds directly from a prime partner without going first through a national level headquarters.

### **5.5.17 Funding Sources / Accounts**

The funding sources tab is the space for OUs to indicate the total funding that will be used for the implementation of FY 2015 COP, and provide details of the breakdown across funding accounts and new vs. prior FY year funds. Country teams are encouraged to think about new planned FY 2015 resources and available pipeline funding as one funding envelope for the mechanism. A strong COP submission will reflect a strategic application of pipeline and allocation of new funds.

## FY 2015 Resources

For new FY 2015 funds, there are as many as three accounts (GHP-State, GHP-USAID and GAP) available to country teams for programming. FACTS Info will be programmed with the available budgets for these three accounts, and not all OUs will have all accounts available to them.

Please note: there are firm parameters as to how the three accounts can be allocated across agencies. The funding source choices for each agency are:

U.S. government Agency	FY 2015 COP Funding Source Categories for New Planned Funding
<b>USAID</b>	GHP (State) GHP (USAID)*
<b>HHS/CDC</b>	GAP** GHP (State)
<b>HHS/HRSA</b>	GHP (State)
<b>HHS/OGA</b>	GHP (State)
<b>DoD</b>	GHP (State)
<b>DoL</b>	GHP (State)
<b>State</b>	GHP (State)
<b>Peace Corps</b>	GHP (State)
<b>ALL OTHERS</b>	GHP (State)

\* The GHP-USAID account is the account appropriated directly to USAID, formerly the Child Survival and Health (CSH) Account (FYs 2007 and prior), and the Global Health and Child Survival (GHCS) Account (FY 2008-FY 2011).

\*\* The GAP account was formerly called "Base (GAP Account)," and is applicable for HHS/CDC activities only.

As noted elsewhere, please ensure that you are coordinating as a USG Team in determining funding decisions and that **all** USG HIV/AIDS funding is being programmed as an interagency country team. Please also ensure that your programming is consistent with your budget controls in order to ensure a smooth submission.

At the top of the Funding Source tab, country teams have the opportunity to enter an amount of “**Applied Pipeline Funding**,” which the system will auto-sum with the new FY 2015 funding requested, by funding account. This applied pipeline data will reflect the amount of PEPFAR pipeline funding, from all accounts, that will be applied to the mechanism for the FY 2015 COP implementation. The applied pipeline is the amount of money you project will not be expended by September 30<sup>th</sup>, 2015 and can be used in the FY 2015 COP (i.e. FY 2016). This total pipeline funding amount may be less than, equal to, or more than the Total Mechanism Pipeline indicated on the mechanism detail tab.

### 5.5.18 Cross-Cutting Budget Attributions

For more information please see Appendix 2.

#### *Overview*

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The importance of cross-cutting budget attributions cannot be over-emphasized. Each represents areas of PEPFAR programming with great potential to contribute to PEPFAR by more consciously seeking opportunities for integration and synergy across program areas. Cross-cutting attributions also reflect areas in which there is continuing stakeholder interest, including recommended (“soft”) Congressional earmarks for food and nutrition activities. Similar to other earmarks and budgetary considerations, only new FY 2015 planned funding can be reflected in cross-cutting attributions (i.e. applied pipeline does not get reflected).

Correct identification of cross-cutting attributions and key issues are **critical** to minimize data calls in the future.

All mechanisms that are applying new FY 2015 planned funding for work in any of the cross-cutting attributions (HRH, Construction/Renovation, Motor Vehicles, Food and Nutrition, Economic Strengthening, Education, Water, Condoms, Gender-based Violence, or Gender Equality) **must** have the cross-cutting budget attributions identified and accurately quantified; if you need assistance in developing standard approaches to quantifying cross-cutting attributions, please contact your CL. For definitions of cross-cutting attributions, please see Appendix 2.

In FY 2015, we will be capturing FY 2015 funding information for fourteen system-level areas, which are listed below and defined in Appendix 2. Individual attributions should not total more than the FY 2015 mechanism planned funding (new FY 2015 funds only), but the sum of all system-level

attributions may exceed the FY 2015 mechanism total planned funding. For example, if a partner is being funded at \$1,000,000 for Pediatric Treatment, the planned funding for each system-level attribution cannot be more than \$1,000,000. A single activity can often have more than one system-level attribution (e.g., service training on safe water would be split between both HRH and Water), and together these attributions could exceed \$1,000,000 in funding. System-level attributions should be identified for all relevant mechanisms, even in the case of TBD mechanisms. In these cases, country teams should estimate the amount of funding for each of the system-level budget categories. The system-level budget information can be updated during subsequent COP update cycles (OPU) if necessary.

System-level attribution categories are as follows:

1. Human Resources for Health
2. Construction
3. Renovation
4. Motor Vehicles: Purchased
5. Motor Vehicles: Leased
6. Key Populations: MSM and TG
7. Key Populations: FSW
8. Food and Nutrition: Policy, Tools, and Service Delivery
9. Food and Nutrition: Commodities
10. Economic Strengthening
11. Education
12. Water
13. Gender: GBV
14. Gender: Gender Equality
15. Condoms: Policy, Tools, and Services
16. Condoms: Commodities

For the Gender: GBV, Gender: Gender Equality, Key Populations: SW, system-level budget attributions, there will be a new required check list of activities that teams must complete. Teams should check all activities that apply. See COP for further information.



Activity managers and technical working groups are asked to give thoughtful consideration to identifying the extent to which planned activities contribute to progress in these areas.

#### 5.5.19 New Mechanism Activity Table

In COP 2015, a **New Mechanism Activity Table** will be required for all new mechanisms. Narratives in FACTS Info are *not required*. The template for the **New Mechanism Activity Table** can be downloaded on the PEPFAR.net COP 15 website. All **New Mechanism Activity Tables** should be uploaded to FACTS Info as a supplemental document. One supplemental upload is expected for each new mechanism identified in COP 2015.

In COP 2015, activity tables for existing mechanisms are *not* required.

#### 5.5.20 Public Private Partnerships

PEPFAR defines Public Private Partnerships (PPPs) as collaborative endeavors that combine resources from the public sector with resources from the private sector to accomplish HIV/AIDS prevention, care, and treatment goals. The three hallmarks of PPPs are: 1) they help ensure sustainability of programs; 2) they facilitate scale-up of interventions; and 3) they leverage significant private-sector resources. PPPs are distinct from traditional contractual arrangements – such as grants, cooperative agreements, and contracts – in that they are rooted in co-creation, co-design, and co-resource mobilization towards a shared and mutually beneficial objective. While some Agency definitions of a PPP require a 1:1 match from the private sector, Country Teams are strongly encouraged to engage with private sector entities regardless of resource inputs whenever it increases the effectiveness of programs.

In COP 2015, PPPs are entered in the mechanism information section of FACTS Info. All PPPs should be linked to an existing or planned mechanism. For additional instructions, see *FACTS Info PEPFAR Module Fiscal Year 2015 COP System Updates*, available for download on the PEPFAR.net COP 15 website.



## **6.0 SUBMITTING COP ELEMENTS**

## 6.1 COP/ROP Submission

The COP is comprised of four primary elements, each submitted using different systems.

The **Strategic Direction Summary (SDS)** outlines key data and analysis results, the strategic plan for the coming year, and the monitoring framework that will be used to measure progress. The SDS is submitted in FACTS Info as a supplemental document. Microsoft Word format is recommended and a template has been provided to assist country teams prepare a comprehensive SDS.

The **Supplemental Data Pack** has been provided to country teams in Microsoft Excel format and is intended to be a template and analysis tool to assist PEPFAR field teams meet the requirements for successful preparation of the SDS. The workbook is also intended to assist reviewers to understand the data analysis completed by the country teams and limit the need for extensive verbal or written clarification. The workbook is submitted in FACTS Info as a supplemental document.

This year, **targets** will be submitted through PEPFAR's new data collection system: DATIM<sup>18</sup>. Targets are required at the site, geographic, mechanism and technical area levels.

The **budget, mechanism information** and **other required documentation** are submitted in FACTS Info by direct entry in the user interface.

Both DATIM and FACTS Info systems are accessible to field teams, and require users to set up accounts to access these systems. Please work with your CL to ensure your team has appropriate.

### 6.1.1 FACTS Info Templates for Data Entry

COP/ROP submission may be done using PEPFAR Module templates that teams can upload directly into FACTS Info, or via direct data entry using the screens in the PEPFAR Module. **OGAC intends to**

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<sup>18</sup> Countries without DATIM operational will be provided an alternative format for submission.

open the PEPFAR Module COP section in January 2015. **Prepopulated templates for new IMs will be available.** The intent is to allow teams to gain access to the prepopulated templates and share these templates with their partners in advance of opening the system in January for data entry/upload. Blank templates will also be made available in October, however, please note that **blank templates CANNOT be used for existing mechanisms.** Teams are required to use prepopulated templates for existing mechanisms in order to maintain the mechanism ID number and history.

Template Name	Function of Template	Where to find the template
<b>Blank Implementing Mechanism Template</b>	For new IMs created in FY 2015 COP, has all elements that will be asked for in FACTS Info and is organized in a way that corresponds to the FACTS Info Tabs for each IM. When the full COP Module is open you can upload this template to FACTS info to create a new IM rather than entering data directly on the screen in FACTS.	FACTS Info only
<b>Pre-populated Implementing Mechanism Template</b>	Format is similar to the Blank IM template but this is specifically for continuing IMs, this template is 'run' in FACTS info in a special early release section. Use to update existing IMs created in previous FYs. When the full COP Module is open you can upload this template to FACTS info to create a new IM rather than entering data directly on the screen in FACTS.	FACTS Info only
<b>New Partner Template</b>	If you don't find a partner's name in the Partner List please fill out this form and submit to PEPFAR-Module-support@state.gov per the guidance on New Partners in Appendix 3 on Building Partner Capacity and Sustainability.	PEPFAR.net >Planning and Reporting Cycles

### 6.1.2 Checking Your Work and Highlights of Key Reports

In addition to systems checks, the FACTS Info system offers multiple options for 'checking your work.' In many countries there are multiple U.S. government team members who enter data in FACTSInfo and DATIM and even more that enter data into templates that are uploaded to FACTS Info that collectively become the COP. By utilizing key reports you can ensure the COP submission (i.e. what is in FACTS Info) is what the country team intended to submit. Checking your work can also lessen the need for extensive clarifications between OGAC, Agency Headquarters, and country teams after COP

submission. We urge all teams to heavily utilize the reports available in both the Standard Reports section of the COP module and within the Budget section of FACTS Info in the 'ad-hoc' reports section where you can customize reports.

### Highlights of Key Reports

- **Standard COP Matrix Report-** Shows all IMs along with Agency, Total Mechanism Pipeline, Funding Source (including Applied Pipeline) and amounts, Budget Code Funding amounts, and crosscutting allocations. This report is the most useful snapshot of critical budget information entered into FACTS Info.
  - Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.
- **Summary of Planned Funding by Agency-** Shows the allocations of the full programmed COP budget by funding account and implementing agency. In addition, can also show pre-COP allocations by agency, total submitted agency mechanism and applied pipeline.
- **Summary of Planning Funding by Budget Code-** Shows the allocations of the full programmed COP budget by budget codes. This report can be filtered by implementing agency. Also, indicates the total budget code allocation "on hold.
- **Agency Cost of Doing Business (CODB)-** Shows the agency-specific allocations across the 11 CODB cost categories by funding source.
  - Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

## **7.0 Budgetary and Reporting Requirements**

Countries or regions should fund their program based upon the COP 2015 planning level and earmark requirements as described in the official planning letter distributed by S/GAC in January 2015. **COP 2015 should be planned to the stated planning level in the letter, which equals the sum of requested new FY 2015 resources and prior year available pipeline applied in support of COP 2015 activities (applied pipeline).** The distribution between new and applied pipeline should be determined based upon the amount of excessive pipeline available for implementation in COP 2015.

PEPFAR will continue to meet previously stipulated Congressional earmarks and fulfill the expectations around other key priority areas while OGAC continues to communicate with Congress about their expectations and will make teams aware of any shifts for programmatic focus.

Please note: earmarks/budgetary considerations can only be satisfied via programming of current year (FY 2015) funds. The application of pipeline cannot be counted towards a team's fulfillment of earmark requirements or other budgetary considerations.

## **7.1 COP Planning Levels, Applied Pipeline and Financial Supplemental Document**

### **7.1.1 COP Planning Levels**

The COP 2015 planning level represents the total resources (regardless of whether they are new FY 2015 resources or prior year pipeline resources) that a country or region will outlay over a 12-month period in order to achieve the stated goals or targets of COP 2015.

The COP planning level is the sum of new FY 2015 resources and pipeline applied to COP 2015 implementation (COP Planning Level = New Funding Request + Total Applied Pipeline). All outlays anticipated to occur during the COP 2015 implementation cycle must be included within the COP 2015 planning level.

As pipeline is applied to COP 2015 implementation, FY 2015 new funds must be decreased in order to keep the entire COP request within the COP 2015 planning level.



Contact your Country Lead prior to final COP submission within FACTS Info in order to ensure FY 2015 funding account control levels are updated within FACTS Info, and the completed COP/ROP balances. A COP/ROP cannot be submitted without these updates made at headquarters.

A COP/ROP may not include any “unallocated” funds within the COP Planning Level. If the total planning level exceeds the overall resource envelope required to achieve targets, or is determined to be greater than a country or region’s actual ability to outlay within a 12-month period, teams are encouraged to submit a final COP requesting a lower COP 2015 planning level, rather than creating TBDs and/or overfunding mechanisms, or stating a higher spend-rate than is feasible. Some examples of instances in which this scenario may occur are as follows: transition, other available donor resources, etc.

Contact your Country Lead if this scenario seems likely during the COP planning process or for more information on expectations.

#### **7.1.2 Applied Pipeline**

Applied pipeline is a data field within the COP/ROP that indicates the total amount of prior year (pipeline) funds that will be “applied” to the 12-month implementation of a certain mechanism (or CODB category), and will assist in the achievement of the COP 2015 goals/targets.

Applied pipeline should reflect the pipeline resources that have been deemed as “excessive pipeline,” and are therefore available for implementation within COP 2015. The applied pipeline field should also include any prior year (non-FY 2015) COP funding that has been planned for implementation with COP 2015 activities (i.e. construction funding programmed in a previous year that continues to outlay during COP 2015).

**It is expected that all agencies within all countries or regions will analyze their pipeline, ensuring that pipeline remains within an acceptable range, and adjust the new funding allocations as required to spend down excessive pipeline.** A submitted COP that does not address excessive pipeline may be subject to delays in approval.

Every PEPFAR program requires a certain amount of pipeline to ensure there is no disruption to services due to funding delays or other unanticipated issues. An acceptable level of pipeline is expected to be reflective of 3-6 months of outlays, unless a country is designated as “Special Notification” within the FY 2015 appropriations bill. Countries designated as “Special Notification” should consider a pipeline that is reflective of 12 months of outlays as acceptable. Pipeline that is

above this accepted level of 3-6 months (or 12 months for special notification) is considered “excessive.” Only “excessive” pipeline should be included in the COP 2015 request as applied pipeline, as this excessive amount must be spent down in order to reduce pipeline and bring it into an acceptable range.

As stated in Section 8 below, funding for Peace Corps Volunteers (PCVs) must cover the full 27-month period of service and thus, countries with PEPFAR-funded volunteers are excepted from the 3-6 months of pipeline rule.

In most instances, the pipeline applied to a mechanism (or CODB category), “applied pipeline,” will be less than the total pipeline available to the mechanism, as the acceptable pipeline level must be maintained and should not be considered as available for application to COP 2015.

The applied pipeline field within COP 2015 should be considered a type of COP 2015 funding source (in addition to the GHP-State, GHP-USAID, and GAP accounts). The sum of these funding sources (new FY 2015 funds + applied pipeline) will equal the total resources expected to be outlayed by an individual mechanism (or CODB category) over a 12-month period. When all mechanism funding sources (new FY 2015 funds + applied pipeline) and all M&O funding sources (new FY 2015 funds + applied pipeline) are added together, this total is equal to the outlay level for COP 2015, i.e. to the COP planning level.

**Note:** *It is understood that many agencies follow a “first-in, first-out” approach to budget execution, requiring the full utilization of older funds before any new FY 2015 funds are obligated and expended. Due to this budget execution approach, the actual fiscal year of funds that are outlayed in support of an approved COP 2015 activity may not match the approved COP 2015 applied/new funding breakdown.*

### 7.1.3 Financial Supplemental Worksheet

Each country or region must submit a financial supplemental worksheet at COP/ROP submission, detailing the historic, current and projected financial performance of all mechanisms and CODB categories included within the COP/ROP. Each country or region must submit one document compiling the information for all agencies.

The **Financial Supplemental Worksheet** can be found on PEPFAR.net COP15 website.

The ***Financial Supplemental Worksheet*** must be uploaded into the FACTS Info Document library upon submission. A COP/ROP submission will not be considered complete without the submission of this supplemental document.

The ***Financial Supplemental Worksheet*** includes three tabs:

Tab 1: Mechanism Data

All mechanisms included in the COP 2015 submission must be represented in this tab. The final submitted Financial Supplemental Worksheet must combine all agencies into one submission, and the totals must match with the data entered into FACTS Info.

The Standard COP Matrix Report should be used as a resource for completing this Tab. It is the best source for a complete listing of all implementing mechanisms and data within that report should be copied and pasted into the worksheet for columns A-M.

The remaining required elements should be completed with assistance from agency field and headquarters financial staff.

Tab 2: CODB Data

See M&O section 8.0 for further details.

Tab 3: Totals (sum of Tabs 1 and 2)

The totals reflected in this Tab must match with the total COP planning level and totals submitted within FACTS Info.

## **7.2 Budget Code Definitions**

### **7.2.1 MTCT- Prevention of Mother to Child Transmission**

MTCT – Includes activities aimed at preventing mother-to-child HIV transmission.

Activities that **should be** included in MTCT:

1. Services and support related to the initiation, adherence, retention, clinical monitoring (including labs), and NACS (including breastfeeding counseling) for HIV+ pregnant and breastfeeding women *newly initiating ARVs under options B*.
2. HIV testing for all pregnant and breastfeeding women and their partner(s).
3. Salary support for CHWs that assist with PMTCT specific adherence and retention activities
4. Training for clinical and other personnel supporting PMTCT activities (i.e., lay counselors, M2M, data clerks)
5. Training for HEI-related services
6. Sample transport systems for specimens at the site level for clinical monitoring of PMTCT clients (CD4/VL)
7. National/district level support for B+ roll-out
8. Program M&E *specifically related to PMTCT*, including:
9. Register revision/program reviews for B+ transition.
10. Real time monitoring and feedback
11. Population transmission rates at national or subnational level
12. Evaluations around B+
13. ARV prophylaxis for newborns

Activities that **should NOT** be included in MTCT (these costs should be accounted for in their respective budget codes):

1. Service delivery for B+ (HTXS)
2. ARV drugs (HTXD)
3. Male and female condoms and lubricant (HVOP)
4. Community based activities focused on family strengthening (HKID)
5. Household and economic food security (HKID)
6. Social welfare (HKID/HBHC)
7. Lab reagents for CD4/VL/EID (care and treatment codes)
8. INH prophylaxis (HVTB)
9. TB screening and treatment for pregnant women (HVTB)
10. Women on their second pregnancy and are on ART from their previous pregnancy – service delivery (HTXS); ARVs (HTXD)

### 7.2.2 HVAB- Abstinence/Be Faithful

Activities that **should** be included in HVAB:

1. All prevention activities that promote abstinence or fidelity
  - a. School-based prevention programs that promote delay of sexual debut
  - b. Sexuality education
  - c. Parenting programs (eg Family Matters)
2. Life Skills Programs
3. Mass Communication and media campaigns (eg Shugga)
4. Behavior change programs

Activities that **should NOT** be included in HVAB:

1. Prevention aimed at Key Populations (HVOP)
2. Condom procurement, distribution or marketing (HVOP)

### 7.2.3 HVOP – Other Sexual Prevention

Activities that **should** be included in HVOP:

1. Services related to the procurement, distribution and marketing of male and female condoms and condom-compatible lubricant
  - a. This can include condom procurement for key populations and for the general public
2. All sexual prevention programs targeted for key populations:
  - a. Peer outreach
  - b. Small group prevention activities
  - c. Hotspot prevention activities
3. NGO Network building
4. Comprehensive care for survivors of sexual assault, including the provision of PEP
5. Activities related to reducing alcohol related sexual disinhibition
6. Linkages to other services and platforms (ie VMMC, Care, Treatment)
7. Engagement with the government and civil society organizations to reduce criminalization of key populations
8. Training for providers for key populations considerations
9. Prevention targeting priority populations (ie military, adolescent girls)
  - a. Adolescent friendly sexual and reproductive health services

Activities that **should NOT** be included in HVOP:

1. Activities for HIV+ key populations (These activities should be tracked using key populations budget attributions- KP : FSW or KP: MSM/TG- if possible):
  - a. STI management for HIV+ in KP setting (HBHC)
  - b. MAT/MMT for PWIDs (HBHC)
2. Community or facility clinical services for HIV+ KP clients (HTXS or HBHC)
3. All PwP or PHDP activities (HBHC)
4. Size estimation surveys or IBBS surveys (HVS)

#### 7.2.4 HMBL- Blood Safety

Activities that **should** be included in HMBL:

1. Activities supporting a nationally-coordinated blood safety program to ensure accessible, safe and adequate blood supply
2. Infrastructure and policy
3. Donor-recruitment
4. Blood collection and blood testing (transfusion-transmissible infections)
5. Storage and distribution
6. Ensuring appropriate clinical use of blood
7. Transfusion procedures and hemovigilance
8. Training and human resource development
9. Monitoring and evaluation for blood safety

#### 7.2.5 HMIN- Injection Safety

Activities that **should** be included in HMIN:

1. Programs, policies, training and advocacy to reduce medical transmission of HIV and other blood borne pathogens
2. Programs to reduce unnecessary injections and promote injection safety
3. Health care waste management programs
4. Management of needle sticks and occupational PEP
5. Safe phlebotomy
6. Infection prevention and control

- a. Single use syringes and needles
- b. Lancets and blood drawing equipment
- c. Safety boxes
- d. Gloves for safe phlebotomy

### 7.2.6 IDUP- Injecting and Non Injecting Drug Use

IDUP- Prevention among people who inject drugs (PWID)

Activities that **should** be included in IDUP:

1. Policy reform around PWIDs
2. Needle and syringe access programs
3. Training and capacity building for providers, including the host government and NGOs
4. Procurement of methadone and other medical-assisted therapies (MAT) should be included ONLY if it is for at HIV negative PWIDs for prevention purposes (see HBHC for MMT/MAT for HIV positive PWIDS)
5. Comprehensive programs for PWIDs included methamphetamine
6. Community mobilization and PWID Networks

Activities that **should NOT** be included in IDUP:

1. Prevention of sexually transmitted HIV infection among PWIDs (HVOP)
2. MMT/MAT for HIV positive PWIDs (HBHC)
3. Continuum of care for HIV+ PWIDs (HBHC)
4. Non-injection drug prevention interventions (i.e., alcohol risk reduction) (HVOP)

### 7.2.7 CIRC- Voluntary Medical Male Circumcision

Activities that **should** be included in CIRC:

1. Support the implementation of VMMC- This includes the minimum package of clinical and prevention services which **MUST** be included at every VMMC delivery point
  - a. Age-appropriate sexual risk reduction counseling
  - b. Counseling on the need for abstinence during the healing process after the procedure
  - c. Circumcision by a medical method recognized by WHO (device or surgery)
  - d. Post-surgery follow-up, including adverse event assessment

- e. Distribution of condoms
- f. HIV testing prior to circumcision for all men and their partners
- 2. Circumcision supplies and commodities
  - a. This includes emergency equipment such as tourniquet, IV and IV catheters, hydrocortisone, adrenaline, sphygmomanometer, stethoscope, and sodium chloride
  - b. PrePex or other circumcision devices (only if they are WHO prequalified)
  - c. Supplies for safety during the procedure: exam gloves, alcohol swabs, gauze, adhesive tape, syringes and needles
- 3. Communication and demand creation
- 4. Training
  - a. Adverse event and safety training
  - b. In-service training for VMMC for either surgery or devices
  - c. Curriculum creation
- 5. Linkages to treatment/ Care services for men who test HIV+

Activities that **should NOT** be included in CIRC:

- 1. Circumcisions for clients between 61 days old up to age to be confirmed by front office
- 2. Circumcisions that require anesthesia or sedation

### 7.2.8 HVCT- HIV Testing and Counseling

Activities that **should** be included in HVCT:

- 1. The provision of HIV testing and counseling across the range of community and facility-based settings (including client and provider- initiated approaches)
  - a. HVCT should include budgets for HIV testing for PHDP, key populations, adult treatment, care and support, pediatric treatment, and for orphans and vulnerable children
- 2. Supply, provision and distribution of RTKs
- 3. Mobilization to support HTC and testing demand creation
- 4. Linking HTC-users to the appropriate services (ie VMMC, Prevention, Treatment, Care) and tracking those linkages

Activities that **should NOT** be included in HVCT



1. Testing and counseling in the context of PMTCT (MTCT)
2. EID (PDCS)
3. Testing and counseling in the context of TB (HVTB)
4. Testing and Counseling in the context of VMCC (CIRC)

### 7.2.9 HBHC- Adult Care and Support

Activities that **should** be included in HBHC:

1. All services provided under the HBHC budget code apply to HIV+ adult clients only. Care and support interventions (as defined in the Technical Considerations), including PHDP interventions, provided to HIV+ adult clients should be attributed to HBHC.
2. Procurement of cotrimoxazole and associated support (e.g. training, monitoring, oversight/mentoring, etc.)
3. Services related to prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria, diarrhea, and Cryptococcal disease (including provision of commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services) to all HIV+ adults,
4. Pain and symptom relief
5. Screening and treatment to prevent cervical cancer in HIV-infected women, specifically screening with visual inspection and treatment with cryotherapy or loop electrosurgical excision procedure (LEEP), including procurement of associated supplies and equipment
6. Nutritional assessment, counseling, and support for HIV+ children, women and men
7. Procurement of HIV+ monitoring commodities (CD4)
8. For HIV+ individuals, all services related to the prevention of onward transmission of HIV as well as maintaining health of the patient:
  - a. Assessment of sexual activity and provision of condoms (and lubricant) and risk reduction counseling (if indicated).
  - b. Assessment for STIs and provision of or referral for STI treatment and partner treatment if indicated.
  - c. Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services.

- d. Assessment of adherence and (if indicated) support or referral for adherence counseling. Assessment of need and (if indicated) refer or enroll PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc.
- e. Condom provision
- 9. Medication Assisted Treatment (MAT – methadone) can be proposed for inclusion in situations where country teams are able to track the portion of the MAT services provided to HIV positive individuals.
- 10. All PHDP activities for HIV+ individuals

Activities that **should NOT** be included in HBHC:

- 1. ARVs (HTXD)
- 2. TB drugs and services, including TB screening and support for IPT (HVTB)
- 3. Costs associated with testing partners and family members of PLHIV (HVCT or MTCT)
- 4. STI drugs used for broader populations (e.g. KPs seen in a general STI clinic) (HVOP)
- 5. Services provided more broadly to key populations of unknown or negative serostatus (HVOP)
- 6. All care interventions for HIV+ children (PDCS).
- 7. With regard to cervical cancer, PEPFAR does not provide funding for primary prevention (HPV vaccine), cytologic screening (Pap smears), or treatment for invasive cervical cancer.

### 7.2.10 HKID- Orphans and Vulnerable Children

Activities that **should** be included in the HKID budget code:

- 1. Support of vulnerable children and their households
  - a. Promotion of Cash Transfers
  - b. Household economic and food security
  - c. Education subsidies
  - d. Improve child and family relationships
  - e. Protective services for children
  - f. Keeping children in family structures
  - g. Access to healthcare and health services
  - h. Access to adolescent friendly services/ Reproductive health services
  - i. Early Childhood Development programs
  - j. Growth monitoring for young children
- 2. Support of the community with OVC

- a. Mobilizing child protection committees
  - b. Strengthening the capacity of local NGOs and CBOs who work on OVC issues
  - c. Building of social welfare and service networks including the social workforce
3. Linkages to other HIV related services
  - a. Linkage and referral to facility and community-based services like HTC, pediatric care and treatment
4. M&E for intervention evaluations of OVC programming

Activities that **should NOT** be funded under HKID:

1. Pediatric drugs, diagnostics and services (HTXD, HVCT, PDCS, PDTX)
2. Pediatric care and support (PDCS)
3. HTC in OVC settings
4. Prevention commodity procurements

**Note:** *Implementing Partners working to serve orphans and vulnerable children should be supported to offer comprehensive programs that include HTC and linkages to care and treatment from both community and facility sites; activities within these comprehensive programs must be coded to HTC and HKID as indicated in the budget code guidance as noted in sections 7.2.8 and 7.2.10.*

#### **7.2.11 HVTB- TB/HIV**

Activities that **should** be included in HVTB:

1. All TB screening, including for pregnant women
2. INH prophylaxis for all HIV+ populations
3. Laboratory investments for TB/HIV, including GeneXpert equipment, test kits, and other consumables and other TB diagnostics (biosafety cabinets, AFB smear and culture)
4. Exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis (including isoniazid and drugs for treating active TB)
5. Screening of TB clinic clients for HIV testing and clinical care, including fast-tracking for initiation of ART for PLHIV with TB.
6. Services that target TB/HIV activities in special populations such as pediatrics, prisons, and miners.
7. Human resources to accelerate planning and implementation of collaborative TB/HIV activities, including site-level integration of TB and HIV activities

8. Efforts to improve monitoring, evaluation and reporting of collaborative TB/HIV activities.

Activities that **should NOT** be included in HVTB:

1. Costs associated with HIV testing among TB patients (HVCT)
2. Costs associated with ART treatment and monitoring of TB/HIV patients

#### **7.2.12 PDCS- Pediatric Care and Support**

Activities that **should** be included in PDCS:

1. All HIV-related care services provided for HIV-positive children and adolescents either in the community or in the facility
2. Facility based services for exposed infants (NACS, insecticide treated bednets, safe water, clinical monitoring, pain and symptom relief, and nutritional assessment and support including food)
3. Early infant diagnosis services implemented at the site level
4. CTX prophylaxis (commodities)
5. Sample transport and results return for pediatric specimens at the site level (CD4/VL/EID)
6. Activities to support the needs of adolescents with HIV (ALHIV) (PwP, support groups, support for transitioning into adult services, adherence support, reproductive health services, educational support for in and out of school youth)
7. Activities promoting integration with routine pediatric care, nutrition services and maternal health services, malaria prevention and treatment.
8. Activities to ensure appropriate dispensation of CTX and INH, prophylaxis in infants, children and adolescents.
9. Activities to address nutritional evaluation and care of malnutrition in HIV+ and exposed infants, children and youth.
10. Activities to address psychosocial support of children and adolescents, including disclosure, adherence counseling, and support groups.
11. Activities that will increase direct linkages to the community to improve communication between facilities and community services for HIV+ children and youth.
12. Activities that support HTC to widen the access, utilization and uptake by families and adolescents
13. Activities that strengthen retention in care from infant to transition from adolescent to adult services

Activities that **should NOT** be included in PDCS:

1. Broader lab capacity, training and equipment, including activities to strengthen laboratory support and diagnostic services for pediatric patients (HLAB)
2. Services that target TB/HIV activities in pediatrics, including INH
3. Infrastructural and construction activities (OHSS)
4. Key pretention activities that address girls, YMSM, LGBT, substance users and youth involved in sexual exploitation (HVOP)

#### 7.2.13 HTXD- ARV Drugs

Activities that **should** be included in HTXD:

1. All ARVs, including ARVs for adult treatment, pediatric treatment, and PMTCT.
2. All antiretroviral Post-Exposure Prophylaxis procurement for rape victims and needlestick injuries
3. Cost of distribution of ARVs to the site level
4. Cost of distribution of ARVs and other care and treatment commodities to the site level

Activities that **should NOT** be included in HTXD:

1. Supply chain management advisors (OHSS)
2. Distribution/supply chain/logistics, pharmaceutical management and related systems strengthening inputs (OHSS)
3. Commodity storage costs or management of those storage costs related to distribution of ARVs (OHSS)
4. Rental costs or the tracking or equipment needed to move commodities inside a warehouse (OHSS)
5. Software or planning costs related to distribution of ARVs (OHSS)

#### 7.2.14 HTXS- Adult Treatment

Activities that **should** be included in HTXS:

1. Direct service provision as well as direct technical support to the site, including:
  - a. Direct services for HIV+ patients related to adherence, retention, and clinical monitoring both at the facility and community-level

- b. Procurement of CD4 and VL reagents (this can be coded in HBHC but costs cannot be double-counted)
2. Service delivery for option B+, including support for clinic personnel
3. In-service training for clinicians and other providers to provide adult care
4. Sample transport and results return for pediatric specimens at the site level (CD4/VL)
5. HIV care and treatment drug delivery – distribution costs to facility level.

Activities that **should NOT** be included in HTXS:

1. Procurement of RTKs (HVCT)
2. ARVs (HTXD)
3. Pre-service training (OHSS)
4. Laboratory services for counseling and testing (HLAB)
5. TB screening (HVTB)
6. Pediatric care and treatment (PDCS or PDTX)
7. HIV drug resistance surveillance activities (HVSI)
8. Services and support related to the initiation, adherence, retention, clinical monitoring (including labs), and NACS (including breastfeeding counseling) for HIV+ pregnant and breastfeeding women *newly initiating ARVs under options A and B.* (MTCT)

### **7.2.15 PDTX- Pediatric Treatment**

Activities that **should** be included in PDTX:

1. Costs associated with providing clinical services to HIV+ children
2. Costs associated with community support to HIV+ children
3. Support to the government to roll out updated pediatric treatment guidelines
4. In-service training for clinicians and other providers to provide pediatric care
5. Clinical and laboratory monitoring of children and adolescents on treatment (CD4/VL reagents)
6. Activities building capacity to monitor, supervise and implement uninterrupted HIV treatment services from infancy to adolescents (including transition to adult services)
7. Activities supporting adherence in pediatric and adolescent populations, improve overall retention on treatment and establish functional linkages between programs and with the community to reduce loss to follow up and improve long-term outcomes
8. Activities promoting case finding and integration of pediatric HIV treatment services into MCH platforms

Activities that **should NOT** be included in PDTX:

1. Pediatric formulations of ARVs (HTXD).
2. Development of capacity to provide laboratory services that escalate case finding for children/adolescents and detect treatment failure (HLAB)
3. Infrastructural and construction activities (OHSS)
4. Promoting integrated approaches to improve outcomes HIV drug resistance surveillance activities (HVSII)
5. Activities related to specialized curriculum development and pre-service training (OHSS)

#### 7.2.16 OHSS- Health Systems Strengthening

Activities that **should** be included in the OHSS budget code:

1. Activities that contribute to improvements in national-, regional- or district-level health systems (generally those that are implemented above the service delivery point (site) level and/or are not directly tied to patients, beneficiaries, facilities or communities)
2. Development and implementation of policy, advocacy, guidelines and tools (e.g., broad-based, such as development of Human Resources for Health Strategic Plan; related to specific technical areas, such as circular/guidelines/protocol development)
3. Technical assistance to improve system-level financial management systems
4. Pre-service training and curriculum development support for in-service trainings at regional training centers
5. An integrated package of activities focused on a range of health systems strengthening building blocks with a SI or lab component that does not constitute the majority of those activities
6. Support for supply chain at above-site level, including support to national and subnational levels for forecasting, warehousing, and distribution of HIV-related commodities
7. Supporting supply chain systems through training and development of cadres with supply chain competencies
8. Capacity building of civil society organizations that interact with the health system, such as local non-governmental, faith-based, and community-based organizations
9. Support to Global Fund programs and activities, and donor coordination

Activities that **should NOT** be included in the OHSS budget code:

1. Laboratory and SI activities that fall under the HLAB and HVSI budget codes, respectively
2. In-service training for care and treatment and should be coded under the relevant care and/or treatment budget code (MTCT, HTXS, HBHC)
3. HIV care and treatment drug commodity distribution to the facility level (HTXS)

### 7.2.17 HLAB- Laboratory Infrastructure

Activities that **should** be included in the HLAB budget code:

1. Development and strengthening of laboratory networks and facilities to support HIV/AIDS-related activities, including purchase of equipment (including Point-Of-Care) and commodities, quality assurance for HIV rapid testing, Lab staff training and other technical assistance
2. Lab training, QA/QI, mentoring/supervision
3. LMIS/forecasting systems
4. Lab commodities/consumables (except reagents for the support of CD4, EID and VL)
5. Lab equipment (except GeneXpert)

Activities that **should NOT** be included in the HLAB budget code:

1. An integrated package of activities focused on a range of health systems strengthening “building blocks” that has a lab component, but where laboratory activities does not constitute the majority of those activities (OHSS)
2. Lab reagents for the support of CD4, EID, and VL (adult and pediatric care and treatment codes)
3. GeneXpert (HVTB)
4. Service delivery costs, including costs associated with providing service to the patient such as phlebotomy or sample transport from the site (care and treatment budget codes)

### 7.2.18 HVSI- Strategic Information

Activities that **should** be included in the HVSI budget code:

1. Activities that build capacity for and ensure the implementation of the collection, analysis and dissemination of HIV/AIDS behavioral and biological surveillance and monitoring information; Supporting capacity building efforts and the implementation of facility and other surveys; Build the capacity for the development of national program monitoring systems;



Support the development of country-led processes to establish standard data collection methods; and

2. Support for the national health information system planning and development.
3. HIVDR surveys
4. HIV Impact Survey (HIA)
5. LMIS
6. IBBS
7. Country wide electronic medical records

Activities that **should NOT** be included in the HVSI budget code:

1. Activities directly supporting one specific program area (i.e., B+ M&E framework);
2. Activities that are integral components of a prevention, care, or treatment funding mechanism;
3. An integrated package of activities focused on a range of health systems strengthening “building blocks” that have a SI component that does not constitute the majority of those activities (OHSS).

## 7.3 Mandatory Earmarks

Planning for mandatory earmarks should be fully integrated into the COP planning process. This funding should complement and enhance the country program, reflect sound and effective allocations to partners with high outlay rates and associated results and ultimately allow for PEPFAR to continue meeting Congressional expectations.

### 7.3.1 Orphans and Vulnerable Children

PEPFAR’s authorizing legislation directs that 10 percent of PEPFAR’s bilateral funds be used for Orphans and Vulnerable Children programming. The OVC earmark focus on socio economic interventions critical to mitigating the impact of HIV and AIDS on children, prioritizing those which contribute to epidemic control, in line with the 2012 OVC Guidance.

**Currently the OVC earmark is met by programming 10 percent of all bilateral funds through the HKID budget code.**

For FY 2015, OGAC will consult with Congress prior to determining the final OVC funding level. For the 2015 COP submissions, PEPFAR country teams will use the final FY 2014 HKID planning level as the baseline planning level for the 2015 COP HKID budget code category. The 2015 COP planning level for HKID can be above this amount; however, it **cannot** fall below it.

As described in the 2015 Technical Considerations, activities should focus on OVC core/near core interventions in close proximity to other PEPFAR supported HIV and AIDS services and interventions and within PEPFAR defined geographically prioritized areas to the extent possible. OVC programs provide socio-economic services that mitigate the impact of AIDS on children by reducing vulnerability, contributing to prevention goals (especially for adolescent girls), and supporting access to and retention in treatment (especially pediatric treatment).

### 7.3.2 Care and Treatment Budgetary Requirements and Considerations

Globally, at least 50 percent of the total FY 2015 bilateral resources must be dedicated to treatment and care for PLHIV. In order to reach this global requirement, each country or region submitting a 2015 COP or ROP has been notified of their specific care and treatment requirement within the planning level letter received in January 2015.

The care and treatment earmark is calculated according to the following formula:

$$\frac{\text{Care \& Treatment for PLHIV (HBHC + HTXS + HTXD + PDCS + PDTX + HVTB + 0.3 * MTCT)}}{\text{Total FY 2015 Resources}}$$

If upon submission of your COP/ROP, the above formula is not greater than or equal to the care and treatment requirement allocated to your team, your Country Lead will be in touch to discuss further how each COP/ROP can reach this mandatory earmark with FY 2015 resources.

## 7.4 Other Budgetary Considerations

While it does not rise to the level of “hard” earmarks in authorizing legislation, our partners in Congress may use the annual appropriations process to emphasize priorities from their unique perspectives and to indicate levels of funding for those priorities which they expect the program to achieve, sometimes referred to as “soft” earmarks. It is vitally important that teams are responsive to these concerns. If

any such provisions are enacted for FY 2015 within the FY 2015 appropriations bill, OGAC and the implementing agencies will communicate any changing or new expectations for teams to incorporate such provisions in their planning processes.

#### **7.4.1 Tuberculosis**

As tuberculosis (TB) remains the most common cause of death among people living with HIV in sub-Saharan Africa, implementation of the package of evidenced-based interventions is a very high-impact, life-saving smart investment of resources and is a priority for PEPFAR programming in areas with the greatest burden of co-infection.

Ending HIV-associated TB among PLHIV is possible through a combination of widespread ART coverage, early identification and treatment of TB, isoniazid preventive therapy (IPT), and infection control activities. These high-impact interventions will be critical to achieving the AIDS-Free Generation goals and need to be integral to COP planning and program implementation.

However, progress has been slower than in other areas of clinical care. There remain important gaps in screening for TB and HIV and assuring effective linkages across TB and HIV services and programs. Rates of ART for co-infected TB patients are lagging behind in many countries. Efforts to overcome barriers to effective service-level integration need ongoing attention as do efforts to explore and adapt models of integration that are country context-specific.

Investment in TB/HIV should therefore be maintained PEPFAR-wide.

Please refer to FY 2015 COP Technical Considerations for further programming guidance.

As Global Fund high-impact countries with the greatest burden of TB and HIV co-infection begin to transition existing grants and new ones to align with the New Funding Model (whether NFM early applicants, interim or standard applicants), PEPFAR teams should also seek opportunities to engage with Ministries, CCMs and other partners to develop robust proposals for TB/HIV activities.

#### **7.4.2 Food and Nutrition**

Food and nutrition support is a critical component of successful HIV/AIDS care and treatment. HIV and malnutrition interact in a vicious cycle. For many PLHIV, the infection causes or aggravates malnutrition through reduced food intake, increased energy needs, or poor nutrition absorption. Malnutrition can hasten the progression of HIV and worsen its impact by weakening the immune

system, increasing susceptibility to opportunistic infections and reducing the effectiveness of treatment. Malnutrition and food insecurity remain highly prevalent in most countries where PEPFAR supports programs, particularly in Sub-Saharan Africa. Nutrition support is a critical component of a comprehensive response to HIV/AIDS.

While the contributions of programs such as Feed the Future, Title II Food Programs, the World Food Program and others cannot be counted toward PEPFAR's food and nutrition directive, country teams are expected to closely coordinate with these key counterpart programs to ensure maximum complementarity of their and our respective investments.

Teams are encouraged to focus resources on this critical priority commensurate with the degree of HIV-related food insecurity and/or malnutrition among PLHIV and to fully consider opportunities for complementary programming with Feed the Future, World Food Program, etc. **While it does not have a separate program budget code, field teams should carefully and comprehensively quantify the level of financial commitment to food and nutrition represented in OVC, care and support, PMTCT, and treatment programs.** The narrative below is intended to assist teams in ensuring they effectively program activities to both meet country needs and respond to Congressional expectations.

The Food and Nutrition Technical Working Group (F&N TWG) has identified three critical areas of programmatic focus for teams to consider as they develop a nutrition portfolio within their COP:

### ***Nutrition Care***

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Nutrition assessment, counseling, and support (NACS) is an essential component of a comprehensive response to HIV care and treatment. Ensuring that basic nutrition assessments and effective nutrition counseling occur consistently and accurately creates a foundation on which all other nutrition activities are based. Therapeutic and supplementary feeding is a critical component of HIV care and support and is most effectively utilized when provision is based on anthropometric criteria. Provision of therapeutic and supplementary feeding support, particularly in resource-poor settings, should be prioritized to assist the most vulnerable individuals as follows:

- Replacement/complementary food to HIV-exposed infants up to 2 years of age
- Supplementary food to underweight HIV+ women in pregnancy and lactation
- Supplementary food to OVC with evidence of growth faltering (wt/ht <-2 z-score)
- Supplementary food to HIV/AIDS patients w/ BMI <18.5

Finally, establishing linkages and two-way referral support between clinical treatment centers and community support services is essential to foster sustainable and comprehensive care and support for PLHIV.

### ***PMTCT and HIV-Free Survival***

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HIV-free survival (infants who remain alive and HIV-free) is the ultimate goal of PMTCT and infant-feeding programs. WHO recommends ARVs for PMTCT during ante- and perinatal periods and throughout the duration of breastfeeding. For countries implementing Option B+, ARVs will be given to mothers throughout the antenatal period and for life. HIV-infected mothers are encouraged to breastfeed exclusively for 6 months and to continue breastfeeding for a minimum of 12 months and beyond until a safe and adequate replacement diet is available. Programmatic emphasis should be placed on pre- and postnatal counseling surrounding infant feeding, nutrition and testing; and maternal nutrition and health. Special attention should be given to link counseling to early infant diagnosis to discourage premature weaning. Regular assessment, counseling, and support should be provided, particularly to encourage EID and exclusive breastfeeding for the first six months of life and appropriate complementary feeding from six months of age and beyond and to provide post-weaning support at 12 months and beyond. Establishing a continuum of care linking clinical and community services should allow for tracking of mother-infant pairs, a focus on improving maternal nutrition status, and provision of basic child survival interventions until at least 24 months of age.

### ***Economic Strengthening, Livelihoods and Food Security***

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Through provision of NACS and other services, care and treatment facilities assist in meeting the needs of PLHIV, their families and OVC. However, these services are not able to address underlying issues, such as generalized food and economic insecurity, that can compromise treatment success and long-term survival of PLHIV, nor are they able to address needs for OVC and their caregivers. Therefore, there is a need to link NACS clients with wrap-around services that address their current economic strengthening /livelihoods/food security (ES/L/FS) needs and the basic needs of children and families. Efforts are needed to identify promising ES/L/FS practices that can be effectively targeted, scaled-up and linked to clinical services to sustainably improve the economic and food security status of HIV/AIDS-affected households. Coordinating programming of PEPFAR nutrition activities and wraparound services with broader food security/nutrition programs, such as those implemented through Feed the Future, will assist in comprehensively addressing the nutrition needs of

PLHIV and their families. Programs that link PEPFAR's nutrition activities to these food security programs provide an opportunity for individuals and households to increase their food security over time, and to be less likely to need nutritional supplementation or assistance from the government or other actors in the future.

### ***Monitoring and Evaluation***

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With the scale-up of NACS activities, monitoring and evaluation data are needed to assess the effectiveness of interventions, inform and improve program design, report results, identify successful and unsuccessful approaches, and plan and budget for expansion of activities as needed.

The NACS TWG has collaborated with international stakeholders to develop a set of harmonized nutrition and HIV indicators. All indicators in this set are included in the UNAIDS Indicator Registry ([www.indicatorregistry.org](http://www.indicatorregistry.org)). Some of the indicators are included in the PEPFAR NGI set and the latest version of the GFATM M&E Toolkit.

The set was designed to be a flexible resource for use by national governments and programs to enhance the monitoring and evaluation of their NACS response. The intention is that country teams will select those indicators from the set that are specifically applicable to the design and status of their NACS programs. Collecting data for these indicators will provide necessary information needed to improve the effectiveness and quality of NACS services.

Technical support for developing a robust set of indicators that can assist in monitoring and evaluating the NACS response can be provided by the NACS TWG as needed.

#### **7.4.3 Abstinence and Be Faithful Reporting Requirement**

*Field teams are reminded that the budgetary requirement ("hard earmark") for Abstinence and Be Faithful (AB) programs in the original PEPFAR authorizing legislation is no longer in place and has been superseded by a reporting requirement for countries with generalized epidemics.*

If AB programmed activities do not reach a 50 percent threshold of all sexual prevention funding in any country with a generalized epidemic, OGAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiological context,

contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS info.

The Abstinence and Be Faithful reporting threshold for countries with generalized epidemics is calculated by dividing the total HVAB budget code funding by the sexual prevention funding (HVAB + HVOP):

$$\frac{\text{AB (HVAB)}}{\text{Sexual Prevention (HVAB + HVOP)}} \leq 50\%$$

#### **7.4.4 Strategic Information**

##### ***Central Support for SI – HVSI Budget Code***

An important consideration when determining the overall COP planned budget is how much to allocate towards Strategic Information (SI). International standards suggest approximately 5-10 percent of the total budget should be dedicated to SI. Some exceptions may include countries with very large planned budgets, which may have a lower percentage in SI, while some technical assistance countries may have SI budgets that far exceed 5 -10 percent. Activities supported by these resources have a more central or SI infrastructure focus, including for example, support to national or district health information systems, government monitoring and evaluation or statistical units, surveillance/survey implementation, university centers of excellence, etc.

##### ***Program Budget Allocated for M&E***

In addition to the overall support for SI activities in the country plan mentioned above, further deliberations are necessary to determine what percentage of program-level funding should be set aside for basic program monitoring and evaluation. International standards suggest approximately 5-10 percent of a program budget should be dedicated to monitoring and evaluation of the program. Regardless of the exact percentage, routine monitoring and evaluation should be integral to all PEPFAR programs. It is important to note that an outcome or impact evaluation may be considered in conjunction with a program, and these studies often require a higher level of funding. In these instances, additional resources above the 5-10 percent range may be necessary.

## 7.5 Single Partner Funding Limit

The single partner funding limit diversifies the PEPFAR partner portfolio, and expands partnerships with local partners, all with the goal of promoting the long-term sustainability of HIV/AIDS programs in our partner countries. For FY 2015, the limit on funding to a single partner is no more than 8 percent of a country's PEPFAR budget, excluding U.S. Government country team management and operations costs.

### 7.5.1 Exceptions to the Single Partner Funding Limit

The limit applies only to grants and cooperative agreements; contracts are exempted. In addition, there are three blanket exceptions to the limit (drug/commodity procurers, Government Ministries and parastatal organizations, and umbrella awards), which are defined as follows:

- A. **Drug/Commodity Procurers:** The exception will apply to organizations that provide technical assistance and services but also purchase drugs and commodities, as well as to organizations that primarily purchase drugs and commodities. All commodity/drug costs will be subtracted from the partners' total country funding applicable against the cap. The remaining awards and all overhead/management costs will be subject to the cap.

When a country team notifies OGAC that an awardee has been selected, it also should note whether the awardee purchases drugs and commodities and identify the amount spent on those drugs and commodities. The amount of funding for drug and commodity procurement should be included in the COP entry for the given partner.

- B. **Government Ministries:** Awards to partner government ministries and parastatal organizations are excluded from the limit. A parastatal organization is defined as a fully or partially state-owned corporation or government agency. Such state-run enterprises may function through a board of directors, similar to private corporations, but ultimate control over the board rests with the government. Parastatal organizations are most often found in centrally planned economies.



C. **Umbrella Agreements**<sup>19</sup>: The grants officer will determine, in consultation with the country team, whether an award is an umbrella for purposes of exception from the cap on an award-by-award basis. This determination may be made at the time the announcement is written based on the statement of work or at the time of award based on the applicant's work plan. The following criteria apply to decisions about umbrella status:

- Awards made with the intent that the organization make sub-awards with at least 75 percent of the grant (with the remainder of the grant used for administrative expenses and technical assistance to sub-awardees) are umbrellas and exempted from the cap.
- Awards that include sub-awards as an activity under the grant but do not meet the above criteria are not exempt, and the full award will count against the cap.

Grantees may have multiple PEPFAR awards in a country, some of which qualify as umbrellas and are thus exempt from the limit, while others are not umbrellas and thus count against the limit. When country teams notify OGAC that the grants officer has selected an awardee, it also should note whether the award qualifies as an umbrella based on the above criteria and identify the amount of the award.

Where a grant has characteristics of an umbrella award but administrative and technical assistance expenses exceed 25 percent, the country team may consider requesting an exception to the cap on a case-by-case basis.

### 7.5.2 Umbrella Award Definition

An “**umbrella award**” is a grant or cooperative agreement that does not include direct implementation of program activities but rather acts as a grants-management partner to identify and mentor sub-recipients, which in turn carry out the assistance programs. Thus, an umbrella award functions primarily as a sub-grant-making instrument, although it may also operate a small administrative program attendant to its grant-making function. Typically, a relatively small percentage of the funds of the overall grant are appropriate for use for administrative purposes. In addition, it is feasible that in situations in which an umbrella award provides significant technical assistance and management support to its sub-recipients, it may reasonably devote a greater percentage of its overall funds to providing these services.

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<sup>19</sup> See definition of and additional guidance on umbrella awards below.

An umbrella award may be made to either a local or an international entity, although PEPFAR strongly encourages teams to use local, indigenous umbrella organizations wherever possible. A basic goal should be to use the umbrella award recipient to develop indigenous capabilities to create a more sustainable program. Umbrella awards are not subject to the eight percent cap on single-partner funding.

The following are “best practices” for umbrella awards:

- Where local organizations are strong, umbrella grant programs hire a strong local or international organization whose role is to run a grant making and administration program by using a relatively small percentage of the funds (usually around seven percent) in the overall grant for these purposes.
- Where local organizations are weak, umbrella grant programs include significant technical assistance, either as part of the responsibilities of the grant-making organization or of a separate organization. The best examples again spend a relatively small proportion of the overall grant (typically 20 to 30 percent) on these services and are quite specific as to the responsibilities of the prime grantee in strengthening local partners. Such awards must move to the seven percent level on a rapid timeframe as the technical capacity of local partners increases.
- To qualify for exemption from the single-partner funding cap, an umbrella award may not spend more than 25 percent of the overall grant for administrative expenses and technical assistance. Where a grant has characteristics of an umbrella award but administrative costs and technical assistance exceed 25 percent, the country team may consider requesting that OGAC authorize an exception to the cap on a case-by-case basis.
- An organization that receives umbrella awards may separately have other grants or contracts in which it engages in direct program implementation activities. However, awards containing such activities are not considered umbrella awards and are subject to the 8 percent single-partner cap. An award that includes both direct implementation and sub-grant-making activities will not normally count as an umbrella award for the purposes of that grant, but OGAC may permit exceptions on a case-by-case basis.

### 7.5.3 Single Partner Limit Justifications

You will be asked to submit a justification for any partner that exceeds the single-partner funding limit, after excluding organizations (host country government organizations, parastatals) and funding (umbrella awards, drug and commodity purchases) exempted under the exceptions noted above. No justification is required for partners that would exceed the 8 percent limit only if procured commodities were included; however, the dollar amount of funding the partner will use for commodity procurement should be included with the implementing mechanism information. Teams can utilize the Single Partner Funding Limit report in the Budget Module of FACTS Info to help determine if a justification is required for any partners. Justifications should be uploaded to the FACTS Info document library as 'Budgetary Requirements Justification'.

## 7.6 Justifications

All justifications should be uploaded into the FACTS Info document library as 'Budgetary Requirements Justification'. Again, the Budgetary Requirements Worksheet and the Single Partner Funding Limit report will help teams to determine if justifications are required for the FY 2015 COP.

Justifications are required in the following instances:

- Generalized epidemic countries not allocating 50 percent or more of their sexual prevention budget to Abstinence and Be Faithful programming
- Any country allocating more than 8 percent of their program budget to more than one partner if this partner does not fall within one of the exceptions.

## 7.7 Pre-COP Funding

Pre-COP funding is a business cycle in which all country teams doing FY 2015 COPs can receive funding for critical **continuing** activities and management and operations expenses. Prior to submission to S/GAC, pre-COP funding requests must be approved by agency HQs.

The COP 2015 has significantly changed the pre-COP funding process. Separate pre-COP funding guidance will be issued to provide further details on the new process.



Under the new process, field teams will be notified of pre-approved funding levels for each country for pre-COP M&O and commodities. The pre-approved levels will take into consideration historical needs and pipeline, and will estimate how much is needed by teams to cover interim costs until the full COP is approved.

If the team projects that additional funds will be needed for specific mechanisms or for M&O costs, a template will be provided for teams to complete as described in the pre-COP guidance. Only the funds requested above and beyond the pre-approved amount will be reviewed by HQ. All additional pre-COP requests should be reviewed and agreed upon by individual agency HQs and the interagency PEPFAR team prior to submission to S/GAC.

All additional requests (beyond the pre-approved levels) for FY 2015 Pre-COP funding will receive a high level of scrutiny from agency HQs and OGAC due to funding constraints under a continuing resolution and our commitment to maintaining the integrity of an interagency COP planning and review process as a time for a comprehensive review of country programming and funding decisions.

## **8.0 U.S. GOVERNMENT MANAGEMENT AND OPERATIONS (M&O)**

## 8.1 Interagency M&O

Supporting the new PEPFAR business model requires strategically aligning staff and agency costs with the new targets and core, near-core, and non-core priorities. The following key questions will help teams evaluate appropriate staffing and CODB levels:

- What are the critical skill sets and knowledge your team needs in order to implement the new PEPFAR business processes (including SIMS and quarterly integrated data reviews) and to carry out other critical job functions?
- How did you assess baseline Level of Effort of current staff in order to determine changes in staffing needs?
- What are the major cost drivers in your COP 2015 CODB? What is the percent change from COP 2014?
- How did you assess the baseline costs in order to determine changes in CODB?
- What trade-offs will you be required to make if your CODB request for COP 2015 is not fully approved?

**Because most teams will have utilized all prior year excess pipeline funds, it is anticipated that any increase to M&O costs will require a decrease in program funds.**

COP 2015 M&O Requirements List:

- Staffing Data
- Functional Staff Chart
- Agency Management Charts (one per agency)
- ***Financial Supplemental Workbook*** – Cost of Doing Business Worksheet

### 8.1.1 PEPFAR Staffing Profile

OU teams should ensure that all management, operations, and staffing decisions are based on meeting PEPFAR programmatic goals, given legislative and budget constraints, rather than agency-specific needs driving organization decisions. Staffing exercises should minimize duplicative efforts, maximize interaction with Embassy and agency management support offices, and follow rightsizing and good position management principles. OU teams should be working in a complementary, non-redundant fashion (e.g. all technical staff working as a team, shared team responsibility for the entire

U.S. government program rather than just one agency's portfolio, new technical staffing needs considered by the team rather than just one agency).

### **8.1.2 Vacant and Proposed New Positions**

To assist teams in best aligning their staff to operationalize the Site Improvement Monitoring System (SIMS) and quarterly data reviews, HQ is providing a Level of Effort (LOE) staffing tool for teams to use to capture information on how PEPFAR funded staff spend their time (i.e. percent program/partner management, percent technical advice and assistance, percent external engagement, and percent administration). The tool will be available on the COP 2015 page on PEPFAR.net. Teams are encouraged to use the tool as a supplement to the staffing database to assist with assessing staff alignment and capacity to successfully implement business model changes. Teams are not required to submit their planned LOE with the COP/ROP 2015, however, this information may be requested or referred to during review to justify proposed staffing shifts and budget/position increases.

Process and Tools for Internal Review and Justification:

1. Use integrated data review tool to determine impact of new data requests on staff time (the demand).
2. Use LOE staffing tool to determine the LOE by individual or group (the capacity).
3. Assess staff distribution by budget code and identify any changes needed to support new business processes (the resources and shifts).
4. Triangulate information regarding demand, capacity, and resources in order to provide a recommendation and justification for new staff.

Updating staffing data prior to responding will ensure accurate depictions of country team staffing footprints (see Section 8.2 of the COP Guidance).

### **8.1.3 Explain Vacant Positions**

For each approved but vacant (as of March 1, 2015) position, the country team must explain the reason(s) it is vacant and describe the plan and timeline for filling the vacant position. Vacant position narratives should be no more than 500 characters and entered directly into the Comments field within the Staffing section of the PEPFAR module. There should be one explanation for each staffing record marked as vacant.

If the position has been previously encumbered, please provide the date that the position became vacant and whether the position has been recruited yet. If recruitment has occurred but the team has been unable to fill it, please indicate why (e.g. lack of candidates, salary too low). Submitting this information will inform understanding of program wide recruitment and retention issues, as well as assist in identifying skill and knowledge gaps within the team.

#### **8.1.4 Justify Proposed New Positions**

For each proposed new position, describe how it fits into the interagency and individual agency staffing footprints (e.g. meets changes in the program, addresses gaps, complements the existing staff composition). New position narratives should be no more than 500 characters and entered directly into the Comments field within the Staffing section of the PEPFAR module. There should be one explanation for each staffing record marked as planned in the staffing data.

Teams should strongly justify why they are proposing new positions instead of repurposing an existing filled or vacant position. For positions that the team plans to fill with a U.S. citizen direct hire or PSC, indicate why this position cannot be hired locally.

In the FY 2015 COP review process, all proposed new positions will be rigorously evaluated for relevance to new business process needs and alignment with programmatic priorities. Because the approval threshold for new positions will be high, wherever possible, country teams are advised to repurpose existing vacancies to fill new staffing priorities (particularly long-standing vacancies, i.e. having been vacant for 2 or more COP cycles). Note that any proposed new positions should spend at least 50 percent of their time on PEPFAR activities.

#### **8.1.5 Engagement and Support of Locally Employed Staff**

The recruitment, retention, and empowerment of Locally Employed Staff (LE Staff) are crucial to accomplishing our goals. OU teams should look for opportunities to train, engage, and empower LE Staff. Good practices include promoting additional leadership roles, such as naming LE Staff to be TWG chairs, creating an interagency LE Staff advisory council for PEPFAR in country, and providing training and international travel opportunities. Providing a work environment that fosters collaboration, respect, and professional development is an essential element in supporting the long-term retention of these staff who maintain critical relationships with the host government and partners and are essentially the institutional knowledge for PEPFAR programs.



## 8.2 Staffing Data

As a part of the COP, country teams are asked to update their staffing data annually within the FACTS Info PEPFAR Module (pre-populated with the latest available staffing data).

The purpose of the staffing tool is to assist each country team with strategic staffing – during the COP planning process and throughout the year – by organizing and managing the demographic information and breakdown of time dedicated to each budget code of each team member working at least part of his/her time on PEPFAR. The information should assist each country team in assessing their current and proposed PEPFAR staff, from interagency and functional perspectives, and for the purposes of program design and oversight.

The annual revision of staffing data should support each U.S. government agency in ensuring that sufficient staff is in place for effective fiscal management and ensure that better information on staffing composition and needs is communicated to headquarters as part of the COP. Staffing data should be integral to COP planning and reporting, staff planning, and position and program management. In both management and technical areas, review of staffing data by each U.S. government agency may help to identify gaps and areas of overlap, as well as support Chiefs of Mission in managing the PEPFAR team while engaging in agency headquarters-driven management exercises such as “rightsizing” and “managing to budget.”

### 8.2.1 Who to Include in the Database

Staffing data should be entered for:

- All PEPFAR or partially-PEPFAR funded current, vacant (as of March 1, 2015), and proposed positions that will spend at least 10 percent of their time working on PEPFAR planning, management, procurement, administrative support, technical, and/or programmatic oversight activities.
- Any non-PEPFAR funded current, vacant (as of March 1, 2015), and proposed positions that will spend at least 30 percent of their time working on PEPFAR planning, management, procurement, administrative support, technical, and/or programmatic oversight activities.

Hiring Mechanism

The database should include all:

- LE Staff (locally hired host country nationals, Americans, and TCNs),
- Internationally recruited TCNs,
- U.S. Direct Hire (USDH) (includes CDC appointed staff, military, and public health commissioned corps),
- Personal Services Contractors (PSCs),
- Personal Services Agreements (PSAs) (includes locally-recruited Eligible Family Members and Foreign Service Nationals),
- Non-personal Contractors (also known as commercial, third party, or institutional contractors)/Fellows, and
- Other employment mechanisms (for which there should be very few entries).

Peace Corps Volunteers should not be included in the staffing data as they are not U.S. government employees. However, Peace Corps staff should be included.

### ***Funding and Time***

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The database should include:

- Any partially or fully PEPFAR funded (i.e. GHP, GAP, or other PEPFAR fund accounts) positions (program or non-program). This includes all previously agency-appropriations-funded (e.g. OE) staff who will be funded by PEPFAR program funds in FY 2014;
- All staff whose PEPFAR percentage of time is combined to equal one FTE; and
- Any remaining non-PEPFAR-funded (i.e. agency core funds) program position in which the incumbent is expected to work at least 30 percent of his/her average annual time on PEPFAR.

Each position's entry should reflect the amount of time spent working on PEPFAR and whether the position is partially or fully PEPFAR-funded. The funded costs for all positions should be reflected in the U.S. government Salaries and Benefits CODB category budget entry for direct hire, PSC, and PSA staff, and in the Institutional Contractors CODB budget entry for non-PSC/PSAs.

### ***Notes***

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**Program staff:** Those who work directly on PEPFAR programs or who provide leadership, technical, and/or management support for PEPFAR and program staff. Program staff includes the Ambassador, DCM, Mission Director, CDC Chief of Party, legal, contracts, financial, and Public Affairs/Public

Diplomacy staff. Administrative staff who provide direct support to the program team also should be included.

**Non-Program staff:** Those who provide valuable administrative support to the PEPFAR team, including travel staff, drivers, and gardeners, but not direct program support.

**Aggregate Entries:** Country teams have the option of including in the database an aggregate entry for program staff who individually contribute less than 30 percent of their average time on PEPFAR, but are one of the same position who in aggregate, work 30 percent or more. In order to aggregate staff into one entry, the positions must have the same answer for “Funding Agency,” “Agency Position Title,” “Type of Position,” “Employment Citizenship,” “Employment Type,” “Funding Type,” “Schedule,” and “Location.” Enter the number of staff included in the entry in the “Number of Individuals” data field. In the “percent Time Devoted to PEPFAR by Each Individual” data field, enter the aggregate amount of time that the positions spend working on PEPFAR annually.

**Inclusion of non-PEPFAR-funded and non-program staff:** While optional, you may also elect to include non-PEPFAR funded program or non-program staff in the database. However, do not include any staff that work on PEPFAR on a temporary or seasonal basis, such as during the COP season. Do not include those working in ICASS-funded offices (e.g. motor pool, GSO, FMO, EX, HR, etc.); staff working in ICASS offices and paid by ICASS contributions should be removed from the staffing data.

**Inclusion of Global Fund Liaisons:** As in past years, Global Fund Liaison positions (whether centrally-funded or cost-share) should be included in Staff Information. For centrally-funded Liaisons, enter the record into the staffing database as “Non-PEPFAR Funded” (i.e., centrally or non-COP funded). As Missions pick up the funding of the Liaison position (full or cost share), enter the record as “PEPFAR Funded,” or “Partially PEPFAR Funded” as relevant. Please contact your CL with any questions about funding stream for this position.

As a part of the cleaning and review process, HQ will review the submission to ensure that positions are actually marked as non-PEPFAR funded where appropriate to avoid skewing staffing analysis. If and when a Mission picks up the position – it can then be marked as either partially or fully PEPFAR-funded.

### 8.2.2 Attribution of Staffing to Technical Areas

Country teams are expected to reflect staff time across technical budget codes as appropriate. See examples below.

- A possible budget code distribution for a PMTCT Senior Technical Advisor is as follows: 70 percent MTCT, 20 percent HLAB and 10 percent HVMS. Note: the 10 percent attributed to HVMS for this position reflects staff time spent on managerial responsibilities.
- A possible budget code distribution for a Finance Specialist is as follows: 100 percent HVMS. Note: this position does not contribute to any technical areas and provides general administrative support.

For U.S. government Staff Salaries and Benefits and Staff Program Travel, country teams will update their staffing data and enter the top-line budget amount for each category, by fund account. Based on the calculated budget code FTE, a portion of the top-line budget amount will be attributed to relevant budget codes and to the M&O funding amounts.

For Institutional Contractors, country teams will enter the budget code planned funding amount for the appropriate technical areas, by fund account - i.e. the area(s) for which institutional contractors are providing personnel support on behalf of the U.S. government.

For Peace Corps staff in FY 2015 COP, country teams should attribute all PCV funding to Management and Operations (budget code HVMS).

### 8.2.3 Staff Information Instructions

Enter staff demographic information in the following fields (data field definitions are included below):

**Operating Unit:** This field is important for analysis across countries. The appropriate OU will be pre-populated by the system.

**Number of Individuals:** Captures the number of staff represented by the entry (typically a value of one). However, if you have aggregated into one entry, several staff who together work 30 percent or more of their time on PEPFAR, please enter the number of staff included in the entry in the "Number of Individuals" field.

**Time Devoted to PEPFAR by Each Individual:** Refers to the annual staff time the person in the position spends on PEPFAR. This is one of the key fields in determining the position's FTE. Enter the

average percentage (10-100 percent) in the data field. If you have aggregated several staff, please enter the average percentage each person spends on PEPFAR (e.g. enter 10 percent if all three drivers devote this amount of time to PEPFAR).

**Staffing Status:** Refers to whether a position is currently staffed or not. Select whether the position is Filled, Vacant (previously approved in COP 2014 or prior), or Planned (new request for FY 2015 COP):

- Filled refers to currently encumbered positions;
- Vacant refers to positions that have been previously approved in a COP, but are currently empty; or
- Planned (new requests) refers to positions that are new for FY 2015 COP and have not been approved in previous COPs. All new planned positions will need to have a new staff justification narrative completed.

**Last Name:** If desired and the position is filled, enter the staff member's last name. If there are multiple positions included in one entry, enter "multiple" in the last name field.

**First Name:** If desired and the position is filled, enter the staff member's first name. If there are multiple positions included in one entry, enter the positions' title in the first name field.

**Funding Agency:** Select from the drop-down menu the employing agency of the staff person. For contractors, select the agency that supports the position.

**Agency Position Title:** Country teams should use a detailed functional title appropriate for each position or use official titles. For example, "Senior Technical Advisor for PMTCT" or "M&E Advisor," or "Management and Program Analyst" and "Public Health Advisor." Teams should be as specific and consistent as possible in their titling methodology.

**Type of Position:** This field includes five categories that have been condensed from previous years. Please note for positions within categories (a) and (b), part or all of the funding will likely be attributed to technical budget codes; whereas for positions within categories (c), (d), and (e), all of the funding will likely be attributed to the management and operations budget code (HVMS). Select the type of position from the following list:

- a. Technical Leadership/Management includes positions that head up the health/HIV team within the agency; e.g., Health Officer, CDC Chief of Party, and Deputy. This

could be the head of the agency (as is usually the case with CDC) or could be someone who oversees all U.S. government health activities and spends only part of the time on the Emergency Plan (for example the head of the PHN Office under USAID). A U.S. Direct Hire Foreign Service officer filling an HIV/AIDS advisor position and thereby leading an HIV/AIDS team would also be placed in this category.

- b. Technical and Programmatic Oversight and Support includes the technical staff within the health/HIV team who spend most of their time implementing or managing programs in technical areas, including Agreement Officer Technical Representatives (AOTRs), Project Officers (POs), and Public Health Advisors. Please also include here any entry and mid-level staff providing direct public health programmatic activities in this category (this is most relevant for CDC staff). Programmatic support positions within the health/HIV team or non-health/non-HIV staff who provide support to the health/HIV team not captured in another category (e.g. Education, Reproductive Health, TB, Food & Nutrition) are also included in this category.
- c. Contracting/Financial/Legal includes acquisition (contracts) and assistance (grants and cooperative agreements) officers and specialists and their support staff. A contracting officer represents the U.S. government through the exercise of his/her delegated authority to enter into, administer, and/or terminate contracts, grants, and cooperative agreements, and make related determinations and findings. Contracting officers and specialists usually support an entire agency in country or will support an entire regional portfolio. If an agency utilizes the contracting officer services of another agency, include the position only in the contractor's home agency. This category also includes the financial management officer or specialist for the agency. These staff members support financial and budget analysis and financial operations functions. Legal includes any staff who provide legal advice and support to PEPFAR.
- d. Administrative and Logistics Support includes any secretarial, administrative, drivers, and other support positions.
- e. U.S. Mission Leadership and Public Affairs/Public Diplomacy (PA/PD) include any non-health/HIV staff who provide management and leadership support to PEPFAR, such as the Ambassador, Deputy Chief of Mission, USAID Mission Director, or Political or Economic Officers, and any PA/PD staff.

**Employee Citizenship: Select the citizenship of the staff member:**

- a. U.S.-based American citizen: Direct hire (including military and public health commissioned corps), appointees (CDC), or PSCs hired in the U.S. for service overseas, often on rotational tours. They are paid on the U.S. Foreign Service or Civil Service pay scale or compensated in accordance with either scale. The U.S. government has a legal obligation to repatriate them at the end of their U.S. government employment to either their country of citizenship or to the country from which they were recruited.
- b. Locally Resident American Citizen: Ordinarily resident U.S. citizens who are legal residents of a host country with work permits. U.S. government agencies recruit and employ them as LE Staff under Chief of Mission (COM) authority at Foreign Service (FS) posts abroad often as PSAs. They are compensated in accordance with the employing post's Local Compensation Plan (LCP).
- c. Host Country National (or legal permanent resident): Citizens of the host country or ordinarily resident foreign nationals who are legal residents of the host country and hold work permits. They are employed as LE Staff at FS posts abroad and compensated in accordance with the LCP of the employing post.
- d. Locally Hired Third Country Citizen: Foreign Service Nationals (FSNs) who are not citizens or permanent residents of either the host country or the United States and are hired locally in the country in which they are employed. They are compensated in accordance with the employing post's LCP.
- e. Internationally Recruited Third Country Citizen: FSNs who are recruited from a foreign country other than where they are employed with whom the U.S. government has a legal obligation to repatriate them at the end of their U.S. government employment to either their country of citizenship, or to the country from which they were recruited.

**Employment Type:** Refers to the hiring authority by which the staff member is employed or engaged:

- a. Direct Hire: A U.S. government position (AKA billet, slot, ceiling, etc.) authorized for filling by a Federal employee appointed under U.S. government personnel employment authority. A civilian direct-hire position generally requires the controlling agency to allocate an FTE resource. NOTE: Host country nationals that are appointed by a U.S. government agency should be listed as a Direct Hire.
- b. Personal Services Contractor (PSC): An individual hired through U.S. government contracting authority that generally establishes an employer/employee relationship. Peace Corps uses PSCs to obtain services from individuals.



- c. Personal Services Agreement (PSA): An individual hired through specialized Department of State contracting authority that establishes an employer/employee relationship.
- d. Non-Personal Services Contractor (non-PSC/PSA): An individual engaged through another contracting mechanism by a non-U.S. government organization that does not establish an employer/employee relationship with the U.S. Government.

**Funding Type:** Select the appropriate choice for the position:

- a. PEPFAR Funded: Any position funded by GHP-State, GHP-USAID, GAP, or other PEPFAR fund accounts.
- b. Partially PEPFAR Funded: Any position partially funded by GHP State, GHP-USAID, GAP, or other PEPFAR fund accounts.
- c. Non-PEPFAR Funded: Any position funded by agency core (State, Defense, and Peace Corps positions). CDC and USAID positions should be partially or fully PEPFAR funded).

**Schedule:** Refers to whether the position is a full-time or part-time position. It does NOT refer to how much time the position spends working on PEPFAR. Do not include any staff who works on PEPFAR on a temporary or seasonal basis, such as during the COP season.

- a. Full-time: Considered to be  $\geq 32$  hours/week for FTE calculations.
- b. Part-time: Considered to be  $<32$  hours/week for FTE calculations.

**Note:** *The full time equivalent (FTE) box will auto-calculate the FTE of the staff's overall time based on:*

- Full-time (= 1) vs. Part-time (= .5),
- Percent Time Devoted to PEPFAR by Each Individual (40% = 0.4; 100% = 1).

**Other Roles:** Identifies additional responsibilities of staff engagement in the following categories:

- a. Education
- b. ES: Economic Strengthening
- c. Food (and Nutrition)
- d. HCD: Human Capacity Development
- e. PHE: Public Health Evaluations



- f. Water
- g. Gender
- h. CTO: CTO (Cognizant Technical Officer)/CTOR (Cognizant Technical Officer Representative)/Project Officer or Agency Equivalent
- i. NPI: New Partners Initiative
- j. PPP: Public Private Partnership
- k. Supervisor: Has official supervisory duties per position description
- l. Financial Manager: Has official management duties per position description

**Gender:** If a staff member works on gender, indicate 'Yes' and include a numeric value of 25-100 indicating the percent of time the staff member spends on gender activities. The amount of time spent on gender will not impact the allocations made to the Program Areas or total percent of time spent on PEPFAR.

For example, a possible scenario is that an OVC Senior Technical Advisor spends 30 percent staff time on gender issues. In the Staff Information tab, time spent on gender will be indicated with 'Yes' and a value of 30. In the Program Area tab, the budget code distribution will follow the division of time associated with the established budget codes (e.g., 80 percent OVC and 20 percent HVMS) with no reference to gender.

**Comments:** Country teams are required to provide additional details for specific vacant or planned records (Justify Vacant and Proposed New Positions). For existing positions, country teams may opt to add comments on an individual position that will aid in institutional memory for the team.

## 8.3 Country Team Functional and Agency Management Charts

OU teams are asked to submit charts reflecting the functional and management structures of the country team. The functional staff chart and agency management charts should be uploaded as required supplemental documents to the FY 2015 COP. The functional chart is not required of smaller country teams that do not have TWGs.

The functional staffing chart and agency management charts are not intended to replace or duplicate existing agency organizational charts depicting formal reporting relationships or existing administrative relationships between staff within agencies.

### **8.3.1 Functional Staff Chart**

The “Program Planning and Oversight Functional Staff Chart” should reflect the PEPFAR OU team’s leadership and TWG organization. Only leadership position and TWG titles should be included; do not include names of persons.

Teams should chart as appropriate to reflect any organizational changes made to assist FY 2015 program implementation and management.

If creating a new chart, the template available on the COP 15 project page on PEPFAR.net may be used. To complete the chart:

- Edit the leadership boxes to reflect the positions that are currently occupied. Add “(vacant)” next to any leadership positions that are currently vacant.
- List in the TWG boxes all of the TWGs present in country. The TWGs represented should reflect what the PEPFAR team uses for its internal PEPFAR/COP planning, NOT any group of partners chaired by the host government.
- For each TWG, list the number of LE Staff serving as chair/co-chair.
- For each TWG, list each USG agency and USG-funded partner (if any) and the number of staff members from each that participate in the TWG. Of these individuals, list the number of LE Staff in parentheses.
- For each TWG, also list non-USG-funded partners (if any) that participate in the USG TWG; it is not necessary to list the number of staff members for these entities.
- Please note that this chart is illustrative, as each OU team has a different composition. Please adjust the table to reflect your current reality.
- In addition, please also note perceived gaps.

### **8.3.2 Agency Management Chart**

Along with the functional staff chart, OU teams should also submit copies of each agency’s existing country organizational chart that demonstrates the reporting structure within the agency. If not already indicated on those charts, please highlight the management positions within the agency organizations. One chart should be uploaded per each USG agency operating in country.

## 8.4 Cost of Doing Business Worksheet

U.S. government Cost of Doing Business (CODB) includes all costs inherent in having the U.S. government footprint in country, i.e. the cost to have personnel in-country providing technical assistance and collaboration, management oversight, administrative support, and other program support to implement PEPFAR and to meet PEPFAR goals.

There are a number of cost drivers in FY15 that OGAC anticipates may cause teams to increase their CODB, including global U.S. Department of State increases in Capital Security Cost Sharing (CSCS), ICASS costs, and Locally Employed (LE) Staff pay increases. In addition, as new PEPFAR business processes come on-line, teams must ensure that they are staffed and supported to successfully implement SIMS, quarterly integrated data reviews, and enhanced routine program planning with civil society, governments, and the Global Fund.

This year teams must submit a **Financial Supplemental Workbook** detailing the historic and projected financial performance of all CODB categories included within the FY2015 COP/ROP. Each OU must submit one document compiling the information for all agencies, and the totals must match with the data entered into FACTS Info. The CODB worksheet can be found in the second tab “CODB Data” of the **Financial Supplemental Workbook** located on the PEPFAR.net COP15 website.

- Teams should refer to the Agency CODB report to complete Tab 2. The data in this report should be copied and pasted into columns A-I of the worksheet.
- Column J requires information on CODB category pipeline as of 12/31/2014 and column K is a new requirement detailing the total funds spent per CODB category in FY 2014. These required elements should be completed with assistance from agency field and headquarters financial staff.
- Column L will auto-calculate the percent change in CODB, per cost category, from the FY14 actual expenditure to the FY15 planned amount.
- Justifications for any increase or decrease from FY14 COP CODB expenditures should be detailed in column M, the “Notes” section of the worksheet.

The completed Financial Supplemental Workbook must be uploaded into the FACTS Info Document Library. A COP/ROP submission will not be considered complete without submission of this supplemental document.

#### 8.4.1 Cost of Doing Business Categories

By capturing all CODB funding information in the M&O section, data are organized in one location, allowing for clear itemization and analysis of individual costs. In addition to providing greater detail to headquarters review teams and parity in the data requirements for field and headquarters management costs, the data provides greater transparency to Congress, OMB, and other stakeholders on each U.S. government agency's costs for managing and implementing the PEPFAR program.

If there is any funding requested for the following CODB categories, then you must complete the "Item Description" field associated with the category and planned amount.

- **Non-ICASS Administrative Costs:** Please provide a detailed cost breakout of the items included in this category and their associated planned funding (e.g. \$1,000 for printing, \$1,000 for supplies). The narrative should be no more than 500 characters.
- **Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) and will be used solely for that purpose, purchase or lease information needs to be justified and dollar amount specified. The narrative should be no more than 500 characters.
- **U.S. Government Renovation:** Describe and justify the requested project. Significant renovation of properties **not** owned by the U.S. government may be an ineffective use of PEPFAR resources, and costs for such projects will be closely scrutinized. The description should be no more than 1000 characters and include the following details:
  - The number of U.S. government PEPFAR personnel that will occupy the facility, the purpose for which the personnel will use the facility, and the duration of time the personnel are expected to occupy the facility.
  - A description of the renovation project and breakout of associated costs. Include a description of why alternatives – facilities that could be leased and occupied without renovation – are unavailable or inadequate to meet personnel needs.

- The mechanism for carrying out the renovation project, e.g. Regional Procurement Support Office (RPSO).
- The owner of the property.
- The U.S. government agency which will implement the project, and to which the funds should be programmed upon approval. If the project will be implemented by DOS through RPSO, the funding agency should be the State Bureau (e.g., State/AF).
- **Institutional Contractors:** Describe the institutional contractor (IC) activities and why these activities will be conducted by an IC rather than a U.S. Direct Hire or PSC/PSA. Where possible, please provide the contracting company name and the technical area(s) which the IC(s) will support.

Once you have completed the steps for one agency, please repeat for all other agencies working in country.

There are eleven U.S. government CODB categories. The following list of CODB categories provides definitions and supporting guidance:

1. **U.S. Government Staff (Direct Hire, Personal Services Contractor [PSC], Personal Services Agreement [PSA]) Salaries and Benefits:** The required costs of having a person in country, including housing costs not covered by ICASS, rest and relaxation (R&R) travel, relocation travel, home leave, and shipping household goods. This category includes the costs associated with technical, administrative, and other staff.
  - a. PEPFAR program funds should be used to support the percentage of a staff person's salary and benefits associated with the percentage of time they work on PEPFAR. The direct costs of PEPFAR, specifically the costs of staff time spent on PEPFAR, need to be paid for by PEPFAR funding (e.g. GHCS, GAP). For example, if a staff person works 70 percent on PEPFAR, PEPFAR program funds should fund 70 percent of that person's salary and benefits. If the percentage worked on PEPFAR is 10 percent, then PEPFAR funds should fund 10 percent of the person's salary and benefits.
  - b. For agencies that cannot split-fund staff with their agency appropriations (such as USAID's OE funds), multiple staff may be combined to form one FTE and one of the staff's full salary and benefits will be funded by PEPFAR. For example, if two staff

each work 50 percent on PEPFAR, PEPFAR funds should be used to fund the salary and benefits of one of the positions. If three staff each work a third of their time on PEPFAR (33% + 33% + 33%), PEPFAR funds should be used to fund the salary and benefits of one of the positions. If multiple staff work on PEPFAR but not equally (such as 10% + 20% + 70% or 25% + 75%), the full salary and benefits of the person who works the most on PEPFAR (in the examples, either 70 percent or 75 percent) should be funded by PEPFAR. This split should be reflected in the staffing data.

- c. If the agency is paying for host country citizen fellowships and is going to only train the fellows, then the funding can remain in an implementing mechanism. If the agency is going to be getting a work product from the fellows, then this cost should be counted in M&O. Similarly, if agencies are paying for trainers who are U.S. government staff, then the costs associated with these staff should be reflected within M&O. If the mechanism is paying for the materials and costs of hosting training, then the funding should be reflected in an implementing mechanism.

- 2. Staff Program Support Travel:** The discretionary costs of staff travel to support PEPFAR implementation and management does NOT include required relocation and R&R travel (those are included in U.S. government Salaries and Benefits).

This category includes the costs associated with technical staff travel and travel costs associated with the provision of technical assistance. All costs associated with technical staff time should be reflected within M&O; other TA funding (e.g. materials) should be reflected in an implementing mechanism.

Teams should include SIMS related travel costs in this category. Refer to your country SIMS data plan and ensure that the following costs are properly captured: driver travel, driver overtime, gas, lodging, and M&IE (GSA rate).

In FY 2015, technical assistance-related travel costs of HHS/CDC HQ staff for trips of less than 3 weeks will be included in the PEPFAR Headquarters Operational Plan (HOP) and funded centrally. Under this model, costs for short-duration technical assistance travel by HHS/CDC staff should not be included in the countries' COPs.

- 3. ICASS (International Cooperative Administrative Support Services):**

- a. ICASS is the system used in Embassies to:
  - i. Provide shared common administrative support services; and
  - ii. Equitably distribute the cost of services to agencies.
- b. ICASS charges represent the cost to supply common administrative services such as human resources, financial management, general services, and other support, supplies, equipment, and vehicles. It is generally a required cost for all agencies operating in country.
- c. Each year, customer agencies and the service providers present in country update and sign the ICASS service “contract.” The service contract reflects the projected workload burden of the customer agency on the service provision for the upcoming fiscal year. The workload assessment is generally done in April of each year. PEPFAR country teams should ensure that every agency’s workload includes all approved PEPFAR positions.
  - i. ICASS services are comprised of required cost centers and optional cost centers. Each agency must sign up for the required cost centers and has the option to sign up for any of the optional cost centers.
  - ii. More information is available at  
<http://www.state.gov/m/a/dir/regs/fah/c23257.htm>.
- d. ICASS charges must be planned and funded within the country/regional budget (COP). However, ICASS costs are typically paid by agency headquarters on behalf of the country team from their budgeted funding. Each implementing agency, including State, should request funding for PEPFAR-related ICASS costs within its M&O budget.
  - i. It is important to coordinate this budget request with the Embassy Financial Management Officer, who can estimate FY 2015 anticipated ICASS costs. This FY 2015 ICASS cost estimate, by agency, should then be included as the planned ICASS funding.
  - ii. It is important to request all funding for State ICASS costs in the original COP submission, as it is difficult to shift funds at a later date.
  - iii. The Peace Corps subscribes to minimal ICASS services at post. Most GSO and all financial management work (except FSC disbursing) are carried out by Peace Corps field and HQ staff. In order to capture the associated expenses, Peace Corps will capture these costs within the indirect cost rate.



- 4. Non-ICASS Administrative Costs:** These are the direct charges to agencies for agency-specific items and services that are easy to price, mutually agreed to, and outside of the ICASS MOU for services. Such costs include rent/leases of U.S. government-occupied office space, vehicles, shipping, printing, telephone, driver overtime, security, supplies, and mission-levied head taxes.

In addition to completing the budget data field, teams are expected to explain the costs that compose the Non-ICASS Administrative costs request, including a dollar amount breakout by each cost category (e.g. \$1,000 for printing, \$1,000 for supplies) in the “Item Description” field.

- 5. Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) and will be used solely for that purpose, purchase or lease information needs to be justified. For new requests in **FY 2015** please explain the purpose of each vehicle(s) and associated cost(s) in the “Item Description” field. It is also a requirement that the total number of vehicles purchased and/or leased under Non-ICASS (Motor Vehicles) costs to date (**cumulative through FY 2015 COP**) are provided in this category. Teams should include new vehicle requests related to the completion of SIMS in this category.

- 6. CSCS (Capital Security Cost Sharing):** Non-State Department agencies should include funding for CSCS, except where this is paid by the headquarters agency (e.g. USAID).
- The CSCS program requires all agencies with personnel overseas subject to Chief of Mission authority to provide funding in advance for their share of the cost of providing new, safe, secure diplomatic facilities (1) on the basis of the total overseas presence of each agency and (2) as determined annually by the Secretary of State in consultation with such agency.
  - The State Department uses a portion of the CSCS amount for the Major Rehabilitation Program (MRP).
  - It provides steady funding annually for multiple years to fund 150 secure New Embassy Compounds in the Capital Security Construction Program.
  - More information is available at <http://www.state.gov/obo/c30683.htm>.
  - Country teams should consult with agency headquarters for the appropriate amount to budget in the COP.



- 7. Computers/IT Services:** Funding attributed to this category includes USAID's IRM tax and other agency computer fees not included in ICASS payments. If IT support is calculated as a head tax by agencies, the calculation should transparently reflect the number of FTEs multiplied by the amount of the head tax.
- a. CDC should include the IT support (ITSO) charges on HIV-program-funded positions; these costs will be calculated at CDC HQ and communicated to country teams for inclusion in the CODB.
  - b. USAID should include the IRM tax on HIV-program-funded positions.
- 8. Management Meetings/Professional Development:** Discretionary costs of country team meetings to support PEPFAR management and of providing training and professional development opportunities to staff. Please note that costs of technical meetings should be included in the relevant technical program area.
- 9. U.S. Government Renovation:**
- a. Country teams should budget for and include costs associated with renovation of buildings owned/occupied by U.S. government PEPFAR personnel.
  - b. Costs for projects built on behalf of or by the partner government or other partners should be budgeted for and described as Implementing Mechanisms (see Sections 5.5.11 of the COP Guidance).
- 10. Institutional Contractors (non-PSC/non-PSA):**
- a. Institutional and non-personal services contractors/agreements (non-PSC/non-PSA) includes organizations such as IAP Worldwide Services, COMFORCE, and all other contractors that do NOT have an employee-employer relationship with the U.S. government.
  - b. All institutional contractors providing M&O support to the country team should be entered in M&O, not as an Implementing Mechanism template.
  - c. *In addition to the budget information, country teams must provide a narrative to describe institutional contractor activities in the "Item Description" field.*

- d. Costs associated with this category will be attributed to the appropriate technical program area within the FACTS Info PEPFAR Module.

#### **11. Peace Corps Volunteer Costs (including training and support):**

- a. Includes costs associated with Peace Corps Volunteers (PCV), Volunteer Extensions, and Peace Corps Response Volunteers (PCRVs) arriving at post between **October 1, 2015** and **September 30, 2016**.
  - i. The costs included in this category are direct PCV costs, pre-service training, **Volunteer-focused** in-service training, medical support and safety and security support.
  - ii. The costs excluded from this category are: U.S. government staff salaries and benefits, staff travel, and other office costs such as non-ICASS administrative and computer costs, which are entered as separate CODB categories. Also excluded are activities that benefit the community directly, such as Volunteer Activities Support and Training (VAST) grants or **selected** training events where the number of host country nationals is greater than the number of PCVs participating. These types of activities should be entered directly into the appropriate program area budget code in an Implementing Mechanism template.
- b. Funding for PCVs must cover the full 27-month period of service. For example:
  - iii. Volunteers arriving in June **2016** will have expenses in **2016, FY 2017 and FY 2018**.
  - iv. Volunteers arriving in September **2016** will have expenses in **FY 2016, FY 2017, FY 2018, and FY 2019**.
- c. PCV services are not contracted or outsourced. Costs are incurred before and throughout the Volunteer's 27-month period of service. Starting in FY 2010, costs incurred by Peace Corps Washington and domestic offices, such as recruitment, placement and medical screening of Volunteers, will be included in the Headquarters Operational Plan (HOP). Costs such as living allowance, training, and support will continue to be included in the COP.

*Inclusion of Global Fund Liaison Costs (where applicable):* For Global Fund Liaison positions that remain centrally-funded at this time, the funding should not be included in the CODB. As Missions pick up the funding of the Liaison position (full or cost share), the percentage of the position which is

PEPFAR funded should be reflected in the COP and allocated to the above CODB categories. Please contact your CL with any questions about funding stream for this position.

## 8.5 U.S. Government Office Space and Housing Renovation

Country teams may include support for U.S. government renovation in their CODB submission. All other construction and/or renovation should be included in the Implementing Mechanism section of the COP. The terms are defined as follows:

**Construction** – refers to projects that build new facilities, or expand the footprint of an already existing facility (i.e. adds on a new structure or expands the outside walls).

**Renovation** – refers to projects with existing facilities intended to accommodate a change in use, square footage, technical capacity, and or other infrastructure improvements.

All construction and renovation projects should be cleared by the Ambassador in country before submission to headquarters. The notes below outline how U.S. government renovation funds may be used.

### PEPFAR Funding May Not Be Used for New Construction of U.S. Government Office Space or Living Quarters

Consistent with the foreign assistance purposes of PEPFAR appropriations, PEPFAR GHAI, GHCS, and GHP-State funding should not be used for the construction of office space or living quarters to be occupied by U.S. government staff. The Embassy Security, Construction, and Maintenance (ESCM) account in the State Operations budget provides funding for construction of buildings to be owned by the Department of State, and the Capital Investment Fund (CIF) is a similar account appropriating funds for USAID construction. Other agencies such as HHS/CDC and DOD have accounts that provide funding to construct U.S. government buildings, and implementing mechanisms may contribute to the ESCM account through the Capital Security Cost Sharing program.

### PEPFAR Funding May Be Used to Lease U.S. Government-Use Facilities

Where essential office space or living quarters cannot be obtained through the Embassy or USAID Mission, a request to use PEPFAR funds may be made in the context of a Country or Regional Operational Plan (COP/ROP) to rent or lease such space for a term not to exceed 10 years, if necessary to implement PEPFAR programs.

#### *PEPFAR Funding for Renovation of U.S. Government-Owned and Occupied Properties*

Country teams may request the use of PEPFAR funds to renovate U.S. government-occupied facilities in exceptional circumstances. The justification for using PEPFAR funds to renovate U.S. government-occupied facilities must demonstrate that the renovation is a “necessary expense” that is essential to carrying out the foreign assistance purposes of the PEPFAR appropriation, and should show that the cost of renovation represents the best use of program funds. The justification should also explain why appropriate alternative sources of funding for renovation are not available. The country team must submit a comprehensive plan that includes an explanation of the unique circumstances around the request to renovate U.S. government-occupied facilities. The plan must have support from the Ambassador that justifies the renovation project. In addition to the “Item Description” narrative, country teams must provide the total costs associated with renovation of buildings owned/occupied by U.S. government PEPFAR personnel under the CODB section. Note, renovation of facilities owned by the U.S. government may require coordination with the State Department’s Office of Overseas Buildings Operations (OBO) and other State Department bureaus, and may require the clearance of the State/Office of the Legal Advisor.

## **8.6 Peace Corps Volunteers**

For each OU and in aggregate, Peace Corps Washington will submit to OGAC the number of PEPFAR-funded:

- Volunteers on board as of October 1, 2015;
- Volunteer Extensions on board as of October 1, 2015;
- Peace Corps Response Volunteers on board as of October 1, 2015;
- New Volunteers proposed in the FY 2015 COP;
- Volunteer Extensions proposed in the FY 2015 COP; and
- New Peace Corps Response Volunteers proposed in the FY 2015 COP.



- Peace Corps Washington will obtain this information from Peace Corps country programs.

## 9.0 Supplemental Document Checklist

## 9.1 Supplemental Document Checklist\*

Supplemental Document	Requirement	Standard Template Location	Instructions to complete
Strategic Direction Summary (SDS)	<b>All OUs</b>	PEPFAR.net, COP 15	Section 3.0
Supplemental Data Pack	<b>Yes:</b> LTS programs <b>Optional:</b> TA/TC programs	PEPFAR.net, COP 15	Section 3.0; in workbook
Chief of Mission Letter	<b>All OUs</b>	None	Section 5.1
Financial Supplement Worksheet	<b>All OUs</b>	PEPFAR.net, COP 15	Sections 7.1.3 and 8.4
Budgetary Requirement Justification	<b>Yes:</b> Earmarks <i>not</i> met <b>No:</b> Earmarks met	None	Sections 7.3 and 7.4
Justification for Partner Funding	<b>Yes:</b> Single partner budget <i>exceeds</i> 8 percent of PEPFAR budget <b>No:</b> No partner exceeds 8 percent of PEPFAR budget	None	Section 7.5
New IM Activity Table	<b>All OUs</b>	PEPFAR.net, COP 15	Section 5.5.19
Laboratory Construction Supplement	<b>Yes:</b> PEPFAR funding proposed for laboratory construction in COP 2015 <b>No:</b> PEPFAR <i>not</i> funding laboratory construction in COP 2015	None	Appendix 4
SIMS Site Monitoring Plan	<b>All OUs</b>	PEPFAR.net, COP 15	Section 3.1.8; additional guidance on PEPFAR.net, COP 15
Implementation Science and Impact Evaluations	<b>Yes:</b> PEPFAR funding proposed for impact evaluation or operations research in COP 2015 <b>No:</b> PEPFAR <i>not</i> funding impact evaluations or operations research	None	Appendix 10
Civil Society Engagement Documentation	<b>All OUs</b>	None	Sections 2.3.3 and 3.3.1
Sustainability Index and Dashboard (SID)	<b>COP OUs</b>	PEPFAR.net, Country Sustainability Index	3.1.1.; additional guidance on PEPFAR.net (Sustainability Index page)
Human Rights Referral System Description	<b>All OUs</b>	None	Section 2.3.5
Functional and Agency Staff Charts	<b>All OUs</b>	None	Section 8.3



**\*All supplemental documents should be uploaded into the file library in FACTS Info.**



## APPENDICES

## 1. Acronyms and Abbreviations

A – Bureau of Administration (State Department Bureau)

A&A – Acquisition and Assistance

AB – abstinence and be faithful

ABC – abstain, be faithful, and, as appropriate, correct, and consistent use of condoms

AF – African Affairs (State Department Bureau)

AIDS – Acquired Immune Deficiency Syndrome

ANC – antenatal clinic

APR – Annual Program Results

APS – Annual Program Statement

ART – antiretroviral therapy

ARV – antiretroviral

CBO – community-based organization

CCM – country coordinating mechanism

CDC – Centers for Disease Control and Prevention (part of HHS)

CN – Congressional Notification

CODB – Costs of Doing the U.S. government's PEPFAR Business

COP – Country Operational Plan

CoR – Continuum of Response

CP – Combination Prevention

CQI – Continuous Quality Improvement

CSH – Child Survival & Health (USAID funding account; replaced by GHCS-USAID)

CL – Country Lead (formerly CSTL)

CSW/SW – Commercial Sex Worker

DFID – Department for International Development (UK)

DOD – U.S. Department of Defense

DOL – U.S. Department of Labor

DOS – U.S. Department of State

EAP – East Asian and Pacific Affairs (State Department Bureau)

EUM – End use monitoring

EUR – European and Eurasian Affairs (State Department Bureau)

F - The Office of U.S. Foreign Assistance Resources

FBO – faith-based organization

FDA – Food and Drug Administration (part of HHS)

FJD – Framework Job Description

FP – Family Planning

FSN – foreign service national

FTE – full-time equivalent

FY – fiscal year

GAP – Global AIDS Program (CDC)

GFATM – The Global Fund to Fight AIDS, Tuberculosis, and Malaria (also “Global Fund”)

GHAI – Global HIV/AIDS Initiative (funding account; replaced by GHCS-State)

GHCS – Global Health Child Survival funds (funding account)

GHI – Global Health Initiative

HCN – Host Country National

HCW – Health Care Workers

HHS – U.S. Department of Health and Human Services

HIV – Human Immunodeficiency Virus

HMIS – Health Management Information System

HQ - headquarters

HRSA – Health Resources and Services Administration (part of HHS)

HRH – Human Resources for Health

HTC – HIV Testing and Counseling

ICASS – International Cooperative Administrative Support Services

ICF – Intensified Case Finding

ICPI – Interagency Cooperative for Program Improvement

INR – Intelligence and Research (State Department Bureau)

IRM – information resources management

LE – Locally Employed (Staff)

LCI – Local Capacity Initiative

LOE – Level of effort

LTFU – Lost to follow up

M&E – monitoring and evaluation

M&O – Management and Operations

MC – Male Circumcision

MOA – Memorandum of Agreement

MOU – Memorandum of Understanding

NEA – Near Eastern Affairs (State)

NIH – National Institutes of Health (part of HHS)

OE – operating expense

OGA – Office of Global Affairs (part of HHS)

OGAC and S/GAC – Office of the U.S. Global AIDS Coordinator (part of State)

OMB – Office of Management and Budget

OS – Office of the Secretary (part of HHS)

OU – Operating Unit

OVC – orphans and vulnerable children

PASA – Participating Agency Service Agreement

PEPFAR – President’s Emergency Plan for AIDS Relief

PLHIV/ PLWHA/PLWA – People Living with HIV/AIDS or People Living with AIDS

PM – Political-Military Affairs (State Department Bureau)

PMTCT – prevention of mother-to-child HIV transmission

PPP – Public-Private Partnership

PR – Principal Recipient

PRH – Population and Reproductive Health

PRM – Population, Refugees, and Migration (State Department Bureau)

PSC – Personal Services Contract

PWID – People who inject drugs

PWUD – People who use drugs

QA – quality assurance

RFA – Request for Application

RFC – Request for Contracts

RFP – Request for Proposal

ROP – Regional Operational Plan

SAPR – Semi-Annual Program Results

SAMHSA – Substance Abuse and Mental Health Services Administration (part of HHS)

SCA - South and Central Asian Affairs (State Department Bureau)

SCMS – Partnership for Supply Chain Management

SDS – Strategic Direction Summary

SI – Strategic Information

TAN – Technical Area Narrative

TB –Tuberculosis

TBD – To Be Determined

TCN – Third Country National

TWG – Technical Working Group

UNAIDS – Joint United Nations Program on HIV/AIDS

UNDP – United Nations Development Program

UNICEF – United Nations Children’s Fund

USAID – U.S. Agency for International Development

USDA – U.S. Department of Agriculture

USDH – U.S. direct hire

USPSC – U.S. personal services contractor

UTAP – University Technical Assistance Project

VCT – voluntary counseling and testing

WHA - Western Hemisphere Affairs (State Department Bureau)

WHO – World Health Organization

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## 2. Cross-cutting attributions

### Definitions

For each implementing mechanism, countries must estimate the amount of funding that is attributable to the following programming:

#### Human Resources for Health (HRH)

This attribution includes the following:

- Workforce Planning
- Human Resource Information Systems (HRIS)
- In-Service Training
- Pre-Service Education
- Task shifting
- Performance Assessment/Quality Improvement
- Retention
- Management and Leadership Development
- Strengthening Health Professional Regulatory Bodies and Associations
- Twinning and Volunteers
- Salary Support

#### Construction or Renovation (two separate attributions)

These attributions are meant to capture construction and renovation costs. Construction refers to projects to build new facilities, such as a health clinic, laboratory, or hospital annex or to expand an already existing facility (i.e. adds on a new structure or expands the outside walls). Renovation refers to projects with existing facilities intended to accommodate a change in use, technical capacity, or other infrastructure improvements. PEPFAR-funded construction projects should serve foreign assistance purposes, will involve facilities that are provided to the partner government (or potentially to another implementing partner) as a form of foreign assistance, and are considered necessary to the delivery of HIV/AIDS-related services. Note, any funding attributed to these codes must have a corresponding should be identified in a Construction/Renovation Project Plan completed directly in FACTS Info. For more information about project plans and details concerning the “bundling” of renovation requests, please consult Section \_\_\_\_ of the COP Guidance.



For U.S. government-occupied rented or owned properties, the cost of renovating should be captured in the Agency Cost of Doing Business (CODB). None of these costs should be captured in budget attributions within Implementing Mechanisms.

### **Motor Vehicles: Purchased or Leased (two separate attributions)**

Countries need to provide the total amount of funding by Implementing Mechanism, which can be attributed to the purchase and/or lease of motor vehicle (s) under an implementing mechanism. The term Motor Vehicle refers to motorcycles, cars, trucks, vans, ambulances, mopeds, buses, boats, etc. that are used to support a PEPFAR Implementing Mechanism overseas.

### **Key Populations: Men who have sex with Men (MSM) and Transgender Persons (TG)**

This budget attribution is meant to capture activities that focus on gay men, other men who have sex with men including male sex workers, and those who do not conform to male gender norms and may identify as a third gender or transgender (TG). Broader definitions can be found in Appendix \_\_\_\_\_. These activities may include 1) implementation of core HIV prevention interventions for MSM/TG that are consistent with the current PEPFAR technical guidance; 2) training of health workers and community outreach workers; 3) collection and use of strategic information; 4) conducting epidemiological, social science, and operational research among MSM/TG and their sex partners; 5) monitoring and evaluation of MSM/TG programs; and 6) procurement of condoms, lubricants, and other commodities essential to core HIV services for MSM/TG.

Activities marked as Key Population: MSM/TG will now be required to provide additional information on activities. Teams should select all that apply and must select at least one tick-box if there is funding in this crosscutting attribution.

Please include the amount of the budget allocated to MSM and TG activities and check all of the following boxes that apply:

- ☐ Implementation of core HIV prevention interventions for MSM/TG that are consistent with the current PEPFAR technical guidance
- ☐ Training of health workers and community outreach workers
- ☐ Collection and use of strategic information
- ☐ Conducting epidemiological, social science, and operational research among MSM/TG and their sex partners

- ☐ Monitoring and evaluation of MSM/TG programs
- ☐ Procurement of condoms, lubricants, and other commodities essential to core HIV services for MSM/TG

### **Key Populations: Sex Workers (SW)**

This budget attribution is meant to capture activities that focus on sex workers. Relevant activities include: 1) implementation of core HIV prevention interventions for SWs consistent with PEPFAR guidance on sexual prevention; 2) training of health workers and community outreach workers; 3) collection and use of SI on SWs and clients; 4) conducting epidemiological, social science, and operational research among SWs, their partners, and clients; 5) monitoring and evaluation of SW programs; and 6) procurement of condoms, lubricants, and other commodities essential to core HIV services for SWs.

Activities marked as Key Population: SW will now be required to provide additional information on activities. Teams should select all that apply and must select at least one tick-box if there is funding in this crosscutting attribution.

Please include the amount of the budget allocated to SW activities and check all of the following boxes that apply:

- ☐ Implementation of core HIV prevention interventions for SWs consistent with PEPFAR guidance on sexual prevention
- ☐ Training of health workers and community outreach workers
- ☐ Collection and use of SI on SWs and clients
- ☐ Conducting epidemiological, social science, and operational research among SWs, their partners, and clients
- ☐ Monitoring and evaluation of SW programs
- ☐ Procurement of condoms, lubricants, and other commodities essential to core HIV services for SWs

### **Key populations: People Who Inject Drugs (PWID)**

Investments in programs for this key population are captured in the IDUP budget code.

### **Food and Nutrition: Policy, Tools, and Service Delivery**

This secondary budget attribution should capture all activities with the following components:

- Development and/or Adaptation of Food and Nutrition Policies and Guidelines – The cost of developing or adapting guidelines that provide a framework for integrating food and nutrition activities within the care and support of people infected and affected by HIV/AIDS, including OVC. This includes policies and guidelines that foster linkages with “wraparound” programs that address food security and

livelihood assistance needs in the targeted population. This also includes activities that improve quality assurance and control for production and distribution of therapeutic and fortified foods for use in food and nutrition activities.

- Training and Curricula Development – The cost of training for health care workers, home-based care providers, peer counselors, and others to enhance their ability to carry out nutritional assessment and counseling. This includes developing appropriate nutrition-related curricula for inclusion in pre- and post-service training programs and development of appropriate job aids for health care workers.
- Nutritional Assessment and Counseling – The cost of providing anthropometric, symptom, and dietary assessment to support clinical management of HIV-positive individuals before and during ART as well as exposed infants and young children. This includes nutrition education and counseling to maintain or improve nutritional status, prevent and manage food- and water-borne illnesses, manage dietary complications related to HIV infection and ART, and promote safe infant and young child feeding practices. It also includes nutritional assessment, counseling and referral linked to home-based care support.
- Equipment – The cost of procurement of adult and pediatric weighing scales, stadiometers, MUAC tapes, and other equipment required to carry out effective nutritional assessment. This also includes more general procurement, logistics and inventory control costs.

### **Food and Nutrition: Commodities**

This secondary budget attribution is meant to capture the provision of food commodities through food by prescription, social marketing, school feeding, OVC, PMTCT or other programs, including:

- Micronutrient Supplementation – The cost of micronutrient supplement provision according to WHO guidance or where individual assessment determines a likelihood of inadequate dietary intake of a diverse diet to meet basic vitamin and mineral requirements.
- Therapeutic, Supplementary, and Supplemental Feeding – The cost of facility- and community-based food support for nutritional rehabilitation of severely and moderately malnourished PLWHA, as well as

supplemental feeding of mothers in PMTCT programs and OVC.

- Replacement Feeding and Support – The cost of antenatal, peri- and postpartum counseling and support to HIV-positive mothers concerning infant feeding options and vertical transmission; on-going nutritional and clinical assessment of exposed infants; replacement feeding support, including limited provision of infant formula where warranted; and associated counseling and program support through at least the first year of life, per national policies and guidelines.

Please note that “safe water” is NOT included in this definition of food and nutrition. It is addressed separately, in the definition for Water.

### **Economic Strengthening**

Countries should estimate the amount of funding for each activity that is attributable to economic strengthening activities, including:

- Economic Strengthening - The portfolio of strategies and interventions that supply, protect, and/or grow physical, natural, financial, human and social assets. For PEPFAR generally, this refers to programs targeting HIV-infected individuals in care and treatment programs, OVC due to HIV/AIDS, and their caregivers. These activities can include a variety of microfinance, vocational training and/or income generation.
- Microfinance - The range of financial products and services, tailored to meet the needs and demands of low-income or otherwise vulnerable populations. This includes group and individual lending, savings, insurance, and other financial products. Microfinance is distinguished from mainstream finance by its outreach to isolated and poor populations and its efforts to make financial services accessible and approachable to them, in terms of product design and delivery systems.
- Microenterprise - A very small-scale, informally organized business activity undertaken by poor people. Generally refers to enterprises with 10 or fewer workers, including the micro-entrepreneur and any unpaid family workers; many income generating activities fall into this category.

- Microcredit - A form of lending which involves very small sums of capital targeted towards micro-entrepreneurs and poor households. Microcredit can take the form of individual or group loans, and have varying terms, interest rates and degrees of formality. Microcredit is a *type* of microfinance.
- Market Development - A fundamental approach to economic development that recognizes and takes advantage of the fact that products and services are most efficiently and sustainably delivered through commercial systems. Market development encompasses more targeted strategies such as microfinance and microenterprise development.

## **Education**

Efforts to promote effective, accountable and sustainable formal and non-formal education systems should be included in this secondary budget attribution. In particular, activities focused on basic education, which is defined as activities to improve early childhood education, program area education and secondary education delivered in formal or non-formal settings. It includes literacy, numeracy and other basic skills programs for youth and adults. Activities related to life skills training and HIV prevention education within the context of education programs or settings should also be included in this budget attribution. Please see the *Technical Considerations* for what can be included as Education.

## **Water**

Countries should estimate the total amount of funding from their country budgets, not including central funds, which can be attributed to safe water. Activities include support for availability, access, and use of products to treat and properly store drinking water at the household level or other point-of-use, and promotion of hand washing with soap.

## **Condoms: Policy, Tools, and Service Delivery**

This secondary budget attribution should capture all activities with the following components:

- Development and/or Adaptation of National Condom Policies and Guidelines – The cost of developing or adapting national guidelines for condom procurement, distribution and promotion. This also includes activities that improve forecasting, procurement and distribution systems.
- Training and Curricula Development – The cost of training for health care workers, HIV prevention program staff, peer educators, and others to enhance their ability to promote and distribute condoms

effectively and efficiently. This includes developing appropriate condom-related curricula for inclusion in pre- and post-service training programs and development of appropriate job aids.

- Condom promotion, distribution and provision – The cost of programs that promote, distribute and provide condoms (but not the cost of procuring condoms – this should be captured in the Condoms: Commodities cross-cutting budget attribution). This includes programs nested within existing clinical and community programs, such as programs for HIV-positive individuals or PMTCT programs, as well as costs for programs that focus exclusively on condom promotion.
- Equipment – The cost of procurement of any tools or equipment necessary to carry out condom programs, such as distribution boxes or dispensing machines, display stands, etc. This also includes more general procurement, logistics and inventory control costs.

### **Condoms: Commodities**

This secondary cross-cutting budget attribution is meant to capture the cost condoms **procured using bilateral funds** including:

- Condoms for free distribution – The cost of condoms procured with bilateral funds for free distribution in clinical, community or other settings.
- Socially marketed condoms – The cost of condoms procured with bilateral funds for socially marketed condoms clinical, community or other settings.

Please note: most PEPFAR OUs order condoms through USAID's Commodity Fund (CF) and do NOT pay for condoms using bilateral funds. Only those few OUs that are not eligible to order condoms through the CF and are therefore purchasing condoms with bilateral funds should be reporting through this secondary cross-cutting budget attribution.

### **Gender: Preventing and Responding to Gender-based Violence (GBV)**

This secondary cross-cutting attribution should capture all activities aimed at preventing and responding to GBV. For PEPFAR, GBV is defined as any form of violence that is directed at an individual based on his or her biological sex, gender identity or expression, or his or her perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation,

whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age. It can affect women and girls, men and boys, and other gender identities. Women, girls, including men who have sex with men and transgendered individuals are often at increased risk for GBV. While GBV encompasses a wide range of behaviors, because of the links with HIV, PEPFAR is most likely to address physical and sexual intimate partner violence, including marital rape; sexual assault or rape; female genital cutting/mutilation; sexual violence against children and adolescents; and child marriage.

Examples of activities for “Preventing and Responding to Gender-Based Violence” include: Collection and Use of Gender-related Strategic Information: assess differences in power and gender norms that perpetuate GBV as well as gender and societal norms that may facilitate protective actions against GBV and changes in attitude and behaviors; analysis of existing data on different types of GBV disaggregated by sex, age and geography, and in relation the HIV epidemiology in order to identify priority interventions and focus in the context of PEPFAR programs; analysis of treatment, care and referral services data by sex and age to ensure the unique needs of actual and potential victims are being met; employ rapid assessment, situational analyses and other quantitative and qualitative methods to understand norms and inequalities perpetuating GBV

- Implementation: Screening and counseling for gender-based violence (GBV) within HIV/AIDS prevention, care, and treatment programs; strengthening referrals from HIV/AIDS services to GBV services and vice-versa; strengthening post-rape care services, including the provision of HIV PEP; interventions aimed at preventing GBV, including interpersonal communication, community mobilization and mass media activities; programs that address societal and community norms that perpetuate violence against women and girls and other marginalized populations; that promote gender equality; and that build conflict resolution skills; strengthening linkages between health, legal, law enforcement, and judicial services and programs to prevent and mitigate gender-based violence; interventions that seek to reduce gender-based violence directed at children and related child protection programs; support for review, revision, and enforcement of laws and for legal services relating to gender-based violence, including strategies to more effectively protect young victims and punish perpetrators
- Capacity building: capacity building for U.S. government staff and implementing partners on how to integrate GBV into HIV prevention, care and treatment programs; capacity building for Ministry of

Women's Affairs, Ministry of Health or other in-line Ministries to strengthen national GBV programs and guidelines; pre and in-service training on the identification, response to and referral for cases of intimate-partner violence, sexual violence and other types of GBV; assist in development and implementation of agency-, government-, or portfolio-wide GBV strategy

- Monitoring and Evaluation: strengthening national and district monitoring and reporting systems to capture information on provision of GBV programs and services, including HIV PEP within health facilities
- Operation Research: to better understand the associations and pathways between GBV and HIV/AIDS; identify promising practices in training and protocol for the effective delivery of GBV screening and services and of GBV prevention programs; evaluate the impact of comprehensive GBV programming on HIV and GBV outcomes of interest

Activities marked as GBV will now be required to provide additional information on specific acuities supported. Upon ticking the GBV crosscutting attribution box a drop-down menu of activities will appear. Teams should select all that apply.

- GBV Prevention
  - Collection and Use of Gender-related Strategic Information
  - Implementation
  - Capacity building
  - Monitoring and Evaluation
  - Operation Research
- GBV Care
  - Collection and Use of Gender-related Strategic Information
  - Implementation
  - Capacity building
  - Monitoring and Evaluation
  - Operation Research

**Gender: Gender Equality**



This secondary cross-cutting attribution should capture all activities aimed at ensuring that men and women have full rights and potential to be healthy, contribute to health development and benefit from the results by taking specific measures to reduce gender inequities within HIV prevention, care and treatment programs. This would consist of all activities to integrate gender into HIV prevention, care, and treatment and activities that fall under PEPFAR's gender strategic focus areas

- Changing harmful gender norms and promoting positive gender norms
- Promoting gender-related policies and laws that increase legal protection
- Increase gender-equitable access to income and productive resources, including education
- Equity in HIV prevention, care, treatment and support

Examples of these activities include:

- Collection and use of Gender-related Strategic Information: Analysis of existing HIV prevention, care, and treatment portfolios and/or individual programs to understand and ensure appropriate response to: gender norms, relations and inequities that affect health outcomes; variation across populations and population subsets (by sex and age) in terms of gender norms, roles and resource needs; differences in power that affect access to and control over resources between women and men, girls and boys, which are relevant to health objectives; key gaps and successful programs in gender integration across HIV prevention, care and treatment; analysis of access and adherence to treatment includes analysis of data by sex and age and assessment of barriers to service by men and women; employ rapid assessment, situational analyses and other quantitative and qualitative methods to understand gender norms and inequalities in the context of HIV prevalence and programming
- Implementation of: HIV prevention interventions redressing identified gender inequalities; Legal, financial or health literacy programs for women and girls; programs designed to reduce HIV that addresses the biological, cultural, and social factors that disproportionately impact the vulnerability of women, men or transgender individuals to the disease, depending of the setting and type of epidemic; a PMTCT or HTC program that implement interventions to increase men's meaningful participation in and use of services; specific programming for out-of-school adolescent and pre-adolescents who are often the most vulnerable, including males and married adolescent girls; male

circumcision programs that include efforts to reach female partners, mothers and other women in the community and incorporate messages around gender norms in pre and post counseling

- Capacity building: assist in development and implementation of agency-, government-, or portfolio-wide gender strategy; conduct training for U.S. government staff and implementing partners on women, girls, and gender equality issues, as well as capacity building on how to integrate gender into HIV prevention, care and treatment programs; capacity building for Ministry of Women's Affairs or the Gender Unit within a Ministry of Health; capacity building interventions for HIV-positive women to assume leadership roles in the community and programs; training for health service providers on unique needs and risks of specific sub-populations such as adolescent girls and older, sexually-active men
- Operational Research: to better understand gender-related barriers and facilitators to HIV prevention, care and treatment programs; identify HIV-related needs and risks specific to adolescent girls and young women; promote constructive male engagement strategies to increase uptake of male circumcision, other prevention strategies, HTC, treatment, and care among adult men
- Monitoring and Evaluation: of programs and services through the use of standardized indicators and strengthening monitoring systems be able to document and report on accessibility, availability, quality, coverage and impact of gender equality activities; ensure that data is disaggregated by sex and age

Activities marked as GBV will now be required to provide additional information as part of a drop-down menu. Teams should select all that apply.

- Changing harmful gender norms and promoting positive gender norms
  - Collection and Use of Gender-related Strategic Information
  - Implementation
  - Capacity building
  - Monitoring and Evaluation
  - Operation Research
- Promoting gender-related policies and laws that increase legal protection
  - Collection and Use of Gender-related Strategic Information

- Implementation
  - Capacity building
  - Monitoring and Evaluation
  - Operation Research
- Increase gender-equitable access to income and productive resources, including education
    - Collection and Use of Gender-related Strategic Information
    - Implementation
    - Capacity building
    - Monitoring and Evaluation
    - Operation Research
- Equity in HIV prevention, care, treatment and support
    - Collection and Use of Gender-related Strategic Information
    - Implementation
    - Capacity building
    - Monitoring and Evaluation
    - Operation Research

### 3. Small Grants Program

Beginning in FY 2005, program funds were made available for all PEPFAR countries and regional programs that follow the criteria and reporting requirements listed below to support the development of small, local partners. The program is known as the PEPFAR Small Grants Program, and replaced the Ambassador's Self-Help Funds program for those activities addressing HIV/AIDS.

Country and regional programs should submit an entry for the PEPFAR Small Grants Program as part of their yearly operational plan (COP or F-OP). The total dollar amount of PEPFAR funds that can be dedicated to this program should not exceed \$300,000 or 5 percent of the country allocation, whichever is the lower amount. This amount includes all costs associated with the program, including support and overhead to an institutional contract to oversee grant management if that is the preferred implementing mechanism.

Construction/Renovation:

☐ ☐ OU teams that have small grant applications for construction/renovation need to submit a **Small Grants Program - Construction/Renovation Project Plan** form for each construction/renovation project (under an already approved COP implementing mechanism) for review/approval throughout the year (there is no set time for submission, but is as needed based on the country's small grants award timeline).

☐ ☐ Please send the project plan form applications directly to your OGAC SCL/CL (copy Javon Williams from the Management and Budget team at [WilliamsJL5@state.gov](mailto:WilliamsJL5@state.gov)) throughout the year during your small grant proposal review periods. Note, all form fields need to be completed.

☐ ☐ The form(s) will be uploaded into the **FACTS Info – PEPFAR Module Document Library** as part of the COP Submission after it is reviewed and approved.

☐ ☐ Once the OU receives confirmation from OGAC that the small grant applications have been approved, the OU team needs to upload the approved application forms (for construction/renovation only) into the **FACTS Info – PEPFAR Module Document**

**Library** under the approved COP cycle (e.g., if the ‘small grants program’ implementing mechanism was approved in the FY 2014 COP, then the OGAC approved small grant applications need to be uploaded in the Facts Info Document Library under the FY 201 COP cycle).

□□N.B. Documents can be uploaded into the Facts Info Document Library throughout the year even after a cycle is closed.

□□The **Small Grants Program - Construction/Renovation Project Plan** form template is located at [www.pepfar.net](http://www.pepfar.net) within the COP 2015 Planning and Reporting cycle folder.

## Proposed Parameters and Application Process

### *Eligibility Criteria*

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- Any awardee must be an entirely local group.
- Awardees must reflect an emphasis on community-based groups, faith-based organizations and groups of persons living with HIV/AIDS.
- Small Grants Program funds should be allocated toward HIV prevention, care and support or capacity building. They should not be used for direct costs of treatment.

### *Accountability*

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- Programs must have definable objectives that contribute to HIV/AIDS prevention, care and/or (indirectly) treatment.
- Objectives must be measurable.
- These will normally be one-time grants. Renewals are permitted only where the grants show significant quantifiable contributions toward meeting country targets.

### *Submission and Reporting*

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Funds for the program should be included in the COP under the appropriate budget category.

- Individual awards are not to exceed \$50,000 per organization per year; the approximate number of grants and dollar amount per grant should be included in the narrative. Grants

should normally be in the range of \$5,000 - \$25,000. In a few cases, some grants may be funded at up to the \$50,000 level for stronger applicants. The labor-intensive management requirements of administering each award should be taken into account.

- Once individual awards are made, the country or regional program will notify their SCL/CL of which partners are awarded and at what funding level. This information will be added in the sub-partner field for that activity.
- Successes and results from the Small Grants Program award should be included in the Annual Program Results and Semi-Annual Program Results due to OGAC. These results should be listed as a line item, like all other COP activities, including a list of partners funded with the appropriate partner designation.

## 4. Construction and Renovation of Laboratories

This supplemental document is required for all new BSL-3 and BSL-2 enhanced laboratory construction or renovation projects. To submit, upload the completed template to the FACTS Info FY 2015 COP document library as part of the COP submission on March 1, 2015. Please provide the following as a supplement to your project proposal:

- Receiving institution information:
  - Name of receiving institution
  - Address of receiving institution
  - A point of contact at the institution
- Purpose of proposed lab:
  - Expected containment level (BSL-2 enhanced or BSL-3)
    - If enhanced BSL-2, what specific enhancements are planned?
  - Rationale for why that containment level is required
    - Presentation of an analysis of alternatives, if appropriate, or plans to conduct one
  - List of Select Agents (if any) and toxins (if any) that the lab anticipates handling
- Proposed timeline:
  - Including additional planning, funding, design and construction
  - For transition to host country oversight

### Sustainability:

- What Ministry/organization/institution will be responsible for the long term sustainability of the lab?
- Involvement of other domestic/international partners

## 5. Technical Assistance Available for Global Fund Activities

A limited amount of central resources are available, as a complement to COP funds, to focus on critical gaps in technical assistance for Global Fund activities. Below is a list of mechanisms and their capabilities. Should you have any questions about the options, please reach out to the SGAC Multilateral TA Coordinator, Kelly Badiane ([kbadiane@usaid.gov](mailto:kbadiane@usaid.gov)) and SGAC Multilateral TA Advisor, Stephanie Weber Moore ([USG\\_GF\\_TA@state.gov](mailto:USG_GF_TA@state.gov)).

1) *Hiring a Global Fund Liaison* – If your USG team is interested in having a Global Fund liaison, there may be central resources to help place the advisor.

2) *Grant Management Solutions (GMS)* – Provides short-term management-related support to Global Fund PRs and Country Coordination Mechanisms (CCM) for leadership and governance; financial and grant management; procurement and supply management; monitoring and evaluation; and reporting.

3) *UNAIDS Technical Support Facilities (TSFs)* – Through regional platforms, provides short-term technical support related to National Strategic Planning and the Investment Approach.

4) *Leadership Management Government (LMG)* – Provides medium to long-term support to address Global Fund governance issues or leadership needs at all levels of the health system. PEPFAR teams have also used LMG to hire short-term consultants to engage with the Global Fund on their behalf.

5) *Health Finance and Governance (HFG)* – Provides medium to long-term support to improve financial management of Global Fund CCMs, PRs (Ministries) and SRs.

6) *Supply Chain Management Solutions (SCMS)* – Provides short, medium, or long-term TA related to procurement and supply-chain management.

7) *CDC Headquarter Technical Assistance Cooperative Agreements (Co-Ags)* – Partners employed through cooperative agreements can provide targeted technical and clinical support during the



National Strategic Plan and Concept Note development process. This support also extends to grant implementation, as needed and requested by PEPFAR teams and national programs.

Access: Centrally funded support may be accessed online through an application. Applications are vetted and coordinated across disease programs, USG agencies and bilateral programs, the Global Fund Secretariat, and multilateral partners to ensure complementarity and non-duplication of support.

Website: <http://www.pepfar.gov/partnerships/coop/globalfund/ta/index.htm>

## 6. PEPFAR.net Contacts and Help Information

Templates and guidance documents for COP 2015 development can be found on the PEPFAR.net COP 15 website here: <https://www.pepfarii.net/Project-Pages/collab-48/SitePages/Home.aspx>

For any questions related to access to or the use of PEPFAR.net in support of this year's COP process, please contact the PEPFAR.net help desk at [help@pepfarii.net](mailto:help@pepfarii.net)

**NOTE:** *The PEPFAR.net site is fully supported by the Microsoft Internet Explorer web browser ONLY. While other popular browsers, such as Google Chrome or Mozilla Firefox, may allow you to view PEPFARii.net, full site functionality cannot be guaranteed using those browsers.*

### **Logging in to PEPFAR.net (Users with existing PEPFAR.net accounts):**

Please use this link to access <https://www.pepfarii.net>.

Your user name and password are required to enter the site. For most users, your user name is **LastNameFirstInitial**

Users who have an account but have not yet logged into PEPFARii.net will need to create their own password upon logging in for the first time. To do so, navigate to [PEPFARii.net](https://www.pepfarii.net) and click "Forgot your password." For most users, your user name is **LastNameFirstInitial**. For example: the user name for John Smith is **SmithJ**. You will then need to follow the on-screen prompts to create your new password.

### **Logging in to PEPFAR.net (Users needing PEPFAR.net accounts):**

#### **Field Users:**

First time field team users will need to have an account established by a designated representative at their location. Contact your country team's PEPFAR.net Power User (or PEPFAR Coordinator if the Power User is unknown or not yet established), who will contact the PEPFAR.net Help Desk by sending an email to [help@pepfarii.net](mailto:help@pepfarii.net), to request an account. After your account has been established, you will receive an email with a temporary password and instructions for resetting your password.

#### Agency Headquarters Users:

If you are based at headquarters, you will need to send an email to the Help Desk at [help@pepfarii.net](mailto:help@pepfarii.net) requesting access to the site. Please note: for HQ personnel, your request must include the name of an individual who can verify your involvement/role within the PEPFAR community, for example, a County Support Team Lead.

For any questions regarding access to or use of the site, email the Help Desk at [help@pepfarii.net](mailto:help@pepfarii.net). Users can also request training on using the new site by emailing the Help Desk. Training materials, as well as a calendar of upcoming live training sessions, are available under the [Help section of PEPFAR.net](https://www.pepfarii.net/help/SitePages/Home.aspx) (<https://www.pepfarii.net/help/SitePages/Home.aspx>).

## 7. Public Private Partnership Tool-kit

No one government or entity can address the HIV epidemic alone. We share responsibility with our partners – including private sector, civil society, multilateral, and bilateral – to achieve an AIDS-free generation. We are building meaningful and wide-ranging partnerships at the global and local levels, so we can make an impact greater than the sums of our USG investments. Scalability and sustainability of programs is more likely to be achieved with support and collaboration of the private sector. PEPFAR has three types of Public Private Partnerships (PPP), based on the origin of the funding for the PPP Program:

1. **Global:** Global PPPs are initiated and managed at the central (HQ) level. They are typically funded by central funds, but they can also be jointly funded with combined central and country funds. These PPPs typically span multiple countries with multiple partners, and are reviewed by the Technical Working Group (TWG) and Deputy Principals (DPs).
2. **Country-Based:** Country-Based PPPs are initiated and managed at the country level. They are funded by the country teams through the Country Operational Plan (COP) process. Countries are responsible for reporting on these programs in the COP and Annual Program Results (APR).
3. **Incentive Fund:** Incentive Fund PPPs are a combination of the two previous types of PPPs. They are initiated and managed by the country teams and reported on in the COP and APR. Incentive Fund PPPs are funded solely through central (HQ) funds or through a combination of country funds and central (HQ) funds.

Country teams should mainstream country-based PPPs into the COP planning process. To strategically develop high-impact partnerships, country teams should prioritize alignment with core and near-core activities and geographic high yield/burden sub-national localities. New ideas and opportunities to scale and expand best practices should be regularly reviewed and discussed interactively with partners.

Beyond the development and launch of a partnership, it is essential to systematically strengthening monitoring and evaluation (M&E), documentation of best practices, and reporting of results to measure impact across all PPPs. Country teams are encouraged through established PEPFAR reporting systems to enter regularly key information including; a) the USG point of contact for the

public-private partnership program, b) financial contributions by fiscal year and lifetime of the partnership, and c) updated status of the public-private partnership. All country teams are encouraged to provide corresponding close out report narratives including as much details as possible regarding the impact of the public-private partnership on core PEPFAR goals at the country level, as well as on quality dimensions of innovation, sustainability, and scalability.

An integral component of driving quality of partnerships within PEPFAR is through sharing of best practices. Country Teams are encouraged to make use of the [Community of Practice Toolkit](#) (Table 1), which was developed by OGAC to assist PPP practitioners with engaging with the private sector, opportunity identification, development, management, and reporting of PPPs. The PPP toolkit, in coordination with targeted TA assistance, can support country teams as they work through the various stages of PPP development process within their portfolios.

**Table 1: PPP Toolkit Index**

Opportunity Identification	Idea Development	Management	Reporting
1. ITT PPP Questionnaire Template	6. Country Analysis Standard Operating Procedure (SOP)	11. Country Team PPP TWG Charter Template	18. Interagency PPP Valuation Handout
2. Presenting PEPFAR to the Private Sector Best Practices	7. Interagency PPP Funding Opportunities Guide	12. Example PPP Analysis Templates	19. PSE Monitoring & Evaluation Handout
3. Private Sector Expression of Interest Form	8. PPP Concept Note Example	13. Implementation Timeline Templates	
4. Private Sector Meeting Preparation Guides	9. PPP Ranking Ideas Template	14. PPP Due Diligence and Vetting Guide	
5. Sample PSE Stakeholder Agendas	10. PPP Technical Assistance SOW Template	15. MOU Templates for PPPS	
		16. PPP Meeting Notes Template	
		17. PPP 101 Overview Presentation	

## 8. UNAIDS Investment Approach and PEPFAR

**Table 3. Unpacking the Investment Approach to Fast Track the HIV Response and Achieve 90-90-90 Treatment Targets**

Entry points for application of the investment approach: New NSPs, Sustainability and Financing Plans, Mid-term Program Reviews, GF Concept Notes\*, Investment Cases, or any other national process

Principles	Analytics/Tools	Messaging	Components that fall outside of PEPFAR Guidance
<b>Fast Track - Timing is essential**</b>	Modeling (i.e. Spectrum, Goals) different scenarios of intervention coverage and impact (infections averted, deaths averted, other)	Fast scale-up will be needed to achieve sustainable epidemic impact and positive health and economic outcomes (return on investments). UNAIDS modeling shows that quick scale-up of targeted, evidenced-based interventions will have greater impact than slower scale-up trajectories.	
<b>UNDERSTAND: Know your epidemic</b>	Epidemiological review and modeling: Prevalence and incidence, with trends and breakdowns by population (Modes of Transmission) and sub-national geographic area. Local response analysis - site-level monitoring may inform these analyses	Know where the epidemic is (location) and among whom (population). Where are the next 1000 infections coming from?  Analyze epidemiology and response at sub-national (local) level	
<b>DESIGN: Allocative Efficiency</b>	Program Mapping - Epidemiology with overlay of program coverage and resource distribution - What interventions are provided, by who, where and for how much?	<b>Priority Programs:</b> Invest resources on priority core programs first (UNAIDS and GFATM programs that are aligned with PEPFAR's include: ART, PMTCT, Key Populations, VMMC, Condoms).  Prioritize HIV services in locations with the highest incidence/prevalence.	Behavior Change is a priority program intervention for the investment approach, but is not included in PEPFAR's core programs
	Modeling - Program scenarios to highlight what program shifts are necessary to optimize response and avert more infections and mortality.	<b>Critical Enablers***</b> Invest in HIV-specific (evidenced-based) activities that are necessary to support the effectiveness and efficiency of Core program activities -- <u>Greater share financed by HIV resources</u>	The UNAIDS definition of Critical Enablers includes activities that PEPFAR might define as Core, Near-Core, and Non-Core activities. PEPFAR has core and near-core COP-funded activities that fall into this category. These activities should be classified as Critical Enablers for purposes of a national planning dialog that is utilizing the investment approach framework. Critical enablers categorized as non-core will not be funded by PEPFAR.
	NASA	<b>Development Synergies***</b> Investment in other sectors that can have a positive effect on HIV outcomes. The Framework identifies a few key development sectors: social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems (including treatment for sexually transmitted infections and blood safety), community systems, and employment practices. <u>Greater share funded by other development sectors</u>	UNAIDS development synergies include Near-Core, and Non-Core activities as defined by PEPFAR. PEPFAR has COP-funded and centrally funded activities that fall into this category (e.g., OVC, Gender). These activities should be classified as development synergies for purposes of a national planning dialog that is utilizing the investment approach framework.
<b>DELIVER: Technical Efficiency</b>	NASA, unit cost analysis; bottleneck analysis, technical efficiency analysis, and benchmark price tools may help inform these analyses  Program evaluation, client survey, PEPFAR SIMs, etc.	Increase the efficiency of program delivery and reduce unit costs Consider alternative service delivery (e.g. community HCT, ART initiation, adherence support)  Demand-side and supply-side barriers must be addressed for effective program delivery	These analyses could support the needs of PEPFAR COP and Global Fund Concept Note development. PEPFAR site-level and SIMs monitoring might help inform this dialog within an investment approach exercise
<b>SUSTAIN: Sustainability</b>	NASA, NHAs, Modeling (Resource needs); financial gap analysis, fiscal space analysis, sustainable financing studies, OneHealth Tool for interventions costing and fiscal space analysis****	Shared responsibility - National programs may require increased domestic funding or innovative financing to fill their financial gaps.  An increased proportion of funding from domestic sources, better integration of programs (e.g. HIV/TB, PMTCT), and shift of programmes from AIDS budget to sectoral budgets (e.g. impact mitigation, social protection, nutrition) will be needed to ensure sustainability.	PEPFAR sustainability objectives are broader than financing. Success for the Sustainability Agenda in PEPFAR countries is defined as affordable, high-quality, locally owned (managed, implemented, and funded) HIV/AIDS services for sustained epidemic control. These analyses could support the needs of both PEPFAR COP and Global Fund Concept Note development. The Sustainability Index could help inform this dialog within an investment approach exercise.

\*Global Fund Information Note: Strategic Investments for HIV programs; Global Fund. [http://asapld.com/wp-content/uploads/2013/07/GF\\_Strategic\\_Investment\\_Information\\_Note.pdf](http://asapld.com/wp-content/uploads/2013/07/GF_Strategic_Investment_Information_Note.pdf)

\*\*Fast Track - Ending the AIDS Epidemic by 2030; UNAIDS. <http://www.unaids.org/en/resources/campaigns/World-AIDS-Day-Report-2014>

\*\*\*Understanding and acting on critical enablers and development synergies for strategic investments; UNDP, UNAIDS. [http://www.undp.org/content/dam/undp/library/hivaids/English/UNAIDS\\_UNDP\\_Enablers\\_and\\_Synergies\\_ENG.pdf](http://www.undp.org/content/dam/undp/library/hivaids/English/UNAIDS_UNDP_Enablers_and_Synergies_ENG.pdf)

\*\*\*\*OneHealth Tool available at: <http://www.futuresinstitute.org/onehealth.aspx>

## 9. Country Health Partnerships

With the expiration of PEPFAR Partnership Frameworks, it is critical to have a formal agreement in place with the partner country government on how PEPFAR and the country will join forces to end AIDS by 2030. Country Health Partnerships (CHPs) solidify how we and the country co-invest to achieve sustainable epidemic control and end AIDS by 2030. Through this process the long term full responsibilities for managing the epidemic should become apparent as the country gains further technical and management capability, and is able to better financially resource epidemic control.

As Ambassador Birx has established PEPFAR's priorities for ending AIDS (programmatic, budget and geographic shifts, and the central role of data use), and what PEPFAR will support, CHP's are being recast to align with successfully implementing the PEPFAR 3.0 agenda.

PEPFAR also intends to leverage the global health diplomacy role of the State Department to communicate to partner governments and civil society the commitment to epidemic control and the critical elements for sustaining that control that U.S. government and Global Fund resources in particular have helped countries achieve, but will require a capacitated country and domestic financing to end AIDS.

Key elements of the CHP to end AIDS include:

- Enduring/formal structures and processes-- through which joint agreement is reached on roles and responsibilities to end AIDS, as well as on high level priority areas associated with ensuring quality, impact, cost, sustainability, and human rights.
- Data Transparency-- data collection and, specifically, its use for decision making, including costs, expenditures, quality and impact (e.g., leverages the PEPFAR dashboard for in-country dialogue and action)
- Financing for Health – from the U.S. government side, both the process and the information that sets at a minimum the trajectory of U.S. and partner government support;; from the partner government side expect growth in domestic investments that parallel local economic growth

- Metrics – jointly access and monitor progress of various functions required to successfully implement CHP at a high level, where remediation in resources, systems, capacity gaps by the country can be addressed and acted on.

Some foundational elements are critical for CHPs to be considered a success, including:

- Progress made towards sustainably ending AIDS due to joint investments – the Sustainability Index would be used as a primary reference document, and where relevant some measurement related to specific management of a “significant” project co-financed by PEPFAR but executed by the country
- Enduring/Formal structures and processes through which we reach joint agreement on roles and responsibilities to end AIDS
- Data Transparency– Country demonstrates capacity to “measure for results” in the Health & HIV sector (Indicators: Statistical capacity – World Bank indicator of statistical practice, data collection and indicator availability in the health sector; Capacity for Dialogue with Rural populations/Civil Society – Existence of forum for meaningful dialogue between the government and rural organizations/civil society, on health matters)
- Financing for Health – Country has a record of economic growth (Indicator: GDP growth) and has contributed more domestic resources to finance ending AIDS.

Formal CHP Guidance regarding the role of the CHP for advancing PEPFAR 3.0 goals, the selection of PEPFAR country programs for early versus later roll out and related timeframes and deliverables, and design and implementation considerations will be finalized and sent to countries during 2015. The CHP Guidance will assist in the planning and implementation of activities prior to the COP16 submission.

**As PEPFAR looks to expand Country Health Partnerships (CHPs) with partner countries in the coming COP 2015 period, teams should answer the question below appropriate to their CHP status:**

For existing CHP countries or those planning to begin the process of developing a CHP during COP 2015: describe specific deliverables in COP 2015 to initiate and/or implement a CHP MOU, specifically: use of enduring/formal structures to jointly monitor programs, engagement on data transparency, and path to joint financing to end AIDS by 2030.



For all other countries: please describe any efforts in COP 2015 that would help lay the groundwork for establishing a future CHP with the host government; in particular, efforts to 1) establish processes and structures for joint decision-making on PEPFAR resource allocation; 2) make program results and financial data more transparent and used for decision-making; 3) promote mutually accountable measures of progress through clear indicators, benchmarks or milestones, and identify what those are; and 4) commit domestic resources to services or system support that directly benefit control of the HIV/AIDS epidemic.

This information will be of assistance to the development of the forthcoming CHP Guidance and, ultimately, establish and guide country specific steps in designing, implementing, managing, and monitoring the CHP.

## 10. Implementation Science and Impact Evaluations

### **Implementation Science and Impact Evaluation: Brief Overview**

As PEPFAR programs move towards targeted services for HIV impact in resource-constrained environments, the need for evidence on which to base decisions has increased. An implementation science (IS) framework will be used to refine programs to maximize impact. IS seeks to describe and inform how to best deliver public health programs through approaches including, but not restricted to effectiveness studies, cost-effectiveness studies and impact evaluation. The PEPFAR IS framework is intended to:

- Emphasize impact evaluations (IEs) for PEPFAR core and near core programs
- Ensure the dissemination and use of evidence in decision-making and the adoption of best practices across PEPFAR programs
- Prioritize analyses of costs and cost-effectiveness of programs
- Guide policy and program development
- Inform the global community on best practices
- Align with overall PEPFAR and other USG standards for program evaluation

There is a distinction between the routine monitoring and evaluation of programs using PEPFAR standard metrics such as Monitoring, Evaluation and Reporting (MER), or site improvement through monitoring system (SIMS) data and Impact Evaluations. Impact Evaluations (IEs) permit the *causal attribution* of health outcomes to programs. IEs utilize the gold standard methodology within the IS spectrum and can incorporate the use of various data streams for estimating program impact. For additional information on IEs, please see the Impact Evaluation **FY 2015 Technical Considerations**. If you have any questions, please contact [PEPFAR\\_ORIS@state.gov](mailto:PEPFAR_ORIS@state.gov).

### **Impact Evaluation Submission and Review Process**

PEPFAR IEs should be driven by in-country priorities as they fit within their definitions of core and near core. This year, IE concepts will be submitted prior to COP submission directly to the Office of Research and Science through the process and timeline outlined below. The IE concept review process will not include a centralized protocol review; however, Internal Review

Board (IRB) functions for studies will go through agency, partner, and country institutions as appropriate.

### **Concept Note Requirements**

The COP2015 IE concept note submission process will be for activities with a planned or existing implementing mechanism identified by the time of submission.

The concept note should be no more than 10 pages plus appendices, and must include the following (suggested page lengths are in parentheses):

- ✓ Cover page (0.5 – 1 page):
  - IE title
  - Name of program or intervention being evaluated
  - Principal investigator
  - Country team contact
  - Implementing agency, partner, and mechanism
  - Start and end dates of agreement for the IE implementing mechanism (to ensure no breaks in funding)
- ✓ Specific Aims (0.5 – 1 page): What is/are the main evaluation question(s) to be addressed by the proposed study? What is the goal of this evaluation? What hypothesis will be tested? What are the primary and secondary outcomes of interest?
- ✓ Background (justification) (0.5-1 page): Why is this question significant to your country program? How will this IE add to the evidence base for your existing or newly funded activities? Describe how the IE results will inform current or future program(s). What work has been done on this topic to date? (Cite relevant work).
- ✓ Evaluation design: (5 pages)
  - Outline the main features of the proposed evaluation design. The following must be addressed:
    - a) description of the program, how exposure to the intervention will be measured and anticipated measurement challenges (if any);
    - b) description of the outcome measures and anticipated challenges (if any);
    - c) expected relationship between “program exposure” and primary outcome measure;
    - d) key confounding factors;
    - e) selection bias;

- f) other sources of measurement error;
- g) spillover effects;
- h) contamination of comparison groups or inadequate programmatic exposure (e.g., effects of in and out migration between intervention and comparison area); and
- i) impact heterogeneity; specifically how might the results differ by beneficiary type (age, gender and other demographic factors) or context (urban, rural, type of habitation). Include methods for data management (including data collection and quality assurance) as well as the overall analytic framework (including proposed interim analyses). Discuss potential problems, alternative strategies, and the study milestones required to achieve the aims.

✓ Required Appendices

- Budget and budget narrative. Cost per year itemized into standard major categories (personnel, ARVs, other commodities, travel, etc.) Please specify the total duration of the study (1-3 years) and the cost per year. IEs without budgets will not be reviewed.
- Timeline: Specify the timeline for protocol development, submission, data collection and study end date.
- Innovation (if applicable): Does the study challenge or seek to shift current programmatic, clinical practice, or evaluation paradigms? Does the study design include novel concepts, approaches or methodologies, instrumentation or intervention(s) to be developed or used? If so, describe them and explain any advantage over existing methodologies, instrumentation or intervention(s).
- References: Cite relevant work and related other background information.

### Submission Timeline and Process

Date	Feb. 2, 2015	Feb. 16, 2015	March 16, 2015	April 3 or April 17, 2015
<b>Deliverable</b>	Email of intent to submit IE concept. Please include draft IE title and program area.	Draft concept note submission due if team is requesting pre-submission technical assistance or	Final concept submission entitled: 1. IE_Country_Brief Title_Review Form 2. IE_Country_Brief Title_Concept	If concept note was recommended, please submit with your COP as a single document. Please include the

		feedback	3. IE_Country_Brief Title_Appendix	recommendation as an appendix.
<b>Submission modality</b>	Email <a href="mailto:PEPFAR_ORRS@state.gov">PEPFAR_ORRS@state.gov</a> with a cc to your country lead	Email <a href="mailto:PEPFAR_ORRS@state.gov">PEPFAR_ORRS@state.gov</a> with a cc to your country lead	Email <a href="mailto:PEPFAR_ORRS@state.gov">PEPFAR_ORRS@state.gov</a> with a cc to your country lead	As supplementary doc in FACTS entitled: IE_Country_BriefTitle
<b>Required or Optional</b>	Required	Optional	Required	Required

### Centralized Review and COP Submission

Concept notes will be reviewed by an interagency technical review panel convened by S/GAC's Office of Research and Science. Technical review comments will be provided by email and recommendations on concept note approval/non-approval will be included in a letter back to the submitting team no later than Wednesday, April 1. **For IE concepts that are recommended by the interagency review panel, please submit them as a supplementary document entitled: IE\_Country\_Brief Title in FACTSInfo with the rest of your COP submission. Please include the approval letter as an appendix to the IE concept.**

### References for IE methods

Gertler P, *et al.* (2011). *Impact evaluation in practice*. Washington, D.C.: World Bank.

[http://siteresources.worldbank.org/EXTHDOFFICE/Resources/5485726-1295455628620/Impact\\_Evaluation\\_in\\_Practice.pdf](http://siteresources.worldbank.org/EXTHDOFFICE/Resources/5485726-1295455628620/Impact_Evaluation_in_Practice.pdf)

Lance P, *et al.* (2014). How do we know if a program made a difference? A guide to statistical Methods for Program Impact Evaluation. Measure Evaluation

<http://www.cpc.unc.edu/measure/publications/ms-14-87-en>

## **11. SIMS Cable**

*[Text Redacted]*

## **12. The PEPFAR “Pivot” Cable**

*[Text Redacted]*

### **13. Alignment of PEPFAR Resources, Specific to HIV Testing Cable**

*[Text Redacted]*



## 14. Additional Considerations for TA/TC Programs

This appendix offers supplemental guidance and recommendations for PEPFAR Targeted Assistance/Technical Collaboration (TA/TC) programs as they work through the modular COP planning steps, required analyses, and COP/ROP development. These recommendations were developed collaboratively with PEPFAR field teams and the PEPFAR Interagency Collaborative for Program Improvement (ICPI). No guidance or recommendations put forth in this appendix in any way contradict or override guidance described in the main body of this document. The information below is intended to address nuances of TA/TC program planning and data review that may not be applicable across all PEPFAR OUs.

PEPFAR TA/TC programs support the host country HIV response through a broad range of service and support activities. The mix of activities depends on national context, epidemic profile, country needs, and other sources of support. Within the PEPFAR TA/TC portfolio, data demonstrate that countries in which we work are located at various points along the continuum of epidemic progression—represented by increasing incidence on one end and realization of an AIDS-free Generation (AFG) on the other. PEPFAR support should be tailored at each stage of the HIV epidemic to most effectively target and address the primary gaps and barriers preventing countries from achieving epidemic control. ***Though the epidemic trajectory and national context may differ, the ultimate goal for PEPFAR remains the same: invest optimally to achieve accelerated and sustained epidemic control.***

### ***Trade-offs in program focus based on progress towards epidemic control***

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As PEPFAR teams in TA/TC contexts assess current investments and intervention mix, trade-offs will need to be considered. In most TA/TC programs, coverage of key and priority populations with combination prevention interventions—including ART—has not reached saturation. In addition, real gaps and barriers to increasing coverage may exist (insufficient resources, lack of data to measure progress, stigma and discrimination, etc.) which require mitigation prior to programs achieving scale. In some settings, countries may be close to, or have surpassed, the technical definition of epidemic control; however, concerns still exist about the sustainability of the program and durability of incidence decline, especially when transitioning to full host country ownership. PEPFAR does not have the resources in any TA/TC operating unit (OU) to address or resolve all challenges that prevent achieving

sustained epidemic control. PEPFAR teams will need to focus on interventions where USG resources and capacity will have the greatest impact, and the optimal mix of interventions will depend on context.

In all TA/TC programs, teams will need to balance investments across several typical categories of support, including direct service provision, support to national systems/authorities, technical support for specific programs/interventions, and piloting/demonstration projects. The mix of investments and implementation models across these categories is expected to look different in each country based on stage of the epidemic. In countries with increasing incidence, the mix should be weighted more heavily toward those activities that assist host countries most quickly and effectively target areas and populations where HIV transmission is most likely to occur. These types of programs should demonstrate a strong focus on evidenced-based or innovative approaches to identifying HIV-positive individuals, linking them to care and treatment, and improving retention and adherence to reduce community viral load. In countries where relatively higher coverage of combination prevention interventions for key populations has been achieved and an AFG is within sight, the mix of interventions should be more heavily weighted toward activities that promote sustainability—in particular, host country government fiscal ownership of the response and durability of progress in HIV incidence declines. For programs closer to realizing an AFG, critical areas for focus will include health financing to maintain patients on ART and some level of prevention efforts, and building sustainable and effective data and surveillance systems that can routinely monitor key HIV indicators to ensure gains are preserved and any resurgence or outbreaks are rapidly identified and contained.

Consistent with guidance to all OUs, and particularly relevant in TA/TC contexts, field teams should accomplish the following objectives to frame COP/ROP 2015 planning in the country context:

1. Use all available data to determine the impediments to **accelerating** achievement of epidemic control and/or an AFG.
2. In consultation with host country government and other stakeholders, prioritize impediments (gaps and barriers) in a data-driven fashion, giving primacy to those that, if addressed, would result in the most new infections averted and lives saved.
3. Assess PEPFAR's technical capacity, comparative advantages, funding level, and scope in the national program to selectively invest in interventions and support activities that target top-ranked impediments to epidemic control. Activities should be clearly and logically linked to uptake of services by key and priority populations, improvements to the clinical cascade, improvements to quality, or increases to sustainability of program activities.
4. Develop a plan to leverage support from other stakeholders (host country, Global Fund, other donors) or the private sector to address major gaps and barriers PEPFAR cannot address.

For more examples of types of gaps and barriers to consider, please see Modular Planning Step 1 (Section 3.1.1). For additional guidance on selecting program support and system-level interventions, please see Planning Step 4 (Section 3.1.4).

### ***Targeting and program design towards achieving saturation of combination prevention and 90-90-90 treatment targets in TA/TC settings***

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Page 21 of the COP 2015 Guidance states:

***PEPFAR teams are expected to submit COPs that are strategic and set targets that will assist host country governments reach 80 percent coverage of PLHIV on ART by the end of USG fiscal year 2017 (September 30, 2017) in select high-burden sub-national units and/or populations.***

PEPFAR recognizes TA/TC programs typically do not provide direct service provision to beneficiaries, with the exception of limited pilot programs or in the event some critical services are not provided by other stakeholders. As such, TA/TC programs have limited ability to use PEPFAR funds to ***directly*** increase coverage of HTC and enrollment of PLHIV in care and treatment. Though the proximity to beneficiaries is different than in LTS settings, ***TA/TC programs should still work towards the same stated goal.*** Epidemic control and an AFG cannot be achieved without a primary focus on saturation of combination prevention, and particularly 80 percent coverage of ART for HIV positives (see Section 2.2). TA/TC programs should ***first*** identify the gaps and barriers to the national program achieving 80 percent coverage of ART for PLHIV and determine how PEPFAR is able to invest more strategically to address these obstacles. Further, the focus on high-burden sub-national units and populations remains a critical lens to hone program focus given resource constraints, both for the PEPFAR program and national response as a whole. The more new infections that are averted now in areas with the highest transmission rates and populations, the fewer total resources will be required to sustain patients on care and treatment in the future.

It may not be possible with the current program scope and funding level in all TA/TC programs to achieve 80 percent coverage of ART for PLHIV by the end of USG FY 2017. However, TA/TC programs are expected to design programs in COP 2015 that (1) incorporate measurable outputs and outcomes and (2) can demonstrate that with PEPFAR support the host country program is able to ***accelerate*** coverage of combination prevention interventions in the highest-burden locations and

populations. To successfully accomplish this goal, PEPFAR teams, along with host country governments and other stakeholders, will need to use host country program data in sufficient detail to measure and communicate progress. Special recommendations to TATC programs for data presentations and alternative formats are below.

Measurable outputs and outcomes should be communicated for each activity outlined in the Strategic Direction Summary (SDS). PEPFAR recognizes that quantitative attribution is often not possible without structured research design and will not expect teams to conduct impact evaluations on every activity proposed for implementation. However, it is appropriate and necessary that each activity described can be logically linked to measurable outputs and outcomes that demonstrate **accelerated** progress towards epidemic control. These may include MER, EA, SIMS, or SID results; key HIV indicators, such as incidence or estimates of unmet need by key population; national program data, such as program coverage, lost to follow-up rates and viral suppression; or custom, near-term deliverables, such as repeal of discriminatory policy affecting key populations or inclusion of ART coverage in the national health insurance scheme. Some examples by typical intervention category and how they might be measured are provided below.

### **Types of PEPFAR support to host country HIV programs in TATC settings:**

#### **1. Support to host country health systems**

PEPFAR programs provide support for host country systems strengthening for activities such as information systems development, supply chain strengthening, health financing, quality improvement programs, human resource development, and laboratory strengthening. Investments in these areas should be focused on improving HIV outcomes.

**Example:** ART retention rates in the country are unknown or high. PEPFAR is supporting the host country government with standardizing HIV patient medical records/registers and assisting with establishment of unique IDs for clinical services. The PEPFAR team should describe the outcome (e.g., documented retention rates) and related activities that will achieve this outcome.

#### **2. Support to specific program areas/interventions**

PEPFAR support to specific national HIV programs (PMTCT, ART, HTC, MAT, and HIV prevention) may not yield results that can be observed by the MER. PEPFAR OUs should be outcome-focused

and describe what PEPFAR is supporting the host country government to improve and document the resulted change.

**Example:** 40% of Injection drug users are lost to follow-up before they are initiated on ART. PEPFAR wants to support the host country government to reduce the lost to follow-up rate. The PEPFAR team should describe the activities and how they are logically linked to the outcome of interest, e.g., PEPFAR will support the host country government to achieve a 50% reduction in HIV positive injection drug users lost to follow-up by providing targeted technical assistance for improving ART access and retention services.

### **3. Piloting innovative programs**

PEPFAR often pilots novel program approaches to find innovative ways to improve national outcomes, such as quality improvement for clinical services, improving access to HIV testing, treatment for key populations, and prevention and treatment services for people who inject drugs (PWID). For these pilots, PEPFAR teams may report results on MER indicators, but they should also describe the national outcome they are supporting the host country government to improve as stated in Scenarios 1 and 2.

### **4. Direct service delivery for key population programs**

In TA/TC settings, PEPFAR programs sometimes provide prevention, HIV testing and referral services to key populations. Achievements for these programs should be reported as results on MER indicators.

## ***Special considerations for data presentation and interpretation in COP 2015***

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Below are recommendations for additions or acceptable alternative formats to present data in the SDS that might be useful to TA/TC programs. In addition, some additional guidance is provided for data interpretation on some key, standard results outputs.

### **1. Table 1.1.1 Key National Demographic and Epidemiological Data**

Table 1.1.1 is required for all OUs. Particularly relevant to TA/TC programs, this table requests data for key (standard) and priority (specified by OU) population size estimates at the national level. Sometimes these data are not available at the national level; however, size estimates may be available for specific areas.

As an optional supplemental table, OUs with KP programs may consider including a KP population size estimate and prevalence table by SNU (wherever data is available) and sort by either disease burden or prevalence of KP. Please see suggested format for optional Table 1.1.1.a below for an example. This table is patterned after a spreadsheet by country compiled by the CDC Surveillance team in 2014. While the spreadsheet is not exhaustive, it does provide the best data known to date. The most recent version of the spreadsheet is available on PEPFAR.net and may be accessed to assist countries populate Table 1.1.1.a.

**Note:** *If presenting size estimate data would compromise the safety of members of a population, please do not enter it in this table.*

**Table 1.1.1.a Key and Priority Populations Size Estimate and HIV prevalence by “Type of Area” and disease burden based on available data**

**(Note: Optional for OUs with KP programming)**

Key Pop	Name of Area	Type of Area	General Adult HIV prev	Gen Pop Size	KP HIV Prevalence (%)	KP Size	Pop Size Estimation method	Year	Reference	Notes
FSW	AA	Capital	3.1%	789,472	31.2%	13,554	Mult methods	2011-12	IBBS Report 2011/12	
FSW	BB	City			23.6%	8,543	Mult methods	2011-12	IBBS Report 2011/12	
FSW	CC	City			17.8%	6,929	Mult methods	2011-12	IBBS Report 2011/12	
MSM	AA	Capital	3.1%	789,472	8.2%	10,121	Mult methods	2011	IBBS Report 2011	
MSM	EE	City			9.1%	3,085	Mult methods	2011	IBBS Report 2011	
MSM	DD	City			3.7%	2,301	Mult methods	2011	IBBS Report 2011	
Prisoners	C	Province	2.7%	1.3 million	11.7%	669	Census	2013	Min of Justice & UNODC Report	
Prisoners	F	Province	1.8%	576,975	18.2%	456	Census	2013	Min of Justice & UNODC Report	
Prisoners	G	Province	4.5%		22.7%	220	Census	2014	Min of Justice	Gen Pop Size not available since this province was formed post 2013 Census
Prisoners	D	Province	2.5%	611,543	27.7%	83	Census	2013	Min of Justice & UNODC Report	

## **2. Table 1.1.2: Cascade of HIV diagnosis, care and treatment (12 months)**

Standard table 1.1.2 is required for all OUs. Depending on data source, service providers may not be able to identify key populations for monitoring as clients can choose not to reveal behaviors that may identify them as a key population. This will impact the ability to complete the cascade table for key population groups. The most ideal KP data source is routine program monitoring data, in addition to the use of unique identifiers (implemented with informed consent process and standard ethical considerations). If an OU does not use unique identifiers to track KPs through the cascade (and routine program data disaggregated by KP are unreliable), recommended alternative data sources include self-reported service utilization from recent bio-behavioral or behavioral surveys (i.e. iBBS and/or TRaC surveys in the relevant areas/SNUs where PEPFAR is funding).

Standard Table 1.1.2 collects information on PWID, including HTC linkage HTC to other services within the clinical cascade. The table does not ask for linkage to medically assisted treatment (MAT), which is valuable information in TA/TC programs driven largely by injection drug use. Teams are encouraged to report linkage of PWID to MAT in the footnote of the table or in the narrative portion of Section 1.1.

## **3. Figure 1.4.1: Percent of PLHIV by SNU and PEPFAR 2014 Expenditure Per PLHIV**

Figure 1.4.1 is required of all OUs. Interpretation of the results outlined in the graphic may be more difficult in TA/TC programs given the limited size of the investment relative to other sources and the implementation level of investments, which often are categorized as “national” versus being tied to a single SNU. Generally, the guidelines for interpretation laid out in the guidance (page 55-57) are applicable to TA/TC countries and should be followed. A couple of special considerations do apply:

- In TA/TC countries, we would anticipate the national bar to be relatively higher compared with other SNUs than in countries with a large amount of site-level activities, and this is okay. It is understood that support at the national level is intended to bolster program activities more broadly.
- Though the national-level PEPFAR investment per PLHIV may be higher than in any one particular SNU, focusing on highest-burden locations and populations is still a PEPFAR priority and the data should indicate if PEPFAR investments below the national level are generally aligned with disease burden. There will be notable confounders that can and should be explained, e.g., Global Fund supports all of a particular high-burden SNU indicating why PEPFAR investments per PLHIV are relatively low compared with other SNUs. Conversely, investment in a particular pilot project could increase the perceived PEPFAR support to an SNU compared with others, but be a completely acceptable



approach. Again, this example can be explained with data to provide context to interpreting this graphic.

To better understand the PEPFAR investments sub-nationally and how they are aligned with the response and burden of disease, TA/TC teams are encouraged to replicate Figure 1.4.1 with host country program data or that of other donors, especially Global Fund investments, if available. The comparison of PEPFAR investments per PLHIV and national program investments per PLHIV can help to contextualize PEPFAR support and alignment considering the full set of program funders and where misalignment may need to be addressed.

Finally, TA/TC teams are encouraged to use population size estimate data sub-nationally to assess alignment of PEPFAR investments to the location of key and priority populations. The ***EA-Epi Alignment Tool*** can assist with plotting this information in graphic form if data are available. In addition, field teams of programs focused on key populations should also consider additional figures<sup>20</sup> that would demonstrate alignment of the following elements:

- 2014 MSM reached with prevention services (per PEPFAR MER Guidance) and MSM population size estimate (PSE) by SNU
- 2014 FSW reached with prevention services and FSW PSE by SNU
- 2014 PWID reached with prevention services and PWID PSE by SNU

These additional formats for Figure 1.4.1 may help reviewers better understand the PEPFAR investments historically and how this information shapes program decisions in COP 2015.

#### **4. Site yield/volume analysis**

All PEPFAR programs with site-level data are required to complete site yield analysis for HIV testing and counseling (including testing through PMTCT and community sites) and site volume analysis for ART. This is true regardless of MER reporting on DSD or TA indicators in these program areas (both apply).

TA/TC programs may be concerned about the relevance or interpretation of these analyses given the volume of site-level data is often much smaller than that of an LTS program and may be limited to, or dominated by, pilot project data. After analysis of available site-level data for some TA/TC programs, it

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<sup>20</sup> The ***EA-Epi Alignment Tool*** does not automatically plot program coverage as recommended in these additional figures; however, this information (if available) could be easily added to Tables 6-11 of the Tool for a more comprehensive analysis.

is evident this requirement is still applicable for all OUs. Even if a pilot or demonstration project is being implemented, sites with low yield or low volume should be scrutinized to determine if the intervention will help achieve the desired HIV outcome and if resources used to support these activities may be more effectively spent in another area or on another intervention to move the country more quickly towards sustained epidemic control.

TA/TC teams with or without PEPFAR site-level results are encouraged to conduct a similar analysis using host country government data. ***This analysis can and should be completed collaboratively and results shared with country stakeholders to inform joint discussions regarding program focus and most efficient use of resources to achieve program goals.***

#### 5. **Table 4.1.1: ART Targets in Priority Sub-national Units for Epidemic Control**

Standard Table 4.1.1 is required for all OUs. TA/TC programs that **do not** report DSD or TA indicators for TX\_CURR and TX\_NEW are encouraged to use host country data to populate Table 4.1.1 and indicate the data source clearly in the table and/or narrative. These data will assist reviewers understand the degree to which the national program is focusing on specific geographical areas and specific plans for scale-up. If an OU includes national or Global Fund targets in Table 4.1.1, it should be agreed upon by the host country government that these SNU targets will be included in the PEPFAR FY15 COP SDS. One should note that the purpose of including national and/or Global Fund targets in the SDS is for better informed decision making and to maximize efficiencies for the PEPFAR program. It is not intended to assess the performance of the host country.

In addition, teams may elect to present further detail on key and priority population targets by SNUs to indicate program focus in additional tables in Section 4.1 (only if data are available and would not compromise the safety of members of a population). Examples are included below.

<b>Table 4.1.1.a ART Targets in Priority Sub-national Units for Epidemic Control Among Sex Workers</b>					
<b>SNU</b>	<b>Estimated FSW PLHIV</b>	<b>Expected current on ART (2015)</b>	<b>Additional patients required for 80% ART coverage</b>	<b>Target current on ART (in FY16) TX_CURR</b>	<b>Newly initiated in FY 16 TX_NEW</b>
A	900	100	620	78	20
B	N/A	N/A	N/A	40	10
<b>Total</b>				<b>118</b>	<b>30</b>
<b>Table 4.1.1.b ART Targets in Priority Sub-national Units for Epidemic Control Among MSM/TG</b>					

SNU	Estimated MSM/TG PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) TX_CURR	Newly initiated in FY 16 TX_NEW
A	700	200	360	56	20
C	N/A	N/A	N/A	30	20
<b>Total</b>				86	40

Finally, TA/TC programs that **do** report TX\_CURR and TX\_NEW should include these targets by SNU in Table 4.1.1 and include a brief description in the narrative of the scope of these activities (e.g., pilot project for increased ART retention program). These programs are still encouraged to present host country targets by SNU (as described above) in an additional table in Section 4.1.

#### 6. **Table 4.1.4: Target Populations for Prevention Interventions to Facilitate Epidemic Control**

To better describe with data program choices for focus geographically, TA/TC teams may consider adding additional tables to present coverage estimates for key and priority populations by SNU. Examples are provided below.

Table 4.1.4.a FSW for Prevention Interventions to Facilitate Epidemic Control				
SNU	Population Size Estimate (priority SNUs)	PEPFAR Coverage Goal (in FY16)	FY16 Target	Is GFATM and/or HCG providing Prevention Intervention for FSW in this SNU? (Y/N)
A	10,000	20%	2,000	Y
B	1,000	50%	500	N
<b>Total</b>	<b>11,000</b>	<b>22.8%</b>	<b>2,500</b>	

Table 4.1.4.b MSM/TG for Prevention Interventions to Facilitate Epidemic Control				
SNU	Population Size Estimate (priority SNUs)	PEPFAR Coverage Goal (in FY16)	FY16 Target	Is GFATM and/or HCG providing Prevention Intervention for MSM in this SNU? (Y/N)
A	7,500	33%	2,500	Y
C	1,000	50%	500	N
<b>Total</b>	<b>8,500</b>	<b>35.2%</b>	<b>3,000</b>	

#### 7. Resource projections and **Appendix B**

All OUs are required to use empirical expenditure and/or cost data to calculate the required resources necessary to support the PEPFAR program (see Planning Step 6 and Method 3.3.6). Given the general lack of recent cost data available at country level, most PEPFAR OUs will rely heavily on Expenditure Analysis (EA) results from the last cycle (2014). TA/TC OUs do not have PEPFAR national unit expenditure (UEs) provided in their EA results, primarily due to the mismatch of expenditures used to benefit the system as a whole and a small volume of results that tend to come from pilot or very focused direct service interventions. Despite a lack of PEPFAR national UEs, TA/TC programs should still work to use actual expenditure or cost data to build budgets grounded in financial reality and design activities that demonstrate affordability and value. To this end, TA/TC teams are encouraged—in an interagency space—to think through the cost drivers of each planned activity and how successful deliverables and efficiency will be monitored. These findings should be described in the log frame tables for section 6.0 of the SDS (deliverable columns) and Appendix B (budget methods).

The PEPFAR Budget Allocation Calculator (PBAC) has been created to assist field teams plan program budgets based on historical PEPFAR costs of achieving results. An OU-specific PBAC has been provided to all LTS programs; however, a pre-populated version could not be provided to TA/TC programs given PBAC was designed to use PEPFAR national UEs as the primary input. Upon discussions with TA/TC OUs and HQ technical staff, it was agreed there may be utility in using a generic version of the tool (i.e., not pre-populated with EA data), which has been created and uploaded to the COP 15 project page on PEPFAR.net. The generic PBAC allows for input of any unit expenditure desired for a specific program activity and inclusion of “lump sum” amounts for activities not projected based on number of individuals reached. Further, it provides a common space to record funding allocations in a transparent and interagency fashion that can be referenced both during planning this year and in the future.

EA advisors can further assist TA/TC teams think through options for projecting the cost of a particular program activity and assessing available inputs/sources. In addition, the EA advisors are prepared to assist TA/TC teams with projecting total resources using PBAC or another method/tool most appropriate for the given context.

## 15. Long-term Strategy (LTS), Targeted Assistance (TA) and Technical Collaboration (TC) PEPFAR Operating Unit Assignments

<b>Long Term Strategy (LTS)</b>	<b>Targeted Assistance (TA)</b>	<b>Technical Collaboration (TC)</b>
Burundi; Cameroon; Cote d'Ivoire; DRC; Ethiopia; Haiti; Kenya; Lesotho; Malawi; Mozambique; Rwanda; Swaziland; Tanzania; Uganda; Zambia; Zimbabwe	Asia Regional (Laos, Thailand); Cambodia; Caribbean Regional (Antigua & Barbados, Bahamas, Barbados, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St Vincent & the Grenadines, Suriname, Trinidad & Tobago); Central America Region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama); Central Asian Republics (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan); Dominican Republic; Ghana; Indonesia; Ukraine; Burma; Papua New Guinea; South Sudan	Asia Regional (China); Brazil; India
<u>Co-Finance Sub-group of LTS Countries</u>	<u>Co-Finance Sub-group of TA Countries</u>	
Nigeria; South Africa	Angola; Botswana; Guyana; Namibia; Vietnam	