President's Emergency Plan for AIDS Relief

FY06

COUNTRY OPERATIONAL PLAN

FINAL GUIDANCE

Revised August 22, 2005

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INTRODUCTION

The Office of the U.S. Global AIDS Coordinator (OGAC) has supported the development of a unified **Country Operational Plan and Reporting System (COPRS)** to combine all U.S. Government (USG) Agencies planning and reporting on Emergency Plan activities into one central data system. This central USG data system provides the means to collect and analyze data related to Emergency Plan planning and reporting requirements, including the Country Operational Plans (COPs) and Annual Program Results (APR). For ease of data entry, the data system is meant to resemble the format of these reports. USG Missions are called upon to input these planning documents and reports into the data system.

A high quality information system is essential to demonstrate program impact and fiscal accountability, thereby better ensuring future funding of the Emergency Plan. Final approval of country plans and annual budgetary decisions are based on the thorough review of information submitted through the COPRS system.

This guidance provides information about both the Content (i.e., definitions and policy related issues) of the COP and the Data Entry for the COP into the data system. In FY05, the FY05 COP Guidance and the User's Guide were separate. We have combined these two documents into one for FY06. We hope this will provide more comprehensive and useful assistance for the entire FY06 COP process.

This document is structured in a similar way to the FY05 COP Guidance. Each table has its own section. For each table there is information regarding the content of what to include, listed under "Content", and information on how to do the specific data entry, listed under "Data Entry". There are also extensive appendixes which should answer many frequently asked questions about the COPRS. There will also be a FAQs page added to the *Help* section of the COPRS. This FAQs page will be updated on a regular basis once the system is live, in order to provide continuously updated answers to questions as they come up.

If you are viewing this document using Microsoft Word, we have included hyperlinks to assist in navigation. All page numbers in the Table of Contents, as well as all appendix references throughout the document, are hyperlinks that will take you to that location when clicked on.

For FY06, there are 5 additional countries, beyond the 15 focus countries, which are also required to complete a Modified Country Operational Plan. Welcome to the Emergency Plan and the COPRS data system to these 5 countries! There is, of course, slightly different information that relates to these 5 countries as opposed to the 15 focus countries. Importantly, throughout the document specific guidance that is different for the 5 countries is highlighted with "5 New Countries".

For information on who to contact with questions, please see Appendix 3.

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COP FORMULATION

In formulating your country's COP, it is critically important to coordinate as a USG Team. It is essential that ALL USG Agencies working in country be included in discussions around the COP. If one or more of the five USG Agencies that are required to be listed in the Contact Section are not present in your country, you should be in contact with someone from the Headquarters Agency (preferable from your Core Team) to involve them in the COP process.

As a coordinated USG team, all funding resources must be programmed as a team. We recognize that countries have several sources of funding (i.e., GHAI and GAP for focus countries and GHAI, GAP, CSH, ESF, FSA, etc. for the 5 new countries). Despite this fact, ALL programming decisions are to be made as a USG team, taking into consideration achieving Emergency Plan results. Funds that are directed through a particular USG Agency are NOT to be programmed independently by that Agency. They are part of the entire country strategy.

As you develop your FY06 COP and prepare for submission of the document to OGAC by September 30th, you should ensure that time for review and approval by your Ambassador and review by the Host Country Government, as appropriate, is included in the schedule.

You should engage your Core Team Leader, Core Team SI Advisor and Core Team Members very early in the process. Your Core Team Leader is your main point of contact at OGAC and should be heavily involved in the planning and drafting of the document. Your Core Team SI Advisor should be engaged early in the process to assist with targeting and with planning of your Strategic Information activities. Your Core Team Members can help with early versions of the document and assisting with strategic planning.

There are additional resources at OGAC and Headquarters Agencies to help in this process. For the FY05 COPs, Headquarters Agencies provided assistance to countries in the form of individuals who went to country to assist in data entry. While this was of great assistance to countries, it was not always used as a capacity building tool to ensure that individuals in-country learned the COPRS. For FY06, OGAC will provide instead a "COPRS Training of Trainers". OGAC will ensure that individuals who are well trained in the COPRS system, the FY06 COP Guidance and the Annual Program Results be available for assistance. These individuals will go to countries for up to one week in late July or during the month of August 2005 upon request (for the 5 new countries these individuals will be available for additional time in-country). They will train in-country staff in the system to ensure that there is in-country capacity on COPRS. Countries should discuss with their Core Team Leader whether they would like this assistance and when would be the best timing.

You can also receive assistance from the Technical Working Groups that have been set up through Headquarters Agencies. These working groups include: Prevention, Human Capacity Development, Care and Treatment, Strategic Information, OVCs, C/FBO, PAWG, and Food, Nutrition and AIDS. Sub-committees exist for many of these groups that deal with smaller parts of the area – for example, TB/HIV or Palliative Care sub-committees under the Care and Treatment Working Group. If you would like assistance from one of these working groups, you must contact your Core Team Leader to facilitate.

These Technical Working Groups have put together additional considerations for countries to assist in formulation of the COP. This is contained in a forthcoming document, Technical Considerations Compendium, which should be available in August. The Compendium is a companion document to the COP Guidance and should be used in conjunction with this guidance. A Q&A for Strategic Information planning for the FY06 COP will be sent out separately in August.

Please make sure that you are aware of the key FY06 policy guidance included within this COP guidance. Areas that you should pay particular attention to in formulating your COP include the Budgetary requirements for funding (see page 47-49) and the A&A guidance (see Appendix 6).

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COP QUICK REFERENCE GUIDE

This quick reference guide has two main purposes: (1) to assist individuals involved in the FY05 COP process to quickly understand key areas that have been modified, and (2) to provide a list and brief description of each of the required sections and support documents in the FY06 COP. These are provided to assist in planning and formulating the FY06 COP.

Key Policy Changes for the FY06 COP

1. **Budgetary Requirements**:

There are several changes in the budgetary requirement for FY06. With the exception of AB, these apply only to the focus countries. We expect that all focus countries, and in particular those with budgets that exceed $75,000,000, will meet these requirements.

Track 1 central budgets (from headquarters) will be attributed to these requirements (See Appendix 8 and further explanation below.) If for some reason meeting any of the requirements is not possible for programmatic reasons, you must submit a justification. Please inform your core team leader as soon as possible if you will have problems meeting these requirements in your country to avoid difficulties after submission of the COP. To help inform planning, your core team leader has an analysis of your FY 05 budget relative to these requirements.

> **a. Prevention: Abstinence and Be Faithful:** ABC – Abstinence, Being faithful and the correct and consistent use of Condoms for populations engaged in high-risk behaviors – is the most effective, evidence-based approach to the prevention of sexual transmission of HIV (as detailed in ABC Guidance #1: *For United States Government In-Country Staff and Implementing Partners, Applying the ABC Approach to Preventing Sexuality-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief*). In each of the focus countries except Vietnam, the primary mode of HIV transmission is through sexual contact; therefore, it is reasonable that we dedicate a significant proportion of prevention funding to ABC activities to prevent sexual transmission of HIV.
>
> In 2006, each country should strive to dedicate at least 50 percent of total prevention funds to sexual transmission[1], and within sexual transmission funds, to dedicate at least 66 percent to AB. If a country does not meet these expectations, a justification is required (e.g., in Vietnam the primary mode of transmission is through injecting-drug use (IDU), and therefore, it is appropriate to dedicate more than 50 percent of funds for prevention within the IDU context rather than at least 50 percent to prevent sexual transmission). However, failure to meet the 50 percent requirement for sexual transmission within all prevention programs would not justify failure to reach the 66 percent requirement within sexual transmission prevention funds for AB activities. Some

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[1] "Total prevention" funds are those budgets defined in Appendix 12 by program areas 1 through 5 (PMTCT, AB, Blood Safety, Injection Safety, and Other Prevention). "Sexual transmission" funds are those budgets defined in Appendix 12 by program areas 2 and 5 (AB and Other Prevention).

countries might have difficulty reaching the 66% requirement. In such a case, a programmatic justification is required. (E.g. 80% of the epidemic is among prostitutes, therefore a higher proportion of sexual transmission funds are directed to correct and consistent condom use among populations engaged in high-risk behaviors within the context of the ABC approach). Please note, that in a generalized epidemic a very strong justification is required to not meet the 66 percent AB requirement. Again, please inform your core team leader as soon as possible with the justification if you think these budget requirements will present a problem. We expect that all focus countries, and in particular those with budgets that exceed $75,000,000, will meet these requirements.

In any case, however, no country should decrease between 2005 and 2006 the percent of sexual transmission activities that are AB. There will be no exceptions to this requirement.

Appendix 8 provides Track 1 FY06 Budget Allocations by Country. You must include the Track 1 AB resources for your country in the calculation of the 66 percent and 50 percent targets. Since the COPR database was not structured to allow entry of Track 1 budget levels for central mechanisms (funded by headquarters budgets), we will provide a separate Excel spreadsheet for your country, which will contain all the information in Appendix 8. You will then need to copy Table 4 from the COP (Summary Budget Table) into the spreadsheet. All formulas will be entered such that the spreadsheet will automatically calculate for you: i) AB resources as a percent of ABC resources for all prevention of sexual transmission of HIV (66 percent target); and ii) Resources for prevention of sexual transmission of HIV as a percent of the overall prevention budget (50% target).

b. Orphans & Vulnerable Children: All countries must use 10 percent of their program resources toward OVC programs. Excluded from the definition of program resources are Strategic Information, Other/Policy Analysis and System Strengthening, and Management and Staffing. In addition to Track 1 OVC grants, countries may select to attribute activities for pediatric AIDS to either the treatment or OVC areas. Again, should you have a problem in meeting this requirement, please notify your core team leader with a justification as soon as possible.

Appendix 8 provides Track 1 FY06 Budget Allocations by Country. You must include the Track 1 OVC resources for your country in the calculation of the 10 percent budgetary requirement. Since the COPR database was not structured to allow entry of Track 1 budget levels for central mechanisms (funded by headquarters budgets), we will provide a separate Excel spreadsheet for your country, which will contain all the information in Appendix 8. You will then need to copy Table 4 from the COP (Summary Budget Table) into the spreadsheet. All formulas will be entered such that the spreadsheet will automatically calculate for you: i) OVC resources as a percentage of all program resources, excluding Strategic Information; Other/Policy Analysis and Systems Strengthening; Management and Staffing.

c. Treatment: To meet the Congressional recommendation that the Emergency Plan allocate 55 percent of its resources to antiretroviral (ARV) treatment in FY06, all countries will need to incorporate the 55 percent goal as a budgetary requirement.

However, since it might not make programmatic sense to meet this requirement in some countries, other countries will have to exceed a 55 percent budgetary requirement to meet the overall objective for the Emergency Plan. It is particularly important that countries that receive over $75,000,000 meet or exceed this requirement.

To assess how close you are to the 55 percent treatment requirement, you should also use the Excel spreadsheet that will include all of the Appendix 8 (Track 1 Budget Allocations) information. Upon entry of data from the COP Table 4, the Excel spreadsheet will generate: Resources for ARV treatment as a percentage of all program resources (55 percent), which will include the Track 1 ARV budget levels. Once again, excluded from the program resources are Strategic Information, Other/Policy Analysis and System Strengthening, and Management and Staffing.

2. Additional Budget Allocation Recommendations:

Strategic Information: You should dedicate an estimated seven percent of your total country budget (all program areas) should be dedicated to Strategic Information.

Management and Staffing: It is estimated that approximately seven percent of total country budget (all program areas) is appropriate for management and staffing.

Further detail concerning these is available beginning on page 47.

3. Results Targets:

In addition to the targets that you have established previously in various program areas, in FY 06 there are three new priority program areas which will require analysis and target-setting at the country level.

a. Pediatric AIDS: The World Health Organization (WHO), the United Nations (UN) Children's Fund, and the Joint UN Programme on HIV/AIDS estimate that approximately 660,000 children globally, including 370,000 in sub-Saharan Africa currently are in need of ARV therapy (ART) (June 2005). Despite this obvious need, only a fraction of children living with AIDS receive life-saving Anti-Retroviral therapy (ARV). Without treatment, most children born with HIV will die before age five – but research shows most children who start ARV therapy early in life can and do flourish.

Clearly scale-up for pediatric treatment is an urgent priority. To assist you with scale-up and to document Emergency Plan efforts to reach children, we request that for the 2006 COP you estimate the number of children you intend to reach with ARV treatment in 2006. In Appendix 5 you will find additional information on pediatric AIDS programming.

b. Confidential Counseling and Testing: To achieve the 2008 treatment goals, countries must focus on counseling and testing larger numbers of individuals, than we have reached so far. For this reason, we have provided a FY08 counseling and testing target for each country (see Appendix 5) to assist countries with program planning, knowing you will be accountable for this target in FY08.

c. Tuberculosis (TB)/HIV: TB is a major killer of people living with HIV/AIDS (PLWHA), and addressing this issue is an important part of meeting the Emergency Plan 2-7-10 goals. The percentage of funding in FY05 in the TB/HIV program area is 1.8 percent (range 0.75-3.15). Given the significance of the TB/HIV problem, this is a relatively low percentage. For FY06, countries should make a significant increase in programming for TB/HIV activities. Additionally, for FY06, countries should place the bulk of TB/HIV related activities in the TB/HIV program budget area. For example, confidential counseling and testing that is focused on TB patients. For broader activities in other program areas that include TB/HIV, you should include a clear description of the TB/HIV activities in the narrative.

A primary focus of addressing TB/HIV is testing TB patients for HIV and supporting ART for eligible TB patients. To assist with programming in this area, we have included motivational targets for the number of TB patients that should receive counseling and testing in 2008 (see Counseling and Testing Table in Appendix 5). These are ambitious goals, and will require considerable work. Please also see the TB/HIV Table in Appendix 5, which illustrates estimated number of adult HIV-positive TB cases eligible for ART in the Emergency Plan. Although it relies on 2002 data, it provides an approximation of the need for ART and other care in this important population. Additional TB/HIV priorities include screening and diagnosing PLWHA for TB and cross referral between TB and HIV/AIDS care. Please use the TB/HIV Technical Working group for support with formulating your TB/HIV activities.

4. Collaboration with the GFATM (Global Fund for AIDS, TB, and Malaria)

Both the focus country bilateral program support and U.S. Government central investments in the GFATM are essential elements to the Emergency Plan Global Strategy in the fight against AIDS. Indeed, implementation of the Emergency Plan has demonstrated the interdependence of these two approaches on the ground. Within this context, and given the commitment of the USG to the principles of the Three Ones, COPs should invest focus country bilateral resources or activities are being used to support the GFATM directly. Examples include: strengthening the capacity of Country Coordinating Committees or placing time-limited logistics advisors in Ministries of Health to strengthen logistics systems and create unified procurement approaches. Such investments should be time-limited, not focused on long-term recurring costs, and be oriented to specific outcomes that will allow GFATM money to flow more quickly and efficiently.

In addition, both the COP and the Annual Program Results should identify areas where pilot programs are being brought to scale using GFATM resources. While this is important for all countries, it is of particular significance to the five bilateral country programs that are not focus countries. In these countries, there is no expectation that bilateral resources will be available to bring programs to scale. Rather, working with other in-country resources, both donor and host government, will be the primary approach.

Descriptions of investments in GFATM programs, and in coordination with the GFATM should appear in the Current Program Context section for each program area.

5. **Time Period:**

The only time period now used in the COP is the Fiscal Year (October 1 - September 30). Both Table 2 and Table 3 of the COP require you to set targets for the Fiscal Year period. Table 2 requires you to set country-level prevention, care, and treatment targets for both the current FY06 Fiscal Year (to be achieved by September 30, 2006), as well as the following FY07 fiscal year (to be achieved by September 30, 2007). Activity-level targets, set in Table 3.3, are defined to be achieved by the end of FY07 (September 30, 2007).

6. **Acquisition and Assistance:**

To facilitate sustainability to increased use of new partners and indigenous organizations, as well as promote efficiencies across U.S. Government Agencies and the program Emergency Plan is paying continued attention to, as well as making some changes in the area of acquisition and assistance. These are more fully detailed in Appendix 6. Two important elements in particularly require note. One is the need to avoid duplication of effort across U.S. Government agencies, particular in terms of using the same implementing organization for the same scope of work. This is costly in terms of management and oversight, and a continued transition away from this practice is essential. In addition, in the assistance arena, we expect that the amount of funding for any single organization will be less than 10 percent of the total COP budget for any given year. Exceptions are possible for organizations that are acting as grant making and administration arms of the Emergency Plan and are building local sustainable capacity, for government Ministries, or for organizations that are major purchasers of pharmaceuticals and other commodities. When determining the 10 percent, your analysis should include total funding for organizations, as prime contractors or sub-contractors. If you have difficulty in meeting this target, a justification is required. This requirement will be taken very seriously.

7. **Key Legislative Issues**

In addition to the legislative budgetary requirements last year, you will note new subcategories under the linkages between HIV/AIDS and other sectors under "Wrap Around". This better articulates where we are leveraging other U.S. Government and donor, including GFATM, resources. We highlight five specific areas: highlighted, education, food, microfinance, democracy and governance and other. Please see Appendix 15 for further information.

8. **Track 1 Anti-Retroviral Therapy**

In FY 2006, central funding for Track 1 ART grantees will be essentially straight-lined at FY05 levels, not including any rapid expansion funds or COP funds transferred to Track 1 grantees in FY05. This has been done to ensure that Track 1 grantee activities are fully integrated into host country and embassy plans. Track 1 treatment grantees have received instructions to straight-line their central costs allocated to countries at the FY 05 level. It is essential that, at a minimum, costs of anyone already on treatment using Track 1 resources must be covered. Therefore, FY06 country budgets must cover the continuing treatment costs of anyone already on treatment using Track 1 resources that exceed those costs that

can be covered by central funding can cover, and the full cost of any expansion of treatment through Track 1 grantees. See Appendix 8 for further details.

Key Functional Changes for the FY06 COP

1. Direct and Indirect targets (and accomplishments) are now mutually exclusive. You should not include Direct as part of the Indirect. The data system will automatically sum Direct and Indirect to give a Total USG target.
2. You will be able to import specific funding mechanisms and activities from table 3 in the FY05 COP into Table 3 of the FY06 COP.
3. There is a check box for early funding requests in table 3.1, to allow us to gather information on those funding mechanisms that need funding early in FY06, i.e., ongoing activities that would be included in a first quarter congressional notification.
4. The total for a Funding Mechanism listed in Table 3.1 is now calculated automatically as Activities by Funding Mechanism are entered in Table 3.3.
5. There is an Activity List function for each Funding Mechanism in Table 3.1. It allows you to see all Activities by Funding Mechanism in Table 3.3 that are linked to that Funding Mechanism.
6. You can now enter comments for the different tables and Activities by Funding Mechanism to assist you with in-country formulation of the COP. These comments can be printed as a report, but do not appear in the COP.
7. You should now include ALL activities that will be continuing in FY06, even those activities for which you are NOT requesting new funding. These activities would be ones that are still continuing from FY05 or FY04, but for which no new funding in FY06 is requested.
8. Results for each program area are no longer required. Instead, we are asking for a narrative to describe program area status and planned accomplishments for FY06.
9. There are now program area summary targets for each of the required indicators. These are unduplicated counts of targets across the program area.
10. The Activity Categories are now called Emphasis Areas. You are asked only to estimate the range of the effort being undertaken in each Emphasis Area, rather than calculating a percent associated with them.
11. There is additional detail for the Management & Staffing Program Area. This Program Area is significantly different from the other 14 Program Areas and we have provided separate instructions for this section.

Required Sections & Support Documents

1. Country Contacts – The contact information for each USG Agency participating in the Emergency Plan in your country.
2. Executive Summary – This should follow the Congressional Notification format provided in Appendix 25.1.
3. Table 1 – This provides space for your country to update any of the information provided in the 5-Year Strategy.
4. Table 2 – There are 6 indicators listed here for which direct and indirect country targets need to be set. Targets are required for both the end of FY06 and the end of FY07.
5. Table 3.1 – This funding mechanism list provides a summary of the unique funding mechanisms in the plan, defined by mechanism type, funding sources, USG Agency and prime partner.

6. Table 3.2 – This table is where sub-partner information is provided.
7. Table 3.3 – The activities by funding mechanism is the core of the COP. It provides the details of what activities are planned for the fiscal year.
8. Table 4 – The summary budget report is generated automatically by the data system.
9. Table 5 – This asks for information on any data collection efforts that are planned for the fiscal year.
10. Required Support Documents –
    a. Explanation of Direct and Indirect Target Calculations for Table 2 – An explanation of how targets listed in Table 2 were calculated. Include both direct and indirect calculations.
    b. Peace Corps Out-Year Funding – Peace Corps and OGAC request that posts also identify the volunteer costs for FY07 and FY08 so that country programs are prepared to request these funds as well in their out-year COPs.
    c. Fiscal Year 2007 Funding Planned Activities – Please provide a one-page document that details the work that will be undertaken with fiscal year 2007 funding. This will be used for the 2007 Congressional Budget Justification.
    d. Staffing Matrix – This matrix shows existing and planned new staff for the USG team.
    e. Potential Plus-Up Funds – This document provides details of activities countries would undertake with potential additional funding.
11. In order to complete submission of the COP, a letter from the Ambassador is required to be uploaded into the data system.

COPRS DATA SYSTEM

SYSTEM MODIFICATIONS FOR FY06

In response to field and headquarters recommendations, we have worked hard over the past year to make the COPRS system more user friendly. For those of you who are already familiar with the data system, outlined here are the key changes in terms of data entry to the system:

1. Screen changes: There are now separate sets of screens for COP and for the Annual Program Results (APR).
2. Improved navigation throughout, including roll over menus so there is now no need to continually return to the table of contents to switch program areas, etc.
3. More save buttons so that you do not need to navigate back and forth to save a page you are continuing to work on.
4. Fewer places where you have to click multiple edit buttons to enter information.
5. Table 3.1 now automatically sums the planned funding for a funding mechanism as activities are added in Table 3.3.
6. All funding mechanisms listed in Table 3.1 will have an ID number. All activities by funding mechanism listed in Table 3.3 will have an ID number. This will assist in referencing specific funding mechanisms or activities during the review process and also in the COP.
7. There is an Activity List function for each Funding Mechanism in Table 3.1. It allows you to see all Activities by Funding Mechanism in Table 3.3 that are linked to that Funding Mechanism.
8. Partners/organizations not already in the data system will now be entered at the HQ level rather than at the country level. Countries will need to send the required information on partner/organizations that are not currently in the data system to Sarah Gorrell (email gorrellse@state.gov) for entry. There is additional information on page 39 about how to do this.
9. The automatic time out for the system has been changed from 20 minutes to 30 minutes.
10. You will now get a warning when you have only 3 minutes remaining to save or navigate before being logged out of the system.
11. You will be able to add comments to the different sections of the COP, which will print as a separate report but will not print in the COP document itself. This will assist in-country with formulation of the COP.

SYSTEM OVERVIEW

The COPRS data system is intended for use after you have largely determined the content of your Country Operational Plan. The Printable COP Template and the Partner Data Entry Forms, available in the *Help* section, can be used to help develop this plan. They are printable and downloadable files that can be used in internal working sessions and with your partners during the process of developing your COP. These documents provide substantial blank space to enter text.

Help: If you need help using the COPRS data system, there is contact information in the *Contact Us* section. There is both an email address (COPRSSupport@s-3.com) and a "warmline" for phone calls (301.562.0770). The email address will be checked on a regular

basis both on weekdays and on weekends. The warmline will be staffed on a regular basis both on weekdays and on weekends. The exact hours of operation will be sent out sent in a News to the Field announcement in August. The warmline will not begin operation until the 1st of September.

Working in Word: Text from the electronic versions of the Printable COP Template and the Partner Data Entry Forms, or other documents, can be copied into the data system by copying the file into the Windows clipboard, and then pasting it into the appropriate box in the COPRS data system. Please be aware that fonts (including underlined, bold, and italic text), bullets, boxes, images, and similar formatting cannot be used in the data system. If you try to copy different fonts (including underlined, bold, or italic text), the font information will be lost and text will be shown in a single font. Bullets may be converted to periods or lost. Images and boxes will usually be ignored.

The COPRS data system will not spell-check your text. However, please note that narratives drafted in Word can be readily edited (including spell-checked; length checked) before being copied into the COPRS data system.

(We received feedback from several users during the COP Evaluation requesting to have both a spell-check and formatting of text available in the COPRS data system. This option is not possible at this time.)

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Clip and post this information near your computer.

Saving: Data you type or paste into your Web browser will be saved in a data system, on a server, in the United States whenever you click on the Save button. You can also save your page by using a navigation link such as Next, Previous, or Table of Contents. For those tables which have automatic formulas, such as Table 2, there is also an Update Total button that will save your information. If you receive the 3 minute timeout warning (discussed below in Authorization and Security), clicking the Continue button will NOT save your work. However, clicking the Continue button will refresh the page, with all of your work still showing. You will then want to immediately click the Save button in order to save your work.

If you are working in an environment where the Internet connection or power to your computer is frequently interrupted, you will want to use the Save button on a regular basis so that you don't lose information.

Please be aware that if you navigate using the roll-over menus at the top of the screen (shown in the screen shot on page 15 below), your information will NOT be saved. Your information will also NOT be saved if you use the browser buttons (the Back and Forward buttons at the top of the screen immediately under File). You will need to click on the Save button or the Update Total button prior to navigating with the roll-over menus in order to save your work.

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Multiple Users: Multiple users can enter data for a single COP at the same time. However, they should coordinate so that they are NOT working on the same sections of the COP at the same time. Saving information for the same section at about the same time may result in data loss. When this happens, the last user to press the Save button determines the content of the data system.

USER ROLES

There are numerous user roles for accessing and using the COPRS data system, each with varying degrees of system access. One user may have more than one user role, as necessary. For a list of all user roles available in the COPRS data system, see Appendix 4. Depending on the administrative rights that you have, you will see only a subset of all the available roles.

The roles for users in-country are the most extensive and most important. They are relied upon to input all of the data and to ensure the accuracy of the data. The type of access in country users have will vary at different times of the year depending upon what reporting is being done. The role of users in Headquarters' organizations is very different from that of in-country users. Core Team Leaders at OGAC have the ability to approve activities outlined in the COP. They are also able to assist countries in terms of data entry and/or reviewing information. Individuals at Headquarters organizations outside of OGAC have read-only access to the COPRS and are only able to read and print information from the system.

The most common user roles are outlined here:

Countries
- **Country-Level System Administrator—**Has full system administrative rights to add users and modify records for a given country and submit the country's final COP or APR to OGAC for approval.

- **Country COP Read/Write/Finalize—**Has full data modification rights to update or add records (e.g., enter data) to the COP for a given country. Users with this access are also able to finalize and submit the COP. This access will only be allowed during those times of the year when the COP is in the process of being submitted.

- **Country PR Read/Write/Finalize—**Has full data modification rights to update or add records (e.g., enter data) to the Program Results for a given country. Users with this access are also able to finalize and submit the APR and S/APR. This access will only be allowed during those times of the year when the Annual and Semi-Annual Program Results are in the process of being submitted.

- **Country COP Read/Write—**Has full data modification rights to update or add records (e.g., enter data) to the COP for a given country. Users with this access are NOT able to finalize or submit the COP. Country COP Read/Write access will only be allowed during those times of the year when the COP is in the process of being submitted.

- **Country PR Read/Write—**Has full data modification rights to update or add records (e.g., enter data) to the Program Results for a given country. Users with this access are NOT able to finalize or submit the APR or the S/APR. Country PR Read/Write access will only be allowed during those times of the year when the Annual and Semi-Annual Program Results is in the process of being submitted.

- **Country COP Read—**Has data read access for the COP for a given country, but cannot update or add any data. This type of access is allowed year round.

- **Country PR Read—**Has data read access for the Program Results for a given country, but cannot update or add any data. This type of access is allowed year round.

<u>Headquarters</u>
- **USG System Administrator—**Has full system administrative rights to add users and modify records across all countries. This role is very limited in terms of who has this access.

- **USG Read-Access Administrator—**Can grant read access (read-only) across all countries. There is one or more individual(s) at each USG Headquarters Agency who acts as the Administrator for that Agency.

- **USG COP Read/Write/Finalize/Approve—**Has full data modification rights to update or add records to the COP across multiple countries. This individual also has access to be able to finalize and approve activities in the COP. This user role is limited to Core Team Leaders.

- **USG PR Read/Write/Finalize—**Has full data modification rights to update or add records to the Program Results across multiple countries. This individual also has access to be able to finalize the Program Result. This user role is limited to Core Team Leaders and/or Core Team SI Advisors.

- **USG COP Read—**Has data read access to the COP across all or several countries, but cannot update or add any data. This access is primarily for Core Team Members or individuals involved in the COP review process.

- **USG PR Read—**Has data read access to the Program Results across all or several countries, but cannot update or add any data. This access is primarily for Core Team Members or individuals involved in the Program Results review process.

GETTING STARTED

<u>Technology Requirements</u>: The system's only technology requirement is a Web browser that supports session variables (non-persistent cookies), which are necessary to allow the system to identify users as they navigate the different data screens in order to ensure data integrity. The latest browser versions are recommended, with Netscape 6.2 and Internet Explorer 5.0 being the minimum requirements. Pop-ups must be allowed.

<u>Login</u>: The Country Operational Plan and Reporting System login screen is located at: https://www.epcopr.net

<u>Welcome</u>: The login screen leads you to the Welcome screen, through which you can access system functions from the toolbar in the top part of the screen (from left to right):
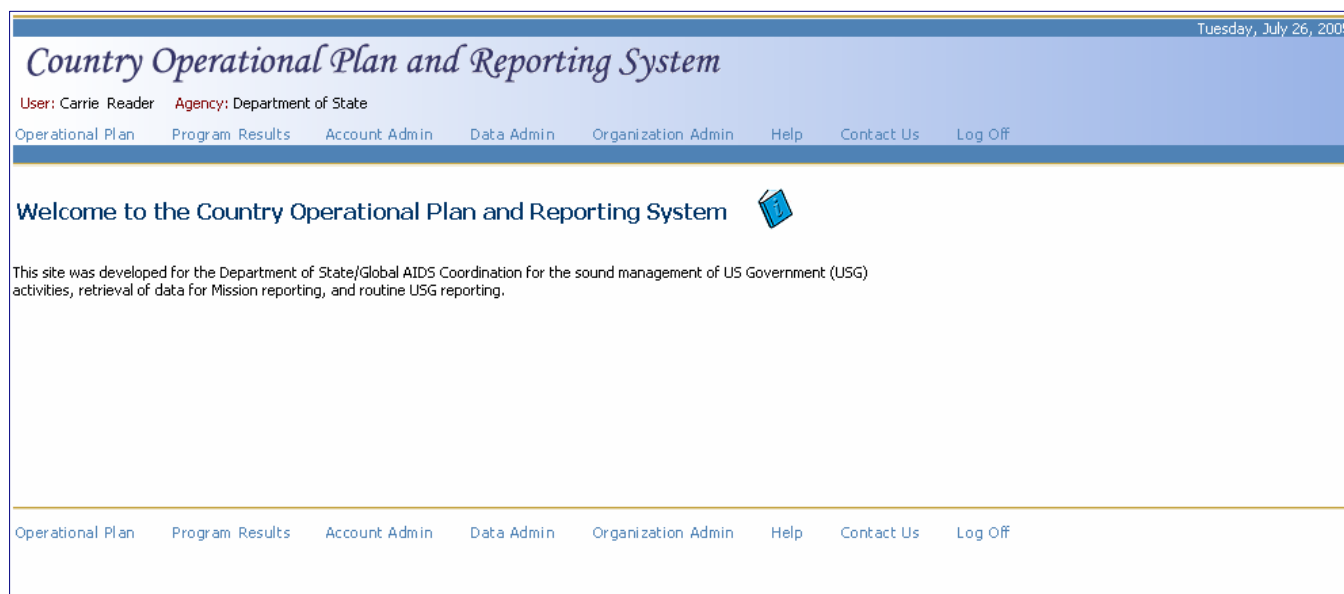
The different **_sections_** of the data system that you can access are:

Operational Plan—Allows users, depending on their access level, to view and/or enter data, print reports, submit and approve the FY06 COP. This section will not be available for data entry while data entry for the Program Results is underway. Users will still be able to review data, search for information and print reports. However, data entry will not be available. For the 15 focus countries, the data entry window for the FY06 Country Operational Plans will begin on July 25th and will end on September 30th. For the 5 new countries, the data entry window for the FY06 Country Operational Plans will begin on August 15th and will end on December 1st.

Program Result—Allows users to enter data, print reports and submit the Program Results. This section will not be available for data entry while data entry for the COP is underway. Users will still be able to review data, search for information and print reports. However, data entry will not be available. For the 15 focus countries, the data entry window for the FY05 Annual Program Results will begin on October 3rd and will end on November 14th. Data entry for the FY06 Semi-Annual Program Results will begin on March 27th, 2006 and will end on May 15th, 2006.

The 5 new countries will not be required to complete a FY05 Annual Program Results or a FY06 Semi-Annual Program Results. The first Program Results that will be required is the FY06 Annual Program Results.

Account Admin—Allows users to change their passwords. Also allows administrators to reset passwords; add, update, or delete users; and generate reports on user activities.

Data Admin—Allows administrators to add and update data (agency, country, funding source type, program type, etc.) in the data system.

Organization Admin—Allows USG administrators to add and update partner and sub-partner information

Help—Provides access to a printable PDF version of support and reference documents.

Contact Us—Provides contact information for the USG "warmline".

Log Off—Allows users/administrators to log off from the system.

Authorization and Security: You will receive notification of authorization to use the COPRS data system from either your Country or HQ Agency System Administrator by e-mail. The e-mail notification will include your assigned user name, temporary password, type of access/user roles, and the link to the COPRS data system. Upon first login, users will be prompted and must change the temporary password to a new password. The temporary password is valid for only ONE log-on.

After receiving authorization and login information, you can freely access the COPRS data system as many times as you like and a record of your edits will be stored. As long as you save data at each page, you are free to navigate to different screens, work on different tables, exit the data system and resume entering or editing data at any time.

As a security feature, the COPRS data system automatically logs off users after 30 minutes of inactivity. After 30 minutes of inactivity, users will be prompted to re-enter their user name and password on the login page. You will be notified when you have only 3 minutes remaining before being logged off. If you receive the 3 minute timeout warning, clicking the Continue button will NOT save your work. However, clicking the Continue button will refresh the page, with all of your work still showing. You will then want to click the Save button in order to save your work.

Information Icons: COP Guidance as directly related to specific required fields/concepts is distributed throughout the system and along side specific fields. This additional guidance is available whenever there is an ⓘ button. Click on the button next to the specific required field or concept to obtain appropriate COP Guidance.

Instructions and references with regard to data entry are also available through the system. This guidance is signified by the 📘 button. Click on the button to obtain instructions on how to enter information into the data system.

CONFIDENTIALITY

Much of the data that is included in the COPRS data system is considered to be sensitive. The system itself is classified as "sensitive but unclassified". Because of the sensitive nature of the information contained in the COPRS data system, all users are required to sign a confidentiality agreement. The system administrator who initiated your user account will have copies of the confidentiality agreement. This confidentiality agreement must be signed and faxed or emailed to OGAC within 2 weeks of receiving your user account. If the confidentiality agreement is not returned to Sarah Gorrell (gorrellse@state.gov) at OGAC within 2 weeks of receiving your user account, your account will be disabled.

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COP SECTIONS

New Feature: Add Comments button – Throughout the different sections of the online COP, you will see an Add Comments button. This button will allow writers to add comments to a particular section of the COP. These comments will NOT print out in the COP Report, but can be printed in a Comments Report. This feature is designed to assist with in-country formulation of the COP. Individuals who have read-only access to the COP will be able to view the comments, though they cannot add any.

GUIDANCE MODIFICATIONS FOR FY06

The following are modifications made to the FY06 COP based on the experience and feedback from the FY05 COP:

1. There is now only the fiscal year time period in the COP. Table 2 requests targets for FY06 and FY07. Table 3.3 requests activity targets to be reached by the end of FY07.
2. There are several budgetary requirements, including AB and OVC, as well as budgetary requirements for pediatric AIDS, TB/HIV, SI and M&S.
3. There is additional Acquisition and Assistance guidance to which details best practices in increasing local partners, limiting funding for single organizations in a given country, and how OGAC/HQ should be involved in new procurements.
4. Direct and Indirect targets (and accomplishments) are now mutually exclusive. You should not include Direct as part of the Indirect. The data system will automatically sum Direct and Indirect to give a Total USG target.
5. You will be able to import specific funding mechanisms and activities in table 3 from your FY05 COP into your FY06 COP.
6. There is a check box for early funding requests in table 3.1, to allow us to gather information on those funding mechanisms that need funding early in FY06, i.e., ongoing activities that would be included in a first quarter congressional notification.
7. You are asked to include activities in table 3.3 which do NOT require FY06 funding. These activities would be ones that are still continuing from FY05 or FY04, but which do not need new funding to continue the activities.
8. *Results* by program area have been replaced with a general narrative overall description of the program area and accomplishments that are to be achieved.
9. There are now program area summary targets for each of the required indicators. These are unduplicated counts of targets across the program area.
10. Activity Categories in table 3.3 are now called Emphasis Areas and will no longer require exact percentage breakdowns, but rather a range of effort associated with the area.
11. We will still gather geographic coverage area in the COP. Where possible, we have provided geographic coverage areas for administrative districts, rather than just province.
12. There is additional detail for the Management & Staffing Program Area. This Program Area is significantly different from the other 14 Program Areas and we have provided separate instructions for this section.

COUNTRY CONTACTS

MODIFICATIONS IN THIS SECTION:

1. Each country is now required to have contact information for 5 of the USG Agencies involved in the Emergency Plan.

CONTENT:

Please list the contact information for each of the USG Agencies working in your country. You are required to have contact information for the following USG Agencies:

1. U.S. Embassy
2. HHS/CDC
3. USAID
4. DoD
5. Peace Corps

If one of these required USG Agencies does not have an office in your country, please list the key individual from either a regional or headquarters office of that Agency who assists with your country. For the 5 focus countries which do not have a Peace Corps presence, please put down Ms. Praya Baruch (PBaruch@peacecorps.gov, 202.692.2662) as your contact person.

Optional contacts from USG Agencies include: HHS/HRSA, HHS/OGHA, HHS/NIH, HHS/SAMHSA, Department of Labor, and USDA. Please list contacts for all USG Agencies present in your country. You may also include additional contact information for any host country ministries, for the Department of State/Office of Population, Refugees and Migration, or other key organizations/individuals that you feel should be listed. Please do not list any implementing partners here, other than those who might be associated with a Host Country Government Agency.

DATA ENTRY:

A "contact type" is an Agency or Organization for which you are required or want to list a contact. By default, a row will appear for each contact type in the data system; however, you can change the types for each row. Additionally, you may enter multiple contacts for a single type.

First Name—The first name can be up to 255 characters in length.
Last Name—The last name can be up to 255 characters in length.
Title—The title can be up to 255 characters in length.
E-mail—The e-mail address can be up to 255 characters in length.

You may add additional contacts by clicking the Add More Rows button, and you may delete your entries by clicking the Delete link at the end of each contact you had previously entered. You will NOT be asked to verify your deletion. Click on the Save button to save your entries without leaving the page or click on the Cancel button to exit the screen without saving.

If you would like to add a new contact type, that is add a contact organization that is not already in the data system, your country system administrator will need to add the contact type.

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Country Contacts

* **Indicates Required First and Last Name**   Add Comments

Contact Type	First Name	Last Name	Title	E-Mail
U.S. Embassy Contact *				
USAID In-Country Contact *				
Peace Corps In-Country Contact *				
DOD In-Country Contact *				
HHS/CDC In-Country Contact *				
HHS In-Country Contact				
HHS/HRSA In-country Contact				
HHS/OGHA In-Country Contact				
HHS/NIH In-Country Contact				

Save   Cancel   Add More Rows

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EXECUTIVE SUMMARY (5 page limit)

MODIFICATIONS IN THIS SECTION:

None

CONTENT:

The format of the Executive Summary should follow the Congressional Notification format and be no longer than five pages in length. A sample of the CN format is attached in Appendix 25.1. The Executive Summary cannot be written in the data system. Rather it will be stored as a separate file on the COPRS server. You are asked to write the Executive Summary in Word and then upload the file into the data system.

Please do not include additional support documents here. There is now a separate section for additional support documents (see page 65 for instructions).

DATA ENTRY:

Country: Ethiopia   FY: 2006

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Executive Summary ⓘ

The format of the Executive Summary should follow the Congressional Notification format and be no longer than five pages in length. Click to view Sample of Congressional Notification Letter Format.

Upload Supporting Document: [_____] Browse...
Click "Browse" to select a file to upload

File must be of the following type:
- TEXT
- RTF
- WORD
- PDF

Description:
(Up to 500 characters) [_____]

Upload File

1. Enter Filename—Click on the Browse button to select appropriate Executive Summary file to upload from your local system to the HQ Data system (Document must be a text file, RTF, Word, or PDF).
2. Additional Description—Click on the Additional Description box and begin entering any additional information you would like included. You may enter up to 500 characters (approximately one paragraph) in this section. You may want to enter the specific date or the author in this box.
3. Click on the Upload File button to upload the country Executive Summary.
4. If you would like to delete a file that you have previously uploaded, click on the Delete File button on the list of uploaded files.

5. If you would like to look at a file that has already been uploaded, select Download.
6. Please do NOT use this section for additional support documents. A section has been added to the data system that allows you to upload additional support documents, such as acronyms lists, maps, explanation of indirect target calculation, etc.

Country: Botswana   FY: 2006

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Executive Summary ⓘ

The format of the Executive Summary should follow the Congressional Notification format and be no longer than five pages in length. Click to view Sample of Congressional Notification Letter Format.

Uploading History:

Add Comments

Get File	File Name	Content Type	Description	Date Uploaded	
Download	Test.doc	application/msword	Testing	5/18/2005 10:40:12 AM	Delete File
Download	test.doc	application/msword	bwtest	5/4/2005 3:24:07 PM	Delete File

Upload New File

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TABLE 1   COUNTRY PROGRAM STRATEGIC OVERVIEW

MODIFICATIONS IN THIS SECTION:

1. You are no longer asked to describe what the country strategy is in Table 1. You are now asked just for a brief description of any significant changes to the environment or revisions that you are planning to your 5 Year Strategy.

CONTENT:

The objective of Table 1 is to draw attention to any modifications to the USG 5 Year Strategy that your country will be undertaking. If you are not planning to make any modifications to the USG 5 Year Strategy at the current time, simply answer no to the fist question and move on.

5 New Countries – Please skip this section. Since you have not yet turned in a 5-Year Strategy, it is not applicable to provide details on updating.

DATA ENTRY:

1. Select either Yes or No from the drop down menu for the question "Will you be submitting changes to your country's 5-Year Strategy this year?"
2. If the answer is No, continue on to Table 2.
3. If the answer is Yes, please provide a brief narrative describing the planned changes. The character limit for the text box is 4,000 characters (approximately 1 page).

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Table 1: Country Program Strategic Overviewⓘ

[Add Comments] [Save]

Will you be submitting changes to your country's 5-Year Strategy this year? If so, please briefly describe the changes you will be submitting. **(Up to 4000 characters)**

● Yes   ○ No

> We will increase programs in western region of the country.

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TABLE 2   PREVENTION, CARE AND TREATMENT TARGETS

For FY06 you will be asked to complete two separate Table 2's. Table 2.1 will be for the period that ends September 30th, 2006 (FY06) and table 2.2 will be for the period that ends September 30th, 2007 (FY07). This will only occur in the FY06 COP and is part of the strategy to move the entire COP to only ONE timeframe. The instructions below apply to both tables.

MODIFICATIONS IN THIS SECTION:

1. For the FY06 COP only, you will be asked to complete two separate Table 2's.
2. The indicators have been modified in terms of wording.
3. There is no longer any PMTCT+ indicator.
4. Direct targets and Indirect targets are now mutually exclusive categories that sum to the Total targets.

CONTENT:

NATIONAL (2-7-10) TARGETS:

The national targets for your country are those set at the initiation of the Emergency Plan. They are the 5-year total targets that are to be achieved by the USG in collaboration with all other donors working in the country and the host country government. These targets will be included in the data system for your country as constant, fixed values. You will not be able to change these national targets.

USG END FY06 TARGETS:

1. Assistance with Targets:
   It is critical that you begin working with your Core Team SI Advisor on this section as early as possible. Your Core Team SI Advisor can assist with setting your FY06 targets. OGAC will not be providing specific guidance on how to set these targets for each country, as this is a very country-specific process.

2. Additional Guidance:
   Please see [*The President's Emergency Plan for AIDS Relief Indicators, Reporting Requirements, and Guidelines: Revised for FY2006 Reporting, July, 2005*] document for additional information and definitions for indicators.

3. Timeframe:
   The timeframe for the USG end of FY06 targets is the actual fiscal year, <u>October 1, 2005 – September 30, 2006</u>. It will be against these targets that the Annual Program Results (APR) will be evaluated. The APR will be due 45 days after the end of the fiscal year (November 14, 2005).
   We will use these targets in reporting to the U.S. Congress on what we plan to accomplish over the coming year. In reporting to Congress, we must use the fiscal year.

4. A target must be expressed as a whole number value (e.g. 400,000), not as a range (e.g. 250,000 – 500,000).

5. Track 1:

The number of individuals receiving care and treatment as a result of Track 1 activities are to be included in your USG end of fiscal year country targets.

6. Prevention Targets:
    Due to the difficulty in estimating infections averted, countries are not required to come up with an overall fiscal year PREVENTION (infections averted) targets. Rather, headquarters will estimate infections averted based on periodic prevalence studies, with the U.S. Census Bureau taking the lead. This approach will establish prevalence trends for each country using data through 2003. In 2005, these prevalence trends will be re-estimated for those countries with additional surveillance data available for 2004 and 2005. The difference in these two prevalence trends will represent the net impact of program activities since the start of the Emergency Plan. During the five years of the Emergency Plan, each focus country will have a number of assessments at strategic intervals; infections averted will be estimated following those assessments.

    Many of you will notice that this is a different approach to the PREVENTION targets from what was discussed for last year. We have worked to refine the approach to estimating infections averted and feel that this approach will produce defensible, acceptable results.

    For further information on the method for estimating prevention targets, contact Tim Fowler at the Bureau of the Census (timothy.b.fowler@census.gov).

7. PMTCT Targets:
    Countries are NOT asked to estimate end of FY06 targets for infections averted.
    However, countries are required to estimate the following two prevention sub-targets:
    i.   Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results.
    ii.   Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting.

8. Care Targets:
    The FY06 CARE target is the sum of the following:
    i.   Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care (excluding those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis) during the reporting period
    ii.   Total Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period
    iii. Number of OVCs served by OVC programs
    The Care sum will be automatically generated by the system as the aggregation of the three care targets.
    The indicator for counseling and testing is not included in the FY06 CARE total.

9. Counseling & Testing Target:
    In Appendix 5 a table has been provided will assist countries in coming up with FY06 counseling and testing targets. This table includes the soft targets for 2008 and the formula for how these targets were calculated. These targets are based on calculations

using each countries 2008 Treatment goal. Additionally, there is a table for calculating FY06 targets using the same formula.
- i.   Number of individuals who received counseling and testing for HIV and received their test results.

10. Treatment Targets:
    The end of FY06 TREATMENT target is the following indicator:
    - i.   Number of individuals receiving antiretroviral therapy at the end of the reporting period.

11. The FY06 COP targets listed here in Table 2 will be evaluated by OGAC based on results reported in the FY06 APR.

USG DIRECT SUPPORT:

Project the number of individuals receiving prevention, care and treatment services through service delivery sites/providers that are directly supported by USG interventions/activities (commodities, drugs, supplies, supervision, training, quality assurance, etc.) at the point of service delivery. An intervention or activity is considered to be a type of "direct support" if it can be associated with counts of uniquely identified individuals receiving prevention, care and/or treatment services at a unique program or service delivery point benefiting from the intervention/activity.

USG INDIRECT SUPPORT:

For indirect results, project the number of individuals receiving prevention, care and treatment services, beyond those counted above under direct USG support, as a result of the USG's contribution to system strengthening or capacity building of the national HIV/AIDS program as a whole.

Examples of this type of indirect support include development of national HIV/AIDS policies; development and implementation of national HIV/AIDS clinical standards and guidelines, as well as associated training protocols and programs; technical assistance for the development and maintenance of national commodity and drug procurement and logistics systems; national laboratory support; technical assistance for strategic information activities such as surveillance and facility-based health management information systems; etc.

It is assumed that some of the individuals who receive services at sites directly supported by the Emergency Plan are the same individuals who receive services as the result of indirect support through national systems strengthening. To avoid double counting, if an individual is being reached directly through a USG supported site and also indirectly through USG support to national systems strengthening, only include the individual in the direct counts. Individuals reached through indirect support should be in addition to those reached via direct support in order to make these categories mutually exclusive.

TOTAL USG SUPPORT:

Total USG Support is the simple sum of direct and indirect support. The data system will automatically calculate the total USG support.

SUPPORT DOCUMENTATION:

It is critical that you work with your core team SI Advisor to develop country-specific USG-supported estimates of targets. Procedures for estimating these targets must be clearly documented and submitted with your COP in the Support Documents section (see page 65).

DATA ENTRY:

	National 2-7-10 ⓘ	USG Direct Target End FY06 ⓘ	USG Indirect Target End FY06 ⓘ	Total USG Target End FY06 ⓘ
Prevention ⓘ	Target 2010: 14,352			
Number of pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting during the reporting period		☐	☐	☐
Number of pregnant women who received PMTCT services during the reporting period		☐	☐	☐
Care ⓘ	Target 2008: 9,000	☐	☐	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period		☐	☐	☐
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care (excluding those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis) during the reporting period		☐	☐	☐
Number of OVC served by an OVC program during the reporting period		☐	☐	☐
Number of individuals who received counseling and testing for HIV and received their test results during the reporting period		☐	☐	☐
Treatment ⓘ	Target 2008: 1,800	☐	☐	☐
Number of individuals with HIV infection receiving antiretroviral therapy at the end of the reporting period (excluding those receiving services at designated PMTCT+ sites)		☐	☐	☐

Update Total

Enter target numbers into the cells for the 2 prevention indicators, the 2 care indicators, the 1 counseling and testing indicator, and the 1 treatment indicator. Enter both direct and indirect targets for each indicator. The data system will automatically sum direct and indirect targets to calculate total targets. Additionally, the data system will automatically sum the components of care to arrive at a total for this section. By hitting the Update Total button at the bottom of the table, the summary information will appear and the data will be saved.

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TABLE 3   USG COUNTRY PLAN

Table 3 is the heart of the Country Operational Plan. Though all sections of this report are important, Table 3 is where the bulk of your time will be spent in the planning process. It is critical that you engage all of the USG Agencies working in country when coordinating your activities in Table 3.

MODIFICATIONS IN THIS SECTION:

1. The timeframe for this section has been changed. It is now a fiscal year timeframe.
2. You can import items from your FY05 COP.
3. There is specific A&A guidance, including information on new partners.
4. There is now an Activity List feature which shows all activities in Table 3.3 linked to a funding mechanism in Table 3.1.
5. Table 3.1 planned funding for a funding mechanism is automatically calculated by the data system.
6. Early requests for funding are collected in Table 3.1.
7. Countries are no longer allowed to enter organizations themselves.
8. Information is requested for the specific program area each sub-partner is working in.
9. Results by program area have been replaced by a narrative program area context.
10. Budgetary requirements are specifically spelled out.
11. Unduplicated summary targets for program areas are required.
12. Activity categories are now called "emphasis areas" and no longer require an exact percentage calculation. There are different emphasis areas for the SI program area than for others.
13. Activity by funding mechanism indirect targets are gathered through a narrative.
14. Target populations have been reworked.
15. One new key legislative issue has been added.
16. Coverage is available at lower levels for those countries that provided administrative districts.
17. The management and staffing program area has its own guidance section.

PLANNING OBJECTIVES AND TIMEFRAME:

Table 3 is, above and beyond all else, a planning and accounting tool. Program areas have been defined to track budgetary requirements and directives required by the legislation and are, therefore, necessary for reporting to Congress, the OMB, and other constituents. Collection of this information through the COPRS data system will minimize the need for follow-up requests and maximize our ability to manage and report on various program elements.

Timeframe:
The time period for Table 3 is now also the Fiscal Year. However, the timeframe for Table 3 in the FY06 COP is the fiscal year that ends September 30th, 2007. For the FY06 COP, there remain two timeframes simply because we are transitioning. Both are the USG fiscal years, FY06 and FY07. For table 2, you are asked to complete both a FY06 and FY07 table for end of year targets. For table 3, the timeframe for the entire table is the period that ends September 30th, 2007.

IMPORTING ITEMS FROM YOUR FY05 COP:

We realize that many funding mechanisms and activities by funding mechanism are the same from one year to the next. Therefore, we have made it possible for you to select items from your FY05 COP to be imported into your FY06 COP. These items will be imported from Tables 3.1, 3.2 and 3.3. There are several changes to the FY06 COP in these tables, for example the revised target populations, and therefore you will be required to update all information that is imported. In addition, you MUST update the imported items based on what will be happening in the current year, particularly with respect to targets. You will receive an error message in the Quality Assurance Report for any items that are not updated after being imported into the FY06 COP.

You are also asked to import activities in table 3.3 that will be continuing in FY06, but for which you do not require new funding (e.g., the activity has enough funding to carry through FY06). This is a change from FY05. This year, you are asked to include all activities operating in FY06 in table 3.3, even those that do not need FY06 funding. These activities that do not require funding will not undergo the review and approval process, but they will be used by the reviewers to get a clear picture of all the work that is being undertaken in your country in this year.

ACQUISITION & ASSISTANCE (A&A) GUIDANCE:

There are several key items that you should consider when planning your FY06 COP. In particular, increasing local and new partners is a principle established in the Emergency Plan's Five Year Strategy. To assist countries in integrating new and local partners in the FY06 COP process, OGAC has created the Community and Faith-Based Organization Integration Work Group (C/FBO). A member of this work group will be assigned to each core team as a resource and point of contact. If you would like to know who the C/FBO point of contact is for your country, please contact your Core Team Leader.

There are several key items that should be considered in formulating your FY06 COP. Please be aware of the following items:

1. Add new organizations to implement all components of the Emergency Plan and ensure that non-local organizations build institutional capacity of indigenous organizations;
2. Assure within all solicitations a level playing field for all potential bidders, including those with limited previous experience working with the USG;
3. Promote the use of indigenous organizations as implementing organizations;
4. Avoid duplication of resources programmed by different USG agencies to the same implementing organization for the same purposes, e.g. two USG agencies funding the same partner to provide the same assistance to orphans or anti-retroviral therapy; and
5. In the assistance arena, to promote the most efficient use of funding, endeavor to limit the amount of funding for any single organization (as prime or sub combined) to less than 10 percent of the total COP budget for that year. Exceptions can be made for: (a) organizations that are acting as grant making and administration arms of the Emergency Plan and are building local sustainable capacity, for government ministries, or (b) organizations that are major purchasers of pharmaceuticals and other commodities.

6. Do not list partners on Table 3 of the COP until they have been formally selected through normal A&A processes, such as Annual Program Statements, Requests for Application, or Requests for Proposals. If a partner has not been formally selected, list the partner as To Be Determined (TBD).

The full A&A Guidance includes additional information on increasing local and new partners as well as additional guidance on new procurements and is included in Appendix 6.

PIPELINE CONSIDERATIONS:

It is important that USG teams in country review pipeline information for their partners prior to requesting additional funding for the partner. It is the responsibility of the USG team to ensure that funding is being spent at a pace that is commensurate with the requirements of the Emergency Plan. Therefore, the USG teams should confirm that partners do not have large pipelines if requesting additional funding.

POTENTIAL PLUS-UP FUNDS:

Appendix 7 (FY06 Budget Allocation by Country) includes a list of the *potential* Plus-Up amount for each country. This additional funding is not to be programmed in the COPRS data system at the present time, since it is uncertain whether this funding will be made available. However, OGAC acknowledges and supports countries' preference to do all fiscal year planning at one time and to have only one COP review by Headquarters. Therefore, OGAC requests that countries provide a support document that defines activities that would be undertaken with these potential Plus-Up Funds; the rationale for the activities; and their prioritization.

A template is provided in Appendix 9 for the support document that is required for these Plus-Up Funds. You will notice in the template, that there are considerably fewer required fields than what would be necessary for data entry into the COPRS. Should the potential Plus-Up Funds become available; countries will be required to provide the remaining information for all approved Plus-Up activities, so as to have a complete set of information for FY06 in the COPRS.

The activities listed in the support document MUST be prioritized with the highest priority activity listed first and the lowest priority activity listed last. There are three sub-tables in Appendix 9 defined according to whether Plus-Up funds are requested for i) an existing funding mechanism and existing program area activity; ii) an existing funding mechanism, but new program area activity; or iii) new funding mechanism and new program area activity. The priority ranking should be for the complete set of activities across all three sub-tables, not for each table alone. Please consult your core team for additional information on the Plus-Up funds and/or filling in the required Appendix 9.

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Table 3.1   FUNDING MECHANISMS & SOURCE TABLE

IMPORTING ITEMS FROM YOUR FY05 COP:

CONTENT:

You are able to import items from your FY05 COP. <u>This import feature will bring in not just the funding mechanisms listed on Table 3.1 but also specific activities linked to that funding mechanism from the different program areas in Table 3.3.</u> You do not have to import everything at one time. The link to import items will remain throughout the COP data entry time period and you will be able to use this link as many times as is necessary. Please be aware that once an activity is imported and updated, the system does not allow you to revert back to the FY05 COP version. In other words, you can only import a given funding mechanism and its associated activities once.

When you do select to import funding mechanisms all of the activities linked to that funding mechanism will also be imported. This includes:
1. The Activities by Funding Mechanism in each Program Area.
2. The Activity Narrative, Emphasis Areas, Targets, Target Populations, and Coverage Areas.

Once you have imported items, you will be able to edit both the funding mechanism information and the activity by funding mechanism information. If you are NOT requesting FY06 funding for an activity by funding mechanism that you have imported, do not change the targets, emphasis areas, etc. If you are requesting FY06 funding for an activity by funding mechanism, you must update the targets, emphasis areas, etc.

When you import items, you will need to ensure that the correct funding source is listed for the funding mechanisms that are imported. If you import a funding mechanism that was funded through a funding source that is no longer available in FY06 (i.e., Deferred, Rapid Expansion), you will need to correctly change that funding mechanism to a funding source that is available in FY06 (i.e., GHAI, GAP).

You are able to re-link specific Activities by Funding Mechanism to a different Funding Mechanism, if that is necessary. For example, if there are specific Activities by Funding Mechanisms listed under a Funding Mechanism that was funded with "Deferred" funding source in FY05, you can import the funding mechanism and relink the activities to a funding mechanism with a different funding source in FY06. Please contact the Help Desk ("Contact Us") if you need assistance with importing or relinking.

DATA ENTRY:

1. In table 3.1, click on the button labeled Carry Over from Previous COP.
2. Put checks into the boxes next to each of the entries that you would like to import. You will notice that some items do not have a check box. These are items that you have already imported into your FY06 COP. Click the Next button at the bottom of the table.
3. You will be asked to verify what you are importing, including the list of all the activities in the program areas that will also be imported. If this is all correct, click Yes. If it is not correct, click Cancel.
4. You will receive a confirmation message that reads "Selected Mechanisms and all related child records from previous fiscal year have been carried over to current fiscal year."
5. Click on the Back button to return to Table 3.1.

FLEXIBLE FUNDING OPTION/UNALLOCATED:

CONTENT:

OGAC recognizes that flexibility is reduced by asking missions to plan early in the fiscal year. Therefore, again we are allowing a flexible funding option in this years COP. You can leave up to 5 percent of your GHAI budget as unallocated. This does NOT 5% of your country's total budget. GAP funding is not included in the 5% calculation. Only GHAI funds can be set aside as unallocated. Please see Appendix 7 for the maximum amount each country can set aside as unallocated.

You will have to specify the amount of unallocated by area: prevention, care, treatment and other. The other category consists of the three budget codes of SI, Policy Analysis/System Strengthening and Management/Staffing. A separate entry is required for each of the areas to which you assign unallocated funds. You are allowed to specify unallocated for any number areas, i.e. if you only want to specify unallocated for treatment and no other area, that is allowed.

DATA ENTRY:

1. Click the Add Mechanism/Source button.
2. In the Mechanism Type drop down box, select Unallocated.
3. Type in the planned Unallocated funding into the cell. You do not need to include the $ sign, comma's, decimal places or cents. Enter a number rounded to the nearest dollar.
4. Select one of the radio buttons – Prevention, Care, Treatment or Other.
5. Click on the Save button.

ACTIVITIES LIST

CONTENT:

You can view a list of all Activities by Funding Mechanisms from Table 3.3 that are linked to a specific Funding Mechanism in Table 3.1. This will allow you to view all Activities linked to a particular Funding Mechanism at once, and you will be able to navigate from this list to the specific Activity by Funding Mechanism entry for editing or review. Simply click on the Activity List link at the far right of each Funding Mechanism link.

DATA ENTRY:

N/A

FUNDING MECHANISM DEFINITION

The COP is designed to be a document that follows funding. Therefore, we are asking you to include information about what we have termed "funding mechanisms". A funding mechanism is defined by a discrete dollar amount passed through a prime partner entity and for which the prime partner is held fiscally accountable. Examples of funding mechanisms are bilateral contracts, bilateral grants, field support (USAID) to a HQ-managed project/entity, PASA, etc. A unique funding mechanism determines the creation of a row entry in Table 3.1.

A unique funding mechanism has four key characteristics that together make up a unique entry:

- funding mechanism type
- USG Agency
- funding source
- prime partner

One or more of these key characteristics should be different for each funding mechanism entry.

In the case of a prime partner, such as Family Health International, or a specific project, such as the Impact Project, which could receive multiple sources of funding in a given country (from more than one USG Agency, more than one funding source within a USG Agency, or more than one funding mechanism type), it will have to be entered more than once in Table 3.1. Each entry corresponds to a unique combination of the four key characteristics and therefore, each entry will have a unique identifier.

You should not have multiple entries for a funding mechanism where the four key characteristics listed above are the same. Fore example, do NOT enter separate funding mechanism entries for each program area that a unique funding mechanism might be working in.

There are, of course, exceptions to every rule, and there is an exception here. You might have a prime partner working in your country under two different HQ mechanisms. For example, Family Health International is the prime partner on both the IMPACT Project and the YouthNet Project. In this case, it is two separate contracts (and therefore two different funding mechanisms) and would be distinguished by the funding mechanism name cell. However, this would happen very infrequently.

Examples (see below for definitions of each of these 4 terms):

Funding Mechanism Type	USG Agency	Funding Source	Prime Partner
HQ	USAID	GHAI	John Snow, Inc.
Local	USAID	GHAI	John Snow, Inc.
HQ	HHS/CDC	GAP	John Snow, Inc.
Central	HHS/CDC	N/A	American Red Cross
Local	Department of State	GHAI	U.S. Department of State

*Note: It is possible for a given USG Agency to also be considered a prime partner. Please see page 39 for further details about this.

FUNDING MECHANISM TYPE:

CONTENT:

Funding Mechanism Type is an extremely important designation. It is critical that headquarters knows what funding is planned for HQ funding mechanisms to ensure the ceiling capacity. To assist you in completing this section accurately, please use the list of HQ mechanisms found in Appendix 10. **Review of this Appendix before entering data in Table 3.1 is crucial!**

There are four options for the funding mechanism type:

1. <u>CENTRAL</u>: Headquarters-procured and centrally-funded (**Central**) - Central activities are currently limited to **ONLY** Track 1 activities <u>funded with HQ funds</u>.
2. <u>HQ:</u> Headquarters-procured and country-funded (**HQ**) - HQ mechanisms include, field support (USAID), MAARDS (USAID), buy-ins to headquarters managed activities, task orders to headquarters managed activities, PASA activities and <u>country funding going into Track One awards</u>. Please see [Appendix 10](#) for a list of HQ mechanisms by Agency. For <u>DoD</u>, this would include:
   a. Military International HIV/AIDS Training Program
   b. Technical assistance including TAD
   c. Similar activities where the funds do not flow through the country.
3. <u>LOCAL</u>: Locally-procured and country-funded (**Local**) - Local mechanisms include, bilateral agreements (either contracts, cooperative agreements or grants), MOUs with the host country government, Associate Awards (USAID) and in-country RFA/RFP/RFC that is not yet awarded.
   For <u>CDC</u>, all funds allotted to post via cable are considered local.
   For <u>DoD</u>, this would include:
   a. NGOs such as PSI, PCI, Kansani
   b. Universities such as Drew, UMd
   c. MIPRS to embassies for locally procured items, regional training, etc
4. <u>UNALLOCATED</u>: Unallocated type is only for the funding that you are reserving for the flexible funding option. Please see the information above under Flexible Funding Option/Unallocated for instructions on how to enter unallocated funds. Only the GHAI account may be tagged for unallocated funding. You will be required in the future to amend this information when decisions are made as to how the funding will be allocated.

Strategic Objective Agreements: Money obligated into a SOAG cannot be considered a funding mechanism until it is sub-obligated to another level with identified partners, activities and planned results.

DATA ENTRY:

This field is a drop down menu that will have the above four options. You must select only one option.

FUNDING MECHANISM NAME:

CONTENT:

If the funding mechanism has a name, that is to say, if there is a project name associated with the funding mechanism you should use it here.

The funding mechanism name cell should be used to assist in clarification of the funding mechanism. You no longer need to use the funding mechanism name cell to make a distinction in Table 3.3 between GHAI/Base mechanisms or USAID/HHS mechanisms as the data system will now show more fields in the drop down menu for activities by funding mechanism.

If this is a <u>HQ funding mechanism</u>, you must use the name of the HQ projects in the funding mechanism name cell. For example, if you are using the IMPACT Project or UTAP,

you should use these names in the funding mechanism name field. Please see Appendix 10 for a listing of HQ mechanisms by Agency, with both the project name and the prime partner name.

Please do not confuse funding mechanism name with prime partner name (see definition below). After the prime partner definition are several examples of the difference between funding mechanism type, funding mechanism name and prime partner name.

For CDC only – If you are doing a new award, please specify in the funding mechanism name field whether the award will be a contract, cooperative agreement or grant.

DATA ENTRY:

Please type directly into the Funding Mechanism Name cell. The character limit for this field is 1,000 characters.

USG AGENCY:

CONTENT:

Drop-down list. Select the USG Agency responsible for managing the funding mechanism. The USG Agency that is selected will be the one that receives the funding from OGAC. Categories are: USAID, HHS/CDC, HHS/HRSA, HHS/NIH*, HHS/OS, HHS/SAMHSA, DoD, State, Peace Corps, DoL.

*The only NIH activities that you should include in your COP are non-research activities. For example, if you are providing country funding to add a service component, such as care or treatment to an NIH study, only the country funding for the additional service component would be put into the COP. The NIH study would NOT be included.

Peace Corps – Funding going to the Peace Corps should be identified with Peace Corps as the USG Agency receiving the funding. Peace Corps should never appear as another USG Agency's prime partner.

Department of Labor – Funding going to the Department of Labor should be identified with Department of Labor as the USG Agency receiving the funding. Department of Labor should never appear as another USG Agency's prime partner.

DATA ENTRY:

Country: Ethiopia   FY: 2006

Table 3.1: Country Plan - Funding Mechanisms and Source ⓘ

Mechanism Type:	Locally procured, country funded (Local) ▾ ⓘ
Funding Mechanism Name:	ⓘ
Planned Funding ($):	$31,400.00 ⓘ
Agency:	Department of State ▾ ⓘ
Funding Source:	Department of State ⓘ
	US Agency for International Development
Prime Partner:	Department of Health & Human Services Select Partner ⓘ
	Department of Defense
	Department of Labor
New Partner:	Peace Corps ⓘ
	National Institutes of Health
	Bureau of the Census
Early Funding Request:	Centers for Disease Control & Prevention
	Health Resources & Services Administration
	Office of the Secretary ▾

Save   Cancel

Please select the USG Agency from the drop down menu.

FUNDING SOURCE:

CONTENT:

Drop-down list that is linked to the USG Agency identified.

The funding source choices for each agency are:

USG Agency	FOCUS COUNTRIES Funding Source Categories	5 NEW COUNTRIES Funding Source Categories
USAID	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account) CSH account *(All countries)* FSA account *(Russia only)* ESF account *(India and Cambodia only)*
HHS/CDC	Base (GAP account) GAC (GHAI account) N/A *(Track 1 only)*	Base (GAP account) GAC (GHAI account)
HHS/HRSA	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account)
HHS/OS	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account)
DoD	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account)
State	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account)
Peace Corps	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account)
DoL	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account)
ALL OTHERS	GAC (GHAI account) N/A *(Track 1 only)*	GAC (GHAI account)

"Base" (GAP account) **–** This category is still applicable. The list, by country, of "Base" levels can be found in Appendix 7. USAID will NOT have "Base" funding for the focus countries.

5 New Countries – USAID and CDC are the only agencies whose HIV funding outside of the GHAI account should be included in the COP. Please do not include DoD, Peace Corps or other HIV funds that are not listed in the table above.

Note – Please ensure that you are coordinating as a USG team in determining funding decisions and that "Base" funding is not being programmed independently of the USG team.

➔ **Central/Track 1 Mechanisms Funded by HQ Budgets**: When the funding mechanism is Central (Track 1 funded out of HQ budgets), the funding source category is "N/A". N/A is only to be used for track 1 activities and ALL track 1 activities should have N/A selected as the funding source. Country funding that is going into a Track One mechanism should be entered as a unique Funding Mechanism and labeled with the HQ funding mechanism type.

DATA ENTRY:

This is a drop down menu. The funding source is linked to the USG Agency, so you must select a USG Agency in order for your funding source selections to appear. Select one choice from the drop down menu.

FY06 PLANNED FUNDING ($):

CONTENT:

This field will automatically be generated by the data system. As you enter planned funding for activities by funding mechanism in table 3.3, the data system will calculate the total amount for that funding mechanism and display it here.

➔**Central Mechanisms FY06 Planned Funding**: In Table 3.3, all Central (Track 1 funded with HQ funding) FY06 Planned Funding should always be entered as "$0".

DATA ENTRY:

N/A

EARLY FUNDING REQUESTED:

CONTENT:

This check box is to allow for requests for funding needed in the first 6 months of the fiscal year. This should be used only in exceptional cases. You should not be requesting (because you will not receive) all of your funding as an early request. If you have a funding mechanism which will be in desperate need of funding prior to March 31, 2006, please check the box for early funding. You can request only part of the total funding for a Funding Mechanisms as early funding. Please provide the specific amount requested for early funding in the space provided.

If you are asking for early funding, you will need to provide information on what specific activities will need early funding. For each funding mechanism that you check, provide a few sentences, which discuss why early funding is needed.

Please take into account two items as you decide on early funding requests:
1. Early funding might need to be requested under a Continuing Resolution and therefore early funding should only be requested for ongoing activities.
2. If drug purchases need to be undertaken early in the year, the funding for these purchases must be included in the early funding request.

DATA ENTRY:

Table 3.1: Country Plan - Funding Mechanisms and Source ⓘ

Mechanism Type:	Headquarters procured, country funded (HQ) ▾ ⓘ
Funding Mechanism Name:	HIV/AIDS Project ⓘ
Planned Funding ($):	$190,000.00 ⓘ
Agency:	USAID ▾ ⓘ
Funding Source:	GAC (GHAI account) ▾ ⓘ
Prime Partner:	Partnership for a Better World [Select Partner] ⓘ
New Partner:	○ Yes ● No ⓘ
Early Funding Request:	☑
Early Funding Request Amount:	25000

Early Funding Request Narrative:
(Up to 2000 characters)
This early funding request will go toward an ongoing activity in the counseling and testing program area. The activity is working on providing counseling and testing services for high risk groups. The early funding will be used to buy test kits for ongoing counseling and testing activities at 3 sites.

Early Funding Associated Activities:

	Program Area	Activity Narrative	Planned Funds
☐	Other Prevention	This is a test. This partner will be working on preventing HIV among high risk groups. Blah blah b	$125,000.00
☐	Counseling and Testing	This is a test. This activity is in collaboration with activity number 05.02 - other prevention. T	$65,000.00

[Save] [Cancel]

For Funding Mechanisms that require early funding, select the check box next to Early Funding Request. This will regenerate the page with additional information needed.

Enter the amount you are requesting for early funding into the box marked Early Funding Request Amount. You do not need to enter a $ sign, comma's, decimal points, or cents. Please round to the nearest dollar.

Enter a brief narrative in the Early Funding Request Narrative box. This narrative should not be more than 2,000 characters (approximately ½ page).

You will also see a list of Activities from Table 3.3 linked to that Funding Mechanism (if any have been entered yet) next to the Early Funding Associated Activities. Please check the box next to any Activities that the early funding will be used for.

PRIME PARTNER:

CONTENT:

A prime partner is defined as the entity an entity which receives funding directly from, and has a direct contractual relationship (contract, cooperative agreement, grant, etc.) with, the USG Agency. This is where the name of the implementing partner should be entered. The data system includes all partner/organizations that were entered in the FY04 and FY05 COPs. The total currently includes over 1,500 organizations. Please search thoroughly before you decide that the entity that you are looking for is not there.

If the partner/organization that you are looking for is not in the data system, you are asked to send an email to Sarah Gorrell (gorrellse@state.gov). You must provide the following information in the email:
1. the full name of the organization (spelled out, without acronyms or abbreviations)
2. the type of organization it is (see below for Prime Partner Type list)
3. the status of the organization as a local entity or not (see below for definition of local organization)

You may provide this information in an Excel spreadsheet (a template spreadsheet is being sent out to all countries that includes the required information). If you provide the information to us in a spreadsheet, we will then upload the data into COPRS. For ALL organizations that need to be added to the COPRS, **we MUST receive your request and list of organizations by August 26th**. This will allow time for verification and entry in time for the data to be available in the data system by September 9th. Any requests for additional organizations that are received after August 26th are not guaranteed to be entered into the system in time for you to complete data entry in country. There is a full list of the organizations already in the data system in the *Operational Plan - Reports* section entitled "Printable COP Annex 2: Partner Names". Please use this early on to determine if all of the organizations that you need for your COP data entry are in the data system.

5 New Countries – The due date for organizations to be included in the COPRS is October 31st. However, the earlier that you provide us with the list of your organizations, the earlier we can have the information in the data system for you.

There can be only one prime partner per funding mechanism. In the case of funding mechanisms that are awarded to a consortium, the lead partner is the prime, and all other partners in the consortium should be identified as sub-partners (see Table 3.2 below). With the exception of the prime partner, you will only need to enter those members of the consortium which are active in your country. For example, if MEASURE/Evaluation is working in your country, the University of North Carolina is the prime partner. If JSI is the only MEASURE/Evaluation sub-partner that is working in your country, JSI needs to be included in the sub-partner table and the University of North Carolina needs to be included as the prime partner.

In the case of an identified funding mechanism (i.e. RFA or RFP) for which the prime partner has not yet been identified, select To Be Determined as the prime partner.

There will be times when you will include one of the USG Agencies as the prime partner for a funding mechanism. This is expected for such items as management and staffing costs,

technical assistance requests from the HQ Agency or technical staffing costs which would fall into one of the program areas. However, for those occasions where a USG Agency is the prime partner, you should **NOT** have sub-partners under that funding mechanism. If there is a sub-partner under a USG Agency this is the same as having a prime partner and therefore should be entered as a separate funding mechanism. For HHS/CDC there is additional guidance on when CDC would be the prime partner and when another organization should be the prime partner in the Helpful Hints in Appendix 11.

Examples of Prime Partners and Funding Mechanism Names:

Mechanism Type	Funding Mechanism Name	Prime Partner Name
Central	Together We Can	American Red Cross
HQ	Twinning	American International Health Alliance
HQ	MEASURE/DHS	Macro International
HQ	Lab Supplies	Crown Agents
HQ	IMPACT	Family Health International
HQ	UTAP	Columbia University
HQ	Child Survival Fellows	Johns Hopkins University
Local	PSC	U.S. Agency for International Development
Local	Network RFP	To Be Determined

DATA ENTRY:

Select box. Please click on the button that says Select Partner. A search box will open which allows you to enter the name of the partner (or any part of the name). You will receive a selection of possible partner names depending upon what you typed into the search box. Once a prime partner is chosen, a separate box will pop-up asking for confirmation of the Prime Partner Type (see definitions below); if the partner is local or not (see definition below); and if the partner is new or not (see definition below). If the partner is not found on the drop down list or if you think that any of the confirmation information is incorrect, you need to email Sarah Gorrell (gorrellse@state.gov) with all of the necessary information (see above).

PRIME PARTNER TYPE:

CONTENT:

This information will be provided by the data system if the chosen prime partner already exists in COPRS. If the prime partner needs to be added to the data system, please send an email to Sarah Gorrell (gorrellse@state.gov) with all of the necessary information (see above under Prime Partner Name). Each prime partner can only be ONE type. If it is an FBO and is also any other type of organization, please select FBO.

1. FBO (Faith Based Organization). Please ensure that the organization is actually an FBO rather than relaying on the name sounding like an FBO (i.e., St. Catherine's Hospital might not be an FBO).
2. NGO (Non-governmental organization other than FBO). This includes organizations created as a private sector company's foundation, e.g. Coca Cola Foundation.
3. Host Country Government Agency
4. Private Contractor. This includes private sector companies such as Deloitte-Touche or John Snow, Inc.

5. University. Note that a university affiliate such as Johns Hopkins JHPIEGO would be listed under NGO, but Columbia University School of Public Health (implementing PMTCT programs) is listed under University.
6. Multi-lateral Agency. This would include organizations such as the World Health Organization or UNAIDS. Also included here are third government organizations, such as DfID, GTZ or JICA.
7. Other USG Agency
8. Own Agency (e.g. for admin and management costs, staff costs, etc. financed with Agency Base or GAC GHAI funds). It is anticipated that many, though not all, of the "Own Agency" activities will fall under the Management and Staffing Program Area (Table 3.3.15).
9. Parastatal. This is a state-owned enterprise which operates using a combination of public and private funds and is sometimes headed by government appointed individual.

Please remember that the choice of type of partner is determined by the entity itself and not by the funding that it might receive. If an entity receives funding from both the host country government this does not necessarily dictate the organization is a host country government agency. It could be a FBO, but it receives funding from different sources. Please make sure that you are identifying the type of organization and NOT the source of funding the organization receives.

DATA ENTRY:

No data entry necessary.

LOCAL (INDIGENOUS) ORGANIZATION:

CONTENT:

Definition: An entity whose primary place of business is in a country or region served under the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals.

This information will be provided by the data system if the chosen prime partner already exists in COPRS. If the prime partner needs to be added to the data system, please email Sarah Gorrell (gorrellse@state.gov) with all necessary information (see above under Prime Partner Name).

DATA ENTRY:

No data entry necessary.

NEW PARTNER:

CONTENT:

Definition: A partner working for the USG for the first time in health projects in the country. A new partner is an organization that has not worked with the USG as a prime partner or sub-partner on a health projects in that country in the past 5 years.

Please be aware that new partners are for the USG in your country as a whole, not for each individual USG Agency. If USAID is already working in health with a partner who will be working with CDC for the first time in FY06, that partner is NOT new. It is important for the USG team to ensure that they are appropriately applying the "new" status.

Additionally, a department within a university is only a new organization if the funding is going directly to that department and is not going through the university. If you are working with additional departments in a university that you have worked with in previous years and the funding goes directly to the university that is NOT a new organization.

EXAMPLES:
- If a contractor has been working on training in family planning but not HIV, it is NOT new.
- If a contractor has been working in food monetization with a health component, it is NOT new.
- If a contractor has been working on micro-finance and is now working in HIV, it is NEW.
- If a contractor had an agreement in the recent past in the health sector (i.e. within the last 5 years), did not have an agreement in FY05, but does have an agreement in FY06, it is NOT a new partner.
- If a contractor has been working with USAID in health programs but is now being funded to work with HHS/CDC as well, it is NOT new.
- If one USG Agency (e.g., USAID) is already working with a partner in HIV/AIDS programs, and another USG Agency (e.g., CDC) will begin working with the same partner for the first time that is NOT a new partner.

DATA ENTRY:

This is a Yes/No check box. If the partner is new, based on the criteria specified above, select "Yes". If the partner is not new, based on the criteria specified above, select "No".

Table 3.2   SUB-PARTNER TABLE

The top of the window will have a summary of the information for that funding mechanism, including: funding mechanism name (combination of funding mechanism type and funding mechanism name), planned funding amount and prime partner.

You are only asked to enter information for those sub-partners for which **EITHER** the sub-partner organization or amount of funding is known. If you know NEITHER the name of the sub-partner NOR the amount that the sub-partner will receive (even though there are plans to have subs under the mechanism), there is nothing to be entered into the COP. Please follow the below guidance in determining if a sub-partner needs to be entered into the data system:

Sub-partner Name	Planned Amount	Action
Known	Known	Included
Known	Unknown	Included
Unknown	Known	Included
Unknown	Unknown	Not Included

Sub-Partner or Sub-Sub-Partner: Please enter all sub-partners here, regardless of whether the sub-partner has a direct relationship with the prime partner or with another sub-partner. The COP does not distinguish between sub-partners and sub-sub-partners. All sub-partners are linked with the prime partner.

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 Ministry of Health in your country, you would not list any district level health ministry as a sub-partner if the funding flows through the national MOH. You should only list the district level health ministries as sub-partners if they are receiving funds directly without going first through a national level headquarters.

Sub-Partners where USG Agency is the Prime Partner: For those occasions where a USG Agency is the prime partner, you should NOT have sub-partners under that funding mechanism. If there is a sub-partner under a USG Agency that is really the same as having a prime partner, then this should be entered as a separate funding mechanism.

Individuals are not to be considered Organizations: Please do not include consultants as organizations in your sub-partner list. Individual consultants should not be entered into the COPRS data system. Only organizations should be entered.

Sub-partners are all linked to an individual prime partner. In order to begin entering sub-partners, click the link that says Add/Edit Sub-Partner.

SUB-PARTNER NAME:

CONTENT:

A sub partner is defined as the entity to which a prime partner allocates funding. The data system includes all partner/organizations that were entered in the FY04 and FY05 COPs. The total currently includes over 1,500 organizations. Please search thoroughly before you decide that the entity that you are looking for is not there. If the sub-partner needs to be added to the data system, please email Sarah Gorrell (gorrellse@state.gov) with all necessary information (see above under Prime Partner Name).

As mentioned before, **we MUST receive your request and list of organizations by August 26th for the focus countries or October 31st for the 5 new countries.**

DATA ENTRY:

Select box. Please click on the button that says Select Partner. A search box will open which allows you to enter the name of the partner (or any part of the name). You will receive a selection of possible partner names depending upon what you typed into the search box. Once a partner is chosen, a separate box will pop-up asking for confirmation of the Partner Type (see definitions above); if the partner is local or not (see definition above); and if the partner is new or not (see definition above). If the partner is not found on the drop down list or if you think that any of the confirmation information is incorrect, please email Sarah Gorrell (gorrellse@state.gov) with all necessary information (see above under Prime Partner Name).

FY06 PLANNED FUNDING ($):

CONTENT:

Enter the amount of FY06 planned funding requested for the sub-partner. Note that the data system will add up all planned funding to sub-partners for a given "funding

mechanism/prime partner". The total across all sub-partners for the unique funding mechanism cannot be greater than the total planned FY06 funding for that same funding mechanism as listed in Table 3.1.

DATA ENTRY:

Enter the planned FY06 funding directly into the field. If the amount of FY06 planned funding has not yet been determined for an identified sub-partner, check the box that says "funding is To Be Determined".

SUB-PARTNER PROGRAM AREAS:

CONTENT:

For each sub-partner, you are asked to let us know which program areas the sub-partner will be working in. You do not need to link sub-partners to specific activities in table 3.3. We only ask that you check the box next to each program area where that particular sub-partner will be working (see Appendix 12 for a list of program areas).

DATA ENTRY:

Please check the box next to each program area where the sub-partner will be working.

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Table 3.3   PROGRAM PLANNING TABLE

Table 3.3 is divided into 15 different program areas or sub-tables, the same program areas as in the FY05 COP. These program areas correspond to budget codes, which are necessary for tracking program funds in response to legislative requirements and Congressional inquiries. The exact definition of what is included in each program area/budget code is found in Appendix 12. The following is a list of each of the program areas:

- PMTCT
- Abstinence and Be Faithfulness
- Blood Safety
- Injection Safety
- Other Prevention
- Palliative Care: Basic Health Care and Support
- Palliative Care: TB/HIV
- Orphans and Vulnerable Children

- Counseling and Testing
- HIV Treatment: ARV Drugs
- HIV Treatment: ARV Services
- Laboratory Infrastructure
- Strategic Information
- Other/Policy Analysis and System Strengthening
- Management and Staffing

Note: Because Table 3.3.15 **Management and Staffing**, differs from the other 14 program areas, instructions for filling out this table are given separately following the instructions for Tables 3.3.1 – 3.3.14.

Program Area Summary Sub-Tables 3.3.1 – 3.3.14

The descriptions for this section do not need to be extensive but should give an appropriate level of detail in order to evaluate whether the entirety of the activities listed for each program area are the right ones to be addressing the needs of the country.

The following information needs to be filled in for each of the 14 program areas.

PROGRAM AREA CONTEXT:

CONTENT:

For each of the 14 program areas (excluding Management & Staffing, which has its own instructions), please provide an overview. This overview should include several items:

15 Focus Countries:
1. Please give a picture of the state of affairs for that program area in your country showing a broader picture of the USG vision in that program area than what a listing of separate activities can provide. Be sure to link the COP with the vision expressed in the 5-year Strategy and accomplishments and program directions established in FY04 and FY05 and, if possible, include linkages with other donors, as well as activities that leverage with the Global Fund.
2. Discuss progress made and barriers encountered since the FY05 COP.
3. Discuss the work of other donors and the host country government in the specific program area.

5 New Countries
1. Please give a picture of the state of affairs for that program area in your country.

2. Discuss the USG activities going on in that program area.
3. Discuss the work of other donors and the host country government in the specific program area. Please make sure to discuss how the USG program is working with the other donors, and in particular how you are working with the Global Fund.
4. Please include information on what activities are going on with sources of HIV/AIDS funding not included in the COP, i.e., DoD and Peace Corps.

This narrative should not be more than 4,000 characters (approximately 1 page).

Pediatric AIDS: In the Program Area Context narrative (above) in the ARV Services program area, please include the estimated number of children 0-14 years of age that you will provide with ARV treatment. Please see page 59 and Appendix 5 for additional information on Pediatric AIDS.

For examples of narrative for the text boxes, see Appendix 25.3.

DATA ENTRY:

This is a narrative that should be entered into text boxes. There is a 4,000 character limit (approximately 1 page) for each of the narratives. You may either type directly into the box on the screen, or you may cut and paste into the box from another program. We would encourage you to write the narrative in Word or another program that allows for spell checking and then cut and paste the text into the text box in the data system (for additional information on this see the Helpful Hints in Appendix 11).

FY06 PLANNED FUNDING FOR PROGRAM AREA:

CONTENT:

The data system will automatically generate for you the Total FY06 Planned Funding for the program area as the sum of all FY06 planned funding for the funding mechanisms activities listed in the program areas of Table 3.3. You will not be able to put any information into this cell.

Budgetary Requirements: There are several budgetary requirements in terms of your program area funding of which you should be aware.

5 New Countries: Of the budgetary requirements that follow, the AB requirement is the only one which applies to the 5 new countries.

1. Table 3.3.2 Abstinence and Being Faithful:
   In 2006, each country should strive to dedicate at least 50 percent of total prevention funds to sexual transmission[2], and within sexual transmission funds, to dedicate at least 66 percent to AB. If a country does not meet these expectations, a justification is required (e.g., in Vietnam the primary mode of transmission is through injecting-drug use (IDU), and therefore, it is appropriate to dedicate more

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[2] "Total prevention" funds are those budgets defined in Appendix 12 by program areas 1 through 5 (PMTCT, AB, Blood Safety, Injection Safety, and Other Prevention). "Sexual transmission" funds are those budgets defined in Appendix 12 by program areas 2 and 5 (AB and Other Prevention).

than 50 percent of funds for prevention within the IDU context rather than at least 50 percent to prevent sexual transmission). However, failure to meet the 50 percent requirement for sexual transmission within all prevention programs would not justify failure to reach the 66 percent requirement within sexual transmission prevention funds for AB activities. Some countries might have difficulty reaching the 66% requirement. In such a case, a programmatic justification is required. (E.g. 80% of the epidemic is among prostitutes, therefore a higher proportion of sexual transmission funds are directed to correct and consistent condom use among populations engaged in high-risk behaviors within the context of the ABC approach). Please note, that in a generalized epidemic a very strong justification is required to not meet the 66 percent AB requirement.

Please inform your core team leader as soon as possible with the justification if you think these budget requirements will present a problem. We expect that all focus countries, and in particular those with budgets that exceed $75,000,000, will meet these requirements.

2. Table 3.3.7 Palliative Care: TB/HIV: Globally TB is the leading killer among individuals that are living with HIV/AIDS. Addressing TB among people living with HIV/AIDS is a high priority of the Emergency Plan, and thus, FY06 COPS should attempt to increase programming in this area. The goal of each country should be:
   a. To provide HIV counseling and testing of all TB patients
   b. To screen all HIV-infected persons (including those identified in VCT, PMTCT settings) for active TB
   c. To increase networking and in particular cross-referral of clients between the TB and HIV/AIDS programs. Cross-referral is needed to ensure that people with TB are placed and continued on ART and patients on ART receive appropriate TB diagnosis and management.

The COP must include resources and programs to address these goals. The COPs will be reviewed based on the amount of funding that is going to TB/HIV programs in FY06 in comparison with what was planned for FY05 (with the expectation of an increase). Please consider using available TB/HIV technical support when planning in this important area.

It is understood that there is significant overlap between the TB/HIV program area and the Counseling & Testing program area (see Appendix 5). The structure of the COP does not easily allow for these overlaps. For countries that are doing significant counseling and testing in the TB/HIV program area, please consider adding a country-specific/custom indicator (see page 56) to capture this counseling and testing in the TB/HIV program area (e.g., number of individuals who received counseling and testing). Countries will need to seek a balance for attributing activities between TB/HIV and counseling and testing.

3. Table 3.3.8 Orphans and Vulnerable Children: 10% of your funding must go to the OVC program area. In calculating this 10%, you should use the sum of funding for your prevention, care and treatment program areas (i.e., Tables 3.3.1-3.3.12) as the denominator (i.e., you should not include funding going towards Strategic Information, Other/Policy Analysis and System Strengthening and Management and Staffing).

While OVC programs are a priority, we acknowledge children infected by AIDS are also vulnerable and thus, funding for pediatric treatment can be counted toward

the 10% budgetary requirement. The Emergency Plan strongly encourages countries to prioritize OVC programming and maintain a balance with pediatric treatment programs.

If countries are implementing pediatric AIDS program in an OVC context, you may program non-treatment interventions under the OVC program area. However, the specific activities related to pediatric AIDS should continue to be included in the HIV Treatment program areas. The calculation of adding pediatric AIDS funding into the OVC funding will have to be done manually. Should you decide to include funding for pediatric AIDS in calculating your 10% OVC budgetary requirement, that funding CANNOT also be included in your treatment funding. Funding can only be counted in one program area (either OVCs or Treatment).

This is a budgetary requirement, meaning that each country must achieve it. However, if a country is unable to meet this requirement, justification must be provided.

4. Table 3.3.11 HIV/AIDS Treatment/ARV Services: To meet the Congressional recommendation that the Emergency Plan allocate 55 percent of its resources to antiretroviral (ARV) treatment in FY06, all countries will need to incorporate the 55 percent goal as a budgetary requirement. However, since it might not make programmatic sense to meet this requirement in some countries, other countries will have to exceed a 55 percent budgetary requirement to meet the overall objective for the Emergency Plan. It is particularly important that countries that receive over $75,000,000 meet or exceed this requirement.

Please ensure that you are answering both questions listed below related to HIV/AIDS treatment (one regarding drug procurement and one regarding pediatric AIDS).

5. Table 3.3.13 Strategic Information: It is reasonable to expect that approximately 7% of your total budget will go towards the Strategic Information program area. This is not a budgetary requirement, but is rather a guideline.

6. Individual countries are not required to meet the 25% care and 20% prevention budgetary requirements in this year's COP. However, countries should continue to move in this direction, as has been done over the past 2 years.

7. Please see information listed under Table 4, page 62, with regards to ensuring that your calculations of budgetary requirements are accurate.

DATA ENTRY:

As noted above, you will not enter summary Program Area Funding data into the COPRS. However, you will be required to provide the following additional information for:

1. **Table 3.3.10 HIV Treatment: ARV Drugs: Percent of Total Funding Planned for Drug Procurement** – Provide the dollar amount that is planned for ARV drug procurement only (including ARVs for PMTCT+), exclusive of logistics costs.

2. **Table 3.3.10 HIV Treatment: ARV Drugs and Table 3.3.11 HIV Treatment: ARV Services – Amount of Funding Planned for Pediatric AIDS**: Provide the dollar amount that is planned for HIV Treatment targeted to Pediatric AIDS.

Please enter the number directly into the cell. You may round to the nearest $100, or you may enter the exact number (including decimal points for cents, if necessary). You do not need to enter the $ symbol.

DIRECT TARGETS BY PROGRAM AREA:

Targets' Timeframe:
The targets in this section relate to the time period that ends September 30th, 2007.

DIRECT SUMMARY TARGETS BY PROGRAM AREA:

CONTENT:

NEW: The specification of summary targets by program area is a new feature of the FY06 COP. We are not asking you to report on any new indicators. The indicators that will be listed here are those that are shown in Appendix 13, the Emergency Plan required indicators/targets by program area.

These summary targets for the program area are a new feature of the FY06 COP. They are intended to show what will be accomplished by the entire set of USG funded activities in that program area. This new feature acknowledges that it is not possible to simply sum the targets for a given indicator across individual activities listed within one program area, since many individual activities may be supporting the same sites or training the same individuals or serving the same clients. Therefore, we are requesting that each USG team provide these summary targets for each program area. Were the system to simply sum across these individual activities within a program area, there would be considerable double counting.

Please ensure that the targets you are articulating here are for your NEW FY06 funding. That is to say, the targets that you list in this section should be an articulation of what you plan to accomplish with your requested FY06 funding. You should only include here targets for ongoing activities for which you are NOT requesting FY06 funding if they will SIGNIFICANTLY contribute to what you will accomplish during this time period, e.g., if the start of the activity was delayed. This would only occur on rare occasions.

For this reason, we are asking that you provide unduplicated direct summary targets for each required indicator at the summary program area level. Please be aware that there is no provision for adding individual country indicators and their corresponding targets at the summary program area level.

DATA ENTRY:
Please fill in the target number for that specific indicator in the space provided next to the indicator.

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Activities by Funding Mechanism Sub-Tables 3.3.1 – 3.3.14

Please complete one table for each Funding Mechanism/Prime Partner that will be undertaking activities in Fy06 for the given program area. The COP Partner Reporting Form illustrates only one "Activity by Funding Mechanism table" per program area, but you will enter as many "Activities by Funding Mechanism tables" per program area as needed.

It is anticipated that each unique funding mechanism outlined in table 3.1 would have only one entry in each program area. If, however, a specific funding mechanism/prime partner is undertaking several activities in a given program area and you feel very strongly that these activities are distinct and would suffer by being lumped together into one narrative, then you may put them into separate entries.

Ongoing activities for which no additional FY06 funds are requested: Please describe activities that will continue from FY05 to FY06 in the Activity Narrative, and designate the planned funding amount as $0. **Do not update targets**, as there is no new funding to link the targets. These activities will not be reviewed for approval during the COP review process.

5 New Countries: The 5 new countries do not need to complete this entire section. They are only asked the first two items listed below – funding mechanism and planned funds. The remaining items (activity narrative, emphasis areas, activity targets, key legislative issues, target populations and coverage area) should be left blank.

Pediatric AIDS: To assist you with scale-up and to document Emergency Plan efforts to reach children, we request that for the FY06 COP you estimate the number of children that you will provide ARV treatment to as part of your **direct** target of people on treatment. Children are defined as individuals from birth through 14 years of age. In the Program Area Context narrative (above) in the ARV Services program area, please include the estimated number of children 0-14 years of age that you will provide with ARV treatment.
> We also encourage you to indicate those activities that are specifically focused on pediatric AIDS. You can do this by checking the target population "HIV positive Infants (0-5 years)" or "HIV positive Children (6-14 years)". This target population should be used for all activities related to pediatric AIDS, including those which are aimed at identifying new cases (i.e., activities with an explicit case finding component for infants).
> If you need assistance in planning such activities, there is a PMTCT/Pediatric AIDS working group who can assist you. Contact your Core Team Leader for such assistance.

FUNDING MECHANISM:

CONTENT:

This is a drop down list of all the funding mechanisms that were entered in table 3.1. The drop down list is organized alphabetically by USG Agency, then by prime partner, then by funding mechanism name, then by funding source. Please choose all the funding mechanisms for which the activity is ongoing whether requesting new funds or not. Also choose the new funding mechanisms, from table 3.1, that will have activities in the given program area. You are not asked to provide information by sub-partner in this table, only by prime partner.

DATA ENTRY:

This field is a drop down menu with all of the funding mechanisms that were entered in table 3.1. You must select only one option.

PLANNED FUNDS:

CONTENT:

Enter the amount of FY06 funding planned for this activity, to the nearest dollar. Please do not round your numbers. The summary budget table (Table 4) is automatically generated from this information, so rounding to anything above the nearest dollar would result in an inaccurate summary budget table.

For ongoing activities that do NOT require new FY06 funding, please enter $0 for the planned funding.

DATA ENTRY:

Please enter the FY06 planned funding directly into the cell.

5 New Countries: Please skip to page 60 where it says "Instructions for Completing Table 3.3.15 Management & Staffing Program Area".

ACTIVITY NARRATIVE:

CONTENT:

The activity narrative is of particular importance as COP reviewers depend heavily on the description in this narrative. Please give enough detail for reviewers to understand what the funding mechanism activity entails, and what will be accomplished by this funding mechanism activity in the program area.

The specific items that should be mentioned in each narrative include:
1. Emphasis areas of the activity (see description below);
2. Key legislative issues the activity will address (see description below);
3. Populations the activity is targeting (see description below);
4. How you will reach the specific planned targets;
5. How this activity will help you reach the vision outlined in the Program Area Context and address the opportunities and challenges outlined in your 5-Year Strategy;
6. If the activity is related to another activity, please list the related activity number as a first sentence in the narrative (i.e., This activity also relates to activities numbered 0367, 3481 and 4510.)

Please provide a maximum of 1 ½ pages that summarize the grouping of activities under any one funding mechanism.

Please see Appendix 25.4 for an example of an activity narrative.

DATA ENTRY:

This is a narrative that should be entered into text boxes. There is a 6,000 character limit (approximately 1 ½ pages) for the narrative. You may either type directly into the box on

the screen, or you may cut and paste into the box from another program. We would encourage you to write the narrative in Word or another program that allows for spell checking and then cut and paste the text into the text box in the data system.

EMPHASIS AREAS:

CONTENT:

This section has been somewhat revised from its application in the FY05 COP. This section was previously called Activity Categories in the FY05 COP.

OGAC does use these Emphasis Areas in responding to both Congressional and media inquiries and therefore it is important that they are taken seriously.

Each program area Activity by Funding Mechanism may be characterized by the types of activities, or emphasis areas, it includes. A list of pre-defined emphasis areas is given in Appendix 14, with the definition of each.

For each Program Area, we are asking you to designate all relevant emphasis areas using two ratings: Major (being 51-100% of the effort for that activity) or Minor (being 10-50% of the effort for that activity). The percentage breakdown for an emphasis area should be based on the effort for that activity rather than necessarily basing it on the funding breakdown. **Emphasis areas representing less than 10percent of the effort for that activity do not need to be selected.**

For example, if you are describing an activity that includes a large effort in Training, and a smaller effort in quality assurance, local capacity building and short-term recruitment, the emphasis area coding would be as follows:

Training	**X**	Major (51-100%)		Minor (10-50%)
Quality Assurance and Supportive Supervision		Major (51-100%)	**X**	Minor (10-50%)
Local Organization Capacity Development		Major (51-100%)	**X**	Minor (10-50%)
Human Resources		Major (51-100%)	**X**	Minor (10-50%)

While we are not asking you to track the exact percentage breakdowns for the Emphasis Areas and ensure that they sum to 100%, we want to stress that it is very important that you carefully consider the Emphasis Areas and only check those that apply. Please do not just check the boxes for all Emphasis Areas. Additionally, though we do not expect that the Emphasis Areas must sum to 100%, we would not anticipate seeing more than one major Emphasis Area for an activity.

An option of 'other' will be available. If you choose 'other', you will be prompted to fill in the name of the emphasis area and a definition for what is included in that emphasis area.

You will notice that "service delivery" is not listed as one of the choices in the emphasis areas. This is a purposeful omission. Please break-down "service delivery" into the component parts that describe the activity (i.e., infrastructure, training, commodity procurement, salaries, etc.). Again, even though there is an option to add "other" if the activity you are undertaking does not fall into one of the categories listed, "service delivery" is NOT an acceptable option for the "other" category.

For example, one area that has been mentioned is direct patient care. If your country is doing direct patient care, please classify this in terms of what you are actually providing, i.e. training of medical personnel doing the patient care, salaries of medical personnel doing the patient care, etc.

These emphasis areas are the same across all program areas, with the exception of Management & Staffing and Strategic Information. For the Management & Staffing program area there are no emphasis areas. For the Strategic Information program area, there is a different set of emphasis areas. The SI Emphasis Areas are listed in Appendix 14.

We recognize that there may well be overlap between emphasis areas. For example, curriculum development may be a component of a training program. In this case, you would not need to list information, education, communication and training separately. It is up to you to break down a funding mechanism into the component activities at a level that makes sense for your country from a budgetary and program management perspective.

You are asked to mention in your Activity Narrative each of the emphasis areas that you check, but you do not need to quantify the amount of funding or effort going toward that emphasis area.

Targeted Evaluations – Please include any targeted evaluations in the appropriate program area, unless it cuts across several areas. Targeted program evaluations will provide evidence-based information, beyond that derived from program monitoring and disease surveillance, to improve prevention programs, support decisions regarding clinical programs, and identify best practices for outreach to and care for those infected and affected by HIV/AIDS. The goal is to increase the efficiency, effectiveness, and quality of HIV/AIDS services, as well as their availability, accessibility, and acceptability. For information on the specific criteria upon which TE proposals will be reviewed, please see Appendix 26.2.

DATA ENTRY:

Please check the appropriate box (Major or Minor) next to the relevant Emphasis Areas. Multiple emphasis areas are allowed. If an Emphasis Area is not applicable to the given activity, do not check either box.

ACTIVITY TARGETS:

Targets' Timeframe:
The targets in this section relate to the time period that ends September 30th, 2007.

You do not need to provide targets for ALL Activities by Funding Mechanism that you
include in Table 3.3. The guidance for which activities require targets follows:
1.   All Track 1 activities should have targets <u>appear</u> in the COP.
2.   For <u>ongoing</u> activities requiring NO new FY06 funding, the FY05 targets will still
        apply.
3.   For <u>ongoing</u> activities that ARE requesting new FY06 funding, you do need to
        provide targets. The targets should reflect achievements expected through
        September 30, 2007.
4.   For <u>new</u> activities, you must provide targets. These targets also reflect
        achievements through September 30, 2007.

Please be aware that each activity by funding mechanism will not need to have all three of
the different types of targets listed below, direct targets, country-specific/custom targets
and indirect targets. Direct targets are required (even if only to include N/A), but country-
specific/custom targets and indirect targets are not required.

DIRECT TARGETS:

CONTENT:

The only required indicators and associated targets for Activities by Funding Mechanism are
those for USG **direct** support. Indirect targets and country-specific indicators are optional
and are discussed in the following paragraphs.

Tables 3.3.1 – 3.3.9 and 3.3.11-3.3.14 have required program monitoring indicators (note:
Table 3.3.10 HIV Treatment: ARV Drugs does not have any required indicators). Appendix
13 shows the full list of all required indicators by program area. You are required to have
some entry for each of these required indicators.

The default setting for all of the required indicators is N/A (not applicable). Therefore, if the
indicator is not applicable to the specific funding mechanism activity, you do not need to
enter a target value. You only need to enter a target value if the indicator applies to the
specific funding mechanism activity.

The target values "N/A" and "0" mean different things. Please consider carefully whether
the indicator and its target is really not applicable to the activity or if, in fact, the target is 0
for planning year. For example, if your program does not train people in blood safety then
you would put N/A for the target "Number of people trained in blood safety". However, if
your program is working in training people in blood safety but the curriculum is still being
developed and you don't anticipate that anyone will be trained, then you would put 0 for the
target "Number of people trained in blood safety".

➔ **NOTE**: not all of the required program level indicators are listed in the indicator targets
   for Table 3.3; that is, reporting requirements will include more than what is listed in the
   target section of the COP. For example, the COP does not require indicators to be
   disaggregated by age or sex for any of the indicators. However, this level of
   disaggregation will be required to be collected and reported in the Program results.
   Please review *The President's Emergency Plan for AIDS Relief Indicators, Reporting*

Requirements, and Guidelines: Revised for FY2006 Reporting, July, 2005 document to ensure that all necessary data are being collected throughout the year.

DATA ENTRY:

1. Click on the Add/Edit Targets button.
2. You will be taken to a new page with the required direct targets listed.
3. If the target is Applicable, deselect the Not Applicable box and enter the value directly into the cell. You do not need to enter comma's. You must enter whole numbers. Targets cannot include decimal points.
4. If the target is 0, deselect the Not Applicable box and enter the value directly into the cell.
5. If the target is Not Applicable, leave the check box selected and DO NOT enter anything into the cell.

Country: Botswana   FY: 2006

Table 3.3.09: Program Planning: Activities by Funding Mechanism
Mechanism/Prime Partner: **HIV/AIDS Project/Partnership for a Better World**
Program Area: **Counseling and Testing**
Budget Code: **HVCT**
Program Area Code: **09**

Targets ⓘ

Target	Target Value	Check if Not Applicable
Number of service outlets providing counseling and testing		☑
Number of individuals who received counseling and testing		☑
Number of individuals trained in counseling and testing		☑

Please enter indirect targets (Up to 2000 characters):

[Save]   [Add Custom Target]   [Save and Return to Activity]   [Cancel]

COUNTRY-SPECIFIC/CUSTOM TARGETS:

CONTENT:

Country-Specific Indicators:
In addition to the indicators provided in the COPRS, you may add other, country-specific indicators that will assist you in managing your country program. If you have added such indicators, you will also need to provide targets for them for each Activity by Funding Mechanism.

If you add individual country indicators, these will appear for every Activity by Funding Mechanism entered in that program area. However, these indicators are not on the required list, and the default for these non-required indicator targets will appear as N/A. Therefore you will not need to fill in the target for each activity by funding mechanism, but only those for which you want the indicator to apply. Please do not add indirect-support

indicators. Finally, please be conservative in adding indicators. Indicators should only be added if a majority of activities in the program area will be contributing to their achievement.

Overlap in Program Areas:
It is understood that there is significant overlap between many program areas, including the TB/HIV program area and the Counseling & Testing program area. The structure of the COP does not easily allow for these overlaps to be articulated. For countries that are doing significant work in one program area that overlaps with another, please consider adding country-specific/custom indicators to capture this. For example, if you are doing significant counseling and testing in the TB/HIV program area, you might want to add a country-specific/custom indicator to the effect of "number of individuals who received counseling and testing" to the TB/HIV program area.

DATA ENTRY:

1. At the bottom of the targets page (see screen shot above under Direct Targets), click the Add Custom Target button.
2. Type the title of the target into the Target Title box. The character limit is 200 characters.
3. Select whether the target is a count, percentage or ratio. The default is count.
4. Select the years which you would like to have the target available for. You can select only one, or all years.
5. Click the Save Custom Target button to return to the targets page.

Country: Botswana   FY: 2006

Table 3.3.09: Program Planning: Activities by Funding Mechanism
Mechanism/Prime Partner: **HIV/AIDS Project/Partnership for a Better World**
Program Area: **Counseling and Testing**
Budget Code: **HVCT**
Program Area Code: **09**

Custom Target   ⓘ

Target Title:	

Data Type:	Count

Count
Percentage
Ratio

FY05
FY06
FY07
FY08
Years   FY09
Available: FY10

Save Custom Target	Cancel and Return to Targets

INDIRECT TARGETS:

CONTENT:

There will also be a text box in each activity entry for you to provide information on any indirect targets to which the activity contributes. There is a 2,000 character limit (approximately ½ a page) on the text in this box.

DATA ENTRY:

In the targets screen (see screen shot above under Direct Targets) use the box labeled with Please Enter Indirect Targets. The narrative should be entered into the text box. There is a 2,000 character limit (approximately ½ a page) for the text. You may either type directly into the box on the screen, or you may cut and paste into the box from another program. We would encourage you to write the narrative in Word or another program that allows for spell checking and then cut and paste the text into the text box in the data system.

KEY LEGISLATIVE ISSUES:

CONTENT:

There are several key legislative requirements that need to be tracked and reported by OGAC. This is a drop down menu that allows you to tag these key legislative issues if they will be addressed by the activities included in the funding mechanism. These key legislative issues are gender (and it's sub-categories), twinning, volunteers, stigma and discrimination, and wrap arounds (and it's sub-categories). You should ensure that each selection of a key legislative issue is justifiable, according to the definition provided for that key legislative issue. That is to say that you would be able to support each selection in the event of an audit.

For a definition of what should be included in each of the key legislative issues please see Appendix 15. It will be possible to choose more than one key issue per activity by funding mechanism sub-table.

If none of the key legislative issues applies to the specific activity by funding mechanism, please check the N/A box.

For each key legislative issue that is checked, please provide some detail in the activity narrative which describes what specifically will be undertaken to address that issue.

DATA ENTRY:

Please check the box next each of the key legislative issues that are relevant to this specific activity. Multiple key legislative issues are allowed.

TARGET POPULATIONS:

CONTENT:

A target population is defined as the specific intended audience for the activity. Please select only those specific audiences or populations that the activity is intended to reach or benefit. OGAC frequently receives inquiries about target populations and the information

you provide here will allow us to better track our programs and how they address the needs of these various populations.

A list of potential target populations is provided in Appendix 16. Please select all applicable populations. We have tried to aggregate target populations where possible, and you may choose either the entire target population category or any individual sub-population. YOU DO NOT NEED TO CHECK BOTH THE ENTIRE TARGET POPULATION AND THE SUB-POPULATION IF YOU ARE ONLY WORKING WITH THE SUB-POPULATION; SELECT ONLY THE SUB-POPULATION. For example, if you are working with "refugees/internally displaced persons", you do not need to select both "mobile populations" and "refugees/internally displaced persons", you can just select the "refugees/internally displaced persons".

The provided list is by no means exhaustive, and we encourage countries to include additions that we may have overlooked. There is an option for 'other' if you do not see a target population on the list. You will then be prompted to add the target population.

We would like to encourage you to indicate those activities that are specifically focused on pediatric AIDS by using the target populations "HIV positive Infants (0-5 years)" and/or "HIV positive Children (6-14 years)". This target population should be used for all activities related to pediatric AIDS, including those which are aimed at identifying new cases (i.e., activities with an explicit case finding component for infants 0-24 months).

If the specific activity that is being undertaken does not have any target populations, please select the box marked N/A.

*Refugees – There will be additional information in the Technical Considerations Compendium about working with refugees.

DATA ENTRY:

Please check the box next each of the target population that are relevant to this specific activity. Multiple target populations are allowed.

COVERAGE AREA:

CONTENT:

Please specify the geographic areas (i.e., provinces/states or administrative districts) that each Activity by Funding Mechanism will cover. You may select from one to all provinces/states. You can also select "national" level indicating that the activity is one that is working at the national or central level rather than in specific provinces/states.

DATA ENTRY:

For each Activity by Funding Mechanism, please check the box(es) next to all relevant coverage areas. Multiple coverage areas are allowed.

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Instructions for Completing Table 3.3.15 Management & Staffing Program Area

CONTENT:

You should have only ONE entry in the Management and Staffing section for each USG Agency. The exception to this rule is CDC, which might have two entries if they will be using both GAP/Base and GHAI funds for Management & Staffing.

Make sure that your local administrative staff has been engaged in the development of the M&S budget.

This section of the COP has two objectives: 1) to provide an overview of all staff working on PEPFAR, and 2) to justify the USG team in-country costs of managing the Emergency Plan. This program area is NOT to be used for reflecting personnel related costs for the implementing partners who are involved in the Emergency Plan.

Program Area Context: Please briefly discuss the state of the USG Team in your country. Include information on whether the team is fully staffed, still working on recruitment, planned changes to key personnel, difficulties in recruitment and retention, difficulties in staying within the 7% budget target, etc. If you are using any innovative approaches to staffing, such as sharing positions across agencies, please describe this here. You are asked to complete an updated staffing matrix. Please discuss the Staffing Matrix in this section, providing any support or explanatory information that would correspond to the matrix, especially any new positions being requested. This matrix is attached in Appendix 17. Please upload this matrix in the Support Documents section.

Summary Targets by Program Area: There are no indicators for the management and staffing program area and therefore no required targets.

Funding Mechanism: The only funding mechanisms that should appear in this program area are those that have one of the 6 USG Agencies involved in the Emergency Plan as the Prime Partner. That is to say, the only prime partner organizations that should appear are: Department of Defense, Department of Labor, Department of State, HHS (HHS/CDC, HHS/HRSA, HHS/OS only), Peace Corps, and USAID.

Planned Funding: Please enter planned funding here in the same way that you did for the other program areas.

Activity Narrative: This narrative should be used to justify the management and staffing cost for the USG Agency, explaining the data provided in the M&S budget table in Appendix 18. Please tell us how many full and part time positions are being funded from the M&S budget.

You should have only ONE entry in the Management and Staffing section for each USG Agency. The exception to this rule is CDC, which might have two entries if CDC will be using both GAP/Base and GHAI funds for Management & Staffing.

For additional guidance on what specific staffing costs to include in the management and staffing program area and what specific staffing costs to include in the other 15 program areas, please see the Helpful Hints in Appendix 11.

ICASS Costs: Each implementing agency, including State, should request funding for Emergency Plan related ICASS costs within the M&S budget. It is important to coordinate this budget request with the Department of State Financial Management Officer, who can estimate FY-2006 anticipated ICASS costs by preparing a "what-if" ICASS budget using each PEPRAR agency's anticipated ICASS workload. This FY-2006 ICASS cost estimate, by agency, should then be included in the M&S budget request. Please budget for your entire estimated FY 2006 costs. Note that non-State Agencies should include the Capital Security Cost Sharing tax, except where this is paid by the headquarters agency. USAID should include the IRM tax on HIV program funded positions. There will be NO opportunity to increase these funds later from OGAC or your agency's headquarters later in the year.

Emphasis Areas: These are not applicable to the management and staffing program area. They will not appear as options.

Key Legislative Issues: These are not applicable to the management and staffing program area and therefore do not need to be selected.

Targets: Again, there are no indicators for the management and staffing program area and therefore no required targets. You will not be able to add either direct or indirect targets to this program area.

Target Populations: These are not applicable to the management and staffing program area and therefore do not need to be selected.

*Note: To assist countries in preparing the M&S section of the COP, a weekly conference call will be scheduled with Ken Schofield (OGAC), Lynn Mercer (CDC), and Paul Mahanna (USAID). These calls will begin in mid-August. The exact schedule for these calls and the call in phone number will be sent out in a News to the Field email in early August.

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Table 4   SUMMARY BUDGET REPORT

Table 4 is generated automatically by the data system. You will not be able to input any information into table 4 in the system.

You are asked to include the Track 1 resources for your country in the calculation of the budgetary requirements.   Since the COPR was not structured to allow entry of Track 1 budget levels for central mechanisms (funded by headquarters budgets), we are providing a separate Excel spreadsheet for your country, which will contain all the information in Appendix 8 (Track 1 FY06 Budget Allocations by Country). You will then need to copy the final column (marked "Total") from Table 4 from the COP (Summary Budget Table) into the spreadsheet. All formulas will be entered such that the spreadsheet will automatically calculate for you all budgetary requirements.

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Table 5   PLANNED DATA COLLECTION IN FY06

CONTENT:

Please answer each of the questions in this table in relation to data collection activities planned in your country during fiscal year 2006. This includes data collection that is being undertaken with any year or type of funding (this includes activities being undertaken by organizations other than the USG). Include ALL activities for which actual data collection efforts are going on during fiscal year 2006 (October 1, 2005 through September 30, 2006). Include ALL significant data collection efforts that are being undertaken by other donors or the host country government in addition to those being undertaken with USG funding.

In question 4, you are asked to indicate the number of service delivery sites that will be included in any ANC surveillance study. In question 5, you are asked to detail any other significant data collection activities that are not detailed in questions 1 through 4. Significant data collection activities could include a Multiple Indicator Cluster Survey (MICS), Priorities for Local AIDS Control Efforts (PLACE), Service Provision Assessment (SPA), Service Availability Mapping (SAM), HIV incidence testing, HIV drug resistance survey, ART impact study, or other national level survey. A brief description should be included if any other significant data collection activities are being undertaken. Also, please tell us if you are planning to do an analysis or updating of the health care workforce or the workforce corresponding to other EP goals for your country.

DATA ENTRY:

Most of the questions require only a yes/no answer. Please also include dates when preliminary data will be available from the survey, where applicable and when known.

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SUPPORT DOCUMENTS

REQUIRED SUPPORT DOCUMENTS:

CONTENT:

Explanation of Direct and Indirect Target Calculations for Table 2
Please provide an explanation of how targets listed in Table 2 were calculated. Include both direct and indirect calculations.

Peace Corps Out-Year Funding
Peace Corps has received agreement from OGAC to fund the costs associated with two-year Volunteers serving in Emergency Plan projects. Since Volunteer services are not contracted or outsourced, the costs are incurred throughout the two-year period of service. Obligations also occur for recruitment, placement and training of the Volunteer prior to the beginning of his or her service. Thus, funding for a Volunteer spans a minimum timeframe of three fiscal years. OGAC will fund these costs on an annual basis. Posts that include the service of Volunteers in their FY06 proposals should present the full-cost (recruitment, placement, training, and service) delineated by fiscal year in which the obligations will occur. For example, volunteers arriving in June 2006 will have expenses in FY06, FY07 and FY08. The FY06 COP should request funds only for FY06. Peace Corps and OGAC, however, request that posts also identify the volunteer costs for FY07 and FY08 so that country programs are prepared to request these funds as well in their out-year COPs.

Fiscal Year 2007 Funding Planned Activities
Please provide a one-page document that details the work that will be undertaken with fiscal year 2007 funding. This document should not reference any other document, but should be a stand alone effort that briefly details what work will be undertaken. This will be used for the FY 2007 Congressional Budget Justification. Please see Appendix 25.2 for an example of what this document should look like.

Staffing Matrix
Please upload the completed staffing matrix that is attached in Appendix 17.

Potential Plus-Up Funds
Please provide one document that details activities the country would undertake with potential additional funds. Please use the template provided in Appendix 9 for this support document.

Excel Track 1 Spreadsheet
This will be provided for you to incorporate Track 1 AB, OVC and treatment dollars to your country budget to demonstrate your percentage allocation across the various budgetary requirements.

OPTIONAL SUPPORT DOCUMENTS:

Acronyms List
Map
Process for COP Development

DATA ENTRY:

1. Enter Filename—Click on the Browse button to select appropriate Support Document file to upload from your local system to the HQ Data system (Document must be a text file, RTF, Word, or PDF).
2. Additional Description—Click on the Additional Description box and begin entering any additional information you would like included. You may enter up to 4,000 characters (approximately 1 page) in this section. You may want to enter the specific date or the author in this box.
3. Click on the Upload File button to upload the Support Document.
4. If you would like to delete a file that you have previously uploaded, click on the Delete File button on the list of uploaded files (see the screen shot on page 21).
5. If you would like to look at a file that has already been uploaded, select Download.

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COP SUBMISSION INSTRUCTIONS

In order to complete final submission of the COP, you will need to have COP read/write/finalize access. The following steps will guide you through the finalization and submission of your COP.

1. Run the Quality Assurance Report to ensure that all sections have been completed and errors have been corrected. For a list of items that are flagged by the QA report, please see Appendix 19.
2. Click on Mark COP Final and Ready for HQ Review and Approval.
3. The screen will show your country and the current fiscal year, click Next to verify.
4. Put a check mark in the box which reads COP is Final and Ready for HQ Review and Approval.
5. Upload a submission letter from the Ambassador.
   a. Enter Filename—Click on the Browse button to select appropriate file to upload from your local system to the HQ Data system (Document must be a text file, RTF, Word, or PDF).
   b. Comments—Click on the Comments box and begin entering any additional information you would like included. You may enter up to 4,000 characters (approximately 1 page) in this section.
   c. Upload a submission letter from the Ambassador.
6. Click the button Mark COP Final and Ready for HQ Review and Approval.
7. Go celebrate the submission of your FY06 COP!

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<u>APPENDIXES</u>

APPENDIXES

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Appendix 1   ACRONYMS LIST

A&A – Acquisition and Assistance

AB – abstinence and be faithful

ABC – abstain, be faithful, and, as appropriate, correct and consistent use of condoms

AIDS – Acquired Immune Deficiency Syndrome

ANC – anti-natal clinic

APR – Annual Program Result

APS – Annual Program Statement

ART – antiretroviral treatment

ARV – antiretroviral

CBO – Community Based Organization

CBJ – Congressional Budget Justification

CCM – country coordinating mechanism

CDC – Centers for Disease Control and Prevention (part of HHS)

CN – Congressional Notification

COP – Country Operational Plan

COPRS – Country Operational Plan and Reporting System

CSH – Child Survival & Health (USAID funding account)

DfID – Department for International Development (UK)

DoD – U.S. Department of Defense

DoL – U.S. Department of Labor

FAQs – frequently asked questions

FBO – faith based organization

FDA – Food and Drug Administration (part of HHS)

FSA – Freedom Support Act (funding account)

FSN – Foreign Service National

FTE – full-time equivalent

FY – fiscal year

GAP – Global AIDS Program (CDC)

GHAI – Global HIV/AIDS Initiative (funding account)

GTZ – Deutsche Gesellschaft für Technische Zusammenarbeit (German)

HCD – human capacity development

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

ICASS – International Cooperative Administrative Support Services

ID - identification

IRM – information resources management

JICA – Japanese International Cooperation Agency

LES – Locally Employed Staff

M&E – monitoring and evaluation

M&S – Management and Staffing

MAARD – Modified Acquisition and Assistance Request Document (USAID term)

MICS – Multiple Indicator Cluster Survey (UNICEF)

MIPRS – Military Interdepartmental Purchase Request (DoD)

MOA – Memorandum of Agreement

MOU – Memorandum of Understanding

N/A – not applicable

NGO – nongovernmental organization

NIH – National Institutes of Health

OE – operating expense

OGAC – Office of the U.S. Global AIDS Coordinator

OGHA – Office of Global Health Affairs (part of HHS)

OMB – Office of Management and Budget

OS – Office of the Secretary (part of HSS)

OVC – orphans and vulnerable children

PASA – Participating Agency Service Agreement

PAWG – Procurement and Assistance Working Group

PEPFAR – President's Emergency Plan for AIDS Relief (Emergency Plan)

PLACE – Priorities for Local AIDS Control Efforts

PLWHA/PLWA – People Living with HIV/AIDS or People Living with AIDS

PMTCT – prevention of mother-to-child HIV transmission

PSC – Personal Services Contract

QA – quality assurance

RSSA – Resource Support Services Agreement

RFA – Request for Application

RFC – Request for Comments

RFP – Request for Proposal

S/APR – Semi-Annual Program Result

SAM – Service Availability Mapping (UNAIDS)

SAMHSA – Substance Abuse and Mental Health Services Administration (part of HHS)

SI – Strategic Information

SOAG – Strategic Objective Agreement (USAID term)

SPA – Service Provision Assessment

TAACS – Technical Advisors in AIDS and
   Child Survival

TAD – Temporary Additional Duty
   (DoD/Navy)

TB - tuberculosis

UNAIDS – Joint United Nations Program on
   HIV/AIDS

UNICEF – United Nations Children's Fund

USAID – U.S. Agency for International
   Development

USDA – U.S. Department of Agriculture

USDH – U.S. direct hire

USG – United States Government

UTAP – University Technical Assistance
   Project

VCT – voluntary counseling and testing

WHO – World Health Organization

Appendix 2   GLOSSARY OF TERMS

Contracting Officer - A contracting officer is a person representing the U.S. Government through the exercise of his/her delegated authority to enter into, administer and/or terminate contracts and make related determinations and findings. Contracting Officers usually support an entire agency in country or will support an entire regional portfolio.

Direct Hire - U.S. citizens employed under the general schedule (Civil Service) and excepted service (non-career or Foreign Service).

Direct Hire Equivalent - These are hired personnel who have signatory authority for the U.S. government (e.g. TAACS, PSC [except for Peace Corps], RSSA, PASA). These positions can be either "OE funded" or "Program funded."

Emphasis Area – This is the new term that we are using to replace "Activity Categories". Emphasis areas are the specific areas of work that make up an activity.

Fiscal Year – The USG fiscal year is defined as the period from October 1 – September 30. Fiscal year 2006 is the period from October 1, 2005 – September 30, 2006.

Foreign Service National - These are positions filled by non-U.S. citizens and can include persons from the host country or third country nationals. These positions can be classified as either direct hire FSN or PSC FSN. They can be funded either out of OE or Program funds.

Funding Mechanism – A funding mechanism is defined by a discrete dollar amount passed through a prime partner entity and for which the prime partner is held fiscally accountable. A unique funding mechanism has four key characteristics that together make up a unique entry: funding mechanism type, USG Agency, funding source and prime partner. One or more of these key characteristics should be different for each funding mechanism entry.

Key Legislative Issue – A key legislative issue is an area of particular interest in terms of our reporting to Congress. These key legislative issues are gender, twinning, volunteers, stigma and discrimination and wrap arounds. These issue areas are either outcomes of activities (in the case of gender or stigma and discrimination) or ways of undertaking activities (in the case of twinning or volunteers).

Non-Direct Hire - These are hired personnel who do not have signatory authority for the U.S. government (e.g. institutional contractors, fellows). These positions are primarily "Program funded."

Operating Expense funds - These are funds that can only be used to pay for an agency's administrative expenses (i.e., rent, staff salaries, etc). Not all agencies pay for U.S. direct hires out of OE funds. Some agencies will list most of their U.S. direct hire staff in this row (i.e., USAID—with the exception of FSLs and the staff positions previously paid for by USAID/Washington listed above), other agencies will list no staff here (i.e., CDC), but will instead list staff under USDH/ FTE, number of program funded column.

Pipeline – A pipeline is the difference between the amount of funding that has been obligated to a partner and the amount of funding that has been expended by that partner.

Program funded - These are funded positions that are paid for from a specific program appropriation, for example GHAI (Global HIV/AIDS Initiative), GAP (Global AIDS Program) or CSH (Child Survival and Health).

USG Agency – A USG Agency is any United States Government entity that is working in your country or which will receive Emergency Plan funding from your country. There are two groups of USG Agencies, those that are considered to be core implementing members of the Emergency Plan in countries and those that play a more supportive role in the Emergency Plan. There are six agencies that are considered to be core implementing members: the Department of Defense, the Department of Labor, the Department of State, the Department of Health and Human Services, the Peace Corps, and the United States Agency for International Development. Other agencies that play a significant supportive role include, but are not limited to: the Department of Commerce and The Bureau of the Census.

Appendix 3   CONTACT INFORMATION FOR QUESTIONS

CONTACT FOR GUIDANCE/CONTENT RELATED QUESTIONS:

Please contact your Core Team Leader for issues related to the content of the COP, the content of this guidance, policy issues regarding the Emergency Plan or other substantive questions. Your FIRST point of contact should be your Core Team Leader. If they are not available, your second point of contact should be your Core Team SI Advisor. Finally, your third point of contact would be the OGAC SI Unit staff.

Core Team Leader
For questions regarding:
1. the Emergency Plan program in your country
2. OGAC Policies
3. the content of what should be included in the COP
4. how things should be included in the COP

Please use only three sources (Core Team Leaders, SI Advisors and OGAC SI Unit) for all of your COP guidance and content related questions. These individuals have been extensively oriented to the COP Guidance and content in an effort to ensure consistency in answers.

5 New Countries – Please also contact the Core Team Leader that has been assigned to your country. It is possible that the Core Team Leaders for the 5 new countries might shift as we bring on additional staff, but you will be notified if this is the case. Each country does have an SI Advisor assigned.

CONTACT FOR COPRS DATA SYSTEM RELATED QUESTIONS:

Please contact the Help Desk for questions related to technology, bugs, connection problems, or other items related to the data system.

E-mail: COPRSSupport@s-3.com
Telephone: 301.562.0770

The email address will be checked on a regular basis both on weekdays and on weekends. The warmline will be staffed on a regular basis both on weekdays and on weekends. The exact hours of operation will be sent in a News to the Field announcement in August. The warmline will not begin operation until the 1st of September.

Appendix 4   FULL LIST OF COPRS USER ACCOUNT TYPES

Countries

- **Country-Level System Administrator—**Has full system administrative rights to add users and modify records for a given country and submit the country's final COP or APR to OGAC for approval.

- **Country COP Read/Write/Finalize—**Has full data modification rights to update or add records (e.g., enter data) to the COP for a given country. Users with this access are also able to finalize and submit the COP. This access will only be allowed during those times of the year when the COP is in the process of being submitted.

- **Country PR Read/Write/Finalize—**Has full data modification rights to update or add records (e.g., enter data) to the Program Results for a given country. Users with this access are also able to finalize and submit the APR and S/APR. This access will only be allowed during those times of the year when the Annual and Semi-Annual Program Results are in the process of being submitted.

- **Country COP Read/Write—**Has full data modification rights to update or add records (e.g., enter data) to the COP for a given country. Users with this access are NOT able to finalize or submit the COP. Country COP Read/Write access will only be allowed during those times of the year when the COP is in the process of being submitted.

- **Country PR Read/Write—**Has full data modification rights to update or add records (e.g., enter data) to the Program Results for a given country. Users with this access are NOT able to finalize or submit the APR or the S/APR. Country PR Read/Write access will only be allowed during those times of the year when the Annual and Semi-Annual Program Results is in the process of being submitted.

- **Country COP Read—**Has data read access for the COP for a given country, but cannot update or add any data. This type of access is allowed year round.

- **Country PR Read—**Has data read access for the Program Results for a given country, but cannot update or add any data. This type of access is allowed year round.

Headquarters

- **USG COP Read—**Has data read access to the COP across all or several countries, but cannot update or add any data. This access is primarily for Core Team Members or individuals involved in the COP review process.

- **USG PR Read—**Has data read access to the Program Results across all or several countries, but cannot update or add any data. This access is primarily for Core Team Members or individuals involved in the Program Results review process.

- **USG PR Read/Write—**Has full data modification rights to update or add records to the Program Results across multiple countries. This individual does NOT have access to finalize the Program Results.

- **USG COP Read/Write—**Has full data modification rights to update or add records to the COP across multiple countries. This individual does NOT have access to finalize the COP.

- **USG PR Read/Write/Finalize—**Has full data modification rights to update or add records to the Program Results across multiple countries. This individual also has access to be able to finalize the Program Result. This user role is limited to Core Team Leaders and/or Core Team SI Advisors.

- **USG COP Read/Write/Finalize/Approve—**Has full data modification rights to update or add records to the COP across multiple countries. This individual also has access to be able to finalize and approve activities in the COP. This user role is limited to Core Team Leaders.

- **USG Organization Admin—**Has access to add or update the organizations/partners across all countries or for a specific country.

- **USG Read-Access Administrator—**Can grant read access (read-only) across all countries. There is one or more individual(s) at each USG Headquarters Agency who acts as the Administrator for that Agency.

- **USG System Administrator—**Has full system administrative rights to add users and modify records across all countries. This role is very limited in terms of who has this access.

Appendix 5   INFORMATION ON RESULTS TARGETS

Pediatric AIDS

The World Health Organization (WHO), the United Nations (UN) Children's Fund, and the Joint UN Programme on HIV/AIDS estimate that approximately 660,000 children globally, including 370,000 in sub-Saharan Africa currently are in need of ARV therapy (ART) (June 2005). Despite this obvious need, only a fraction of children living with AIDS receive life-saving Anti-Retroviral therapy (ARV). Without treatment, most children born with HIV will die before age five – but research shows most children who start ARV therapy early in life can and do flourish.

Clearly scale-up for pediatric treatment is an urgent priority. The international goal, set by UNICEF and others is that 15% of all people on treatment should be children. The President's Emergency Plan supports national scale up to reach this goal. We request that this year you estimate the number of children to be targeted in your **direct** treatment services.

We recognize that different country epidemics result in varying numbers of children requiring ARV treatment. In setting a target for FY06 please take into consideration (1) the type of epidemic and prevalence of infection in your countries, (2) the estimated number of children requiring ARV, (3) treatment capacity, and (4) the complexity and cost of treating children. Accurate diagnosis of HIV in the youngest children, when treatment may be most effective, is complex and difficult (early infant diagnosis is being recommended as a priority area for support by the PMTCT/Peds TWG). Older children who may have survived are often hidden in communities without access to services, or remain undiagnosed on hospital wards. Once a child is diagnosed, in resource poor settings, health providers may not be familiar with how to treat and follow children with AIDS and ARVs in formulations appropriate for children may be limited. The cost of these formulations may be up to three times that of adult ones. Some countries may be able to target children as 15% of patients on ARV's in FY06, while others may be just beginning pediatric programs and more feasibly would target in the 5-10% range, with the goal of increasing to 15%.

Bi-annual reporting of the number of children directly on treatment already occurs within the Emergency Plan. *In the FY06 COP, you are requested to estimate the number of children that you expect to report as directly on treatment by September 2006. (Children are defined as individuals from birth through 14 years of age). Please place the FY06* **direct** *target in the narrative section for Treatment (HIV/AIDS Treatment: ARV Services) in Table 3.3.11 along with a short description of activities to support national pediatric HIV efforts to scale up treatment for children. It would be helpful to know the overall national pediatric treatment target (if there is one) and pediatric treatment outside of direct Emergency Plan support.*

Counseling & Testing

Overall a country's counseling and testing strategy should include a mix of provider-initiated and client-initiated programs. If one of the goals of a Counseling and Testing Program is to identify persons needing ARV therapy, then the mix of provider-initiated and client-initiated programs will be determined by the percentage of persons at these different sites that are HIV positive and ARV-eligible. While we recognize the value of counseling and testing as an opportunity for counseling on HIV prevention and its impact on HIV stigma reduction, the following estimates are intended to assist in determining how best to direct counseling and testing resources to reach your country's ARV treatment targets.

STEP ONE - Prevalence Data:

A) <u>% HIV positive in medical facilities:</u>

%HIV positive in TB clinics_____

%HIV positive in STD clinics_____

%HIV positive in in-patient medical wards_____

(a) take the average of the available data from above_____

(b) If no data available use the Assumption Table below

Determine as per your country's general population data ("A" in table below)

Assumptions Table

Gen. Population Prevalence If your country's gen. Pop prevalence is:	Then:% HIV+ In medical facilities (A)	Then: % HIV+ ARV eligible in medical facilities (B)	Then: % HIV+ In VCT (C)	Then: % HIV+ ARV eligible in VCT (D)
< 3	10	30	10	10
> 3 < 10	20	40	15	20
> 10 < 20	40	50	20	25
> 20	60	60	25	30

B) <u>% HIV-positive in client-initiated facilities:</u>

%HIV positive in stand alone VCT sites_____

(a) if no data from VCT sites use the general population or ANC data

STEP TWO - Calculating the numbers to be tested by medical facilities:

The number of people needing ARVs by facility type will be a function of the general population prevalence. The appropriate proportion of counseling and testing clients from provider-initiated and client-initiated programs is presented in the following table:

Proportion Table:

If Gen Pop Prevalence is:	Then: % people tested medical facilities (A)	And % of people tested VCT (B)
< 3	90	10
> 3 < 10	85	15
> 10 < 20	80	20
> 20	75	25

Equation:

 # needing C&T in medical facilities =

ARV target **X** percentage of people coming from medical facilities

%HIV positive in medical facilities **X** %ARV eligible in medical facilities

Calculating "ARV target" - the ARV target is the number of persons expected to be on ARV in the year minus the number of ARV eligible persons expected to be identified from PMTCT programs – take your FY06 ARV Target number and subtract the PMTCT number supplied below: (Eg. ARV target for 2008 in Botswana = 33,000 – 2,984 = 30,016)

Country	2005 # PMTCT Women Eligible and Receiving HAART (5% HIV+ pregnant women)	2006 # PMTCT Women Eligible and Receiving HAART (10% HIV+ pregnant women)	2007 # PMTCT Women Eligible and Receiving HAART (15% HIV+ pregnant women)	2008 # PMTCT Women Eligible and Receiving HAART (20% HIV+ pregnant women)
Botswana	746	1,492	2,238	2,984
Cote D'Ivoire	2,660	5,320	7,980	10,640
Ethiopia	6,722	13,444	20,166	26,888
Guyana	35	70	104	139
Haiti	586	1,171	1,757	2,342
Kenya	5,400	10,800	16,200	21,600
Mozambique	6,237	12,474	18,711	24,947
Namibia	725	1,451	2,176	2,901
Nigeria	10,925	21,850	32,775	43,700
Rwanda	1,030	2,060	3,091	4,121
South Africa	9,765	19,530	29,295	39,060
Tanzania	6,898	13,795	20,693	27,590
Uganda	2,460	4,920	7,380	9,840
Zambia	4,059	8,118	12,176	16,235
**Vietnam	319	637	956	1,274
	58,566	**117,131**	**175,697**	**234,263**

Percentage of people coming from medical facilities – see Proportion Table (A)

% HIV positive in medical facilities – Results from Step 1 A

% ARV eligible in medical facilities – if not known for your country see Assumption Table (B)

STEP THREE - Calculating the numbers to be tested by VCT (stand alone) facilities

needing C&T in client initiated (VCT) facilities =
ARV target **X** percentage of people coming from VCT
%HIV positive in VCT **X** %ARV eligible in VCT

Calculating "ARV target" – as above in step two

Percentage of people coming from VCT facilities – see Proportion Table (B)

% HIV positive in VCT facilities – Results from Step 1 B

% ARV eligible in VCT facilities – if not known for your country see Assumption Table (D)

STEP FOUR – Total # needing counseling and testing

The total is the sum of the number in steps two and three. This will be a large number. This should demonstrate to you that you will need to think strategically about the appropriate mix of provider-initiated and client-initiated programs to assist you in meeting your ARV treatment targets. You may have other venues in which to provide counseling and testing. These should also be integrated into your analysis. The Counseling and testing technical working group would be happy to assist you in these calculations. Please let your Core Team Leader know if you would like assistance.

Example: Botswana 2008

ARV target (30,016) **X** percentage of people coming from medical facilities (75%)
% HIV positive in medical facilities (60% from assumptions table – if known in your country use that number) **X** % ARV eligible in medical facilities (60% from assumptions table – if known in your country use that number)
= 62,533

PLUS

ARV target (30,016) **X** percentage of people coming from VCT(25%)
% HIV positive in VCT (25%) **X** % ARV eligible in VCT(30%)
=100,053

TOTAL NUMBER OF PERSONS NEEDING TO BE COUNSELED & TESTED IN 2008 = **162,586**
The following table is provided for your assistance. An "X" indicates that you will need to provide or calculate the numbers. Please note that in the "people to be tested in medical facilities" column the bracketed TB numbers indicate the number of persons in TB clinics that

are potentially available for counseling and testing. You may have more recent general population prevalence data in your country.

Counseling and Testing Targets for PEPFAR Focus Countries: FY06

Country	ARV 2006 Target minus those identified in PMTCT	% General Population Prevalence	% Breakdown *	# People to be tested in medical facilities**	# People to be tested VCT	Total # to be tested	Total Population
Botswana	X	37.3	75/25	X (TB: 13,053)	X	X	1,640,115
Côte d'Ivoire	X	7	85/15	X (TB: 18,378)	X	X	17,298,040
Ethiopia	X	4.4	85/15	X (TB: 141,077)	X	X	73,053,286
Guyana	X	2.5	90/10	X (TB: 541)	X	X	765,283
Haiti	X	5.6	85/15	X (TB: 11,068)	X	X	8,121,622
Kenya	X	7	85/15	X (TB: 102,567)	X	X	33,829,590
Mozambique	X	12.2	80/20	X (TB: 32,675)	X	X	19,406,703
Namibia	X	21	75/25	X (TB: 16,243)	X	X	2,030,692
Nigeria	X	5.4	85/15	X (TB: 49,411)	X	X	128,771,988
Rwanda	X	5.1	85/15	X (TB: 7,689)	X	X	8,440,820
South Africa	X	21.5	75/25	X (TB: 275,172)	X	X	44,344,136
Tanzania	X	7	85/15	X (TB: 77,141)	X	X	36,766,356
Uganda	X	7	85/15	X (TB: 52,055)	X	X	27,269,482
Viet Nam	X	.4	90/10	X (TB: 139,761)	X	X	85,535,576
Zambia	X	16.5	80/20	X (TB: 69,356)	X	X	11,261,795

**Projected notified TB cases—optimal target would be a percentage that makes progress toward optimal 100% HIV testing goal

TB/HIV Estimates by Country

COUNTRY	EST. HIV PREVALENCE IN ADULT TB PATIENTS (%)*	EST NO. OF TB CASES REPORTED IN 2006	EST. ADULT HIV+ TB CASES TO BE REGISTERED BY TB PROGRAM IN 2006	NO. TB/HIV ELIGIBLE FOR ART 2006 (OF REGISTERED CASES)**		EST NO. OF TB CASES REPORTED IN 2007	EST. ADULT HIV+ TB CASES TO BE REGISTERED BY TB PROGRAM IN 2007	NO. TB/HIV ELIGIBLE FOR ART 2007 (OF REGISTERED CASES)**		EST NO. OF TB CASES REPORTED IN 2008	EST. ADULT HIV+ TB CASES TO BE REGISTERED BY TB PROGRAM IN 2008	NO. TB/HIV ELIGIBLE FOR ART 2008 (OF REGISTERED CASES)**	
				50% of TB/HIV cases	80% of TB/HIV cases			50% of TB/HIV cases	80% of TB/HIV cases			50% of TB/HIV cases	80% of TB/HIV cases
Botswana	79	13,053	7,314	3,657	5,851	13,727	7,692	3,846	6,153	14,290	8,007	4,004	6,406
Côte d'Ivoire	39	18,378	5,084	2,542	4,067	19,327	5,346	2,673	4,277	20,120	5,566	2,783	4,452
Ethiopia	29	141,077	29,019	14,509	23,215	148,362	30,517	15,259	24,414	154,450	31,770	15,885	25,416
Guyana	14	541	46	23	37	555	48	24	38	557	48	24	38
Haiti	14	11,068	951	475	761	11,343		487	780	11,390	978	489	783
Kenya	51	102,567	37,102	18,551	29,682	107,863	39,018	19,509	31,215	112,289	40,619	20,310	32,496
Mozambique	47	32,675	10,893	5,446	8,714	34,362	11,455	5,728	9,164	35,772	11,925	5,963	9,540
Namibia	64	16,243	7,373	3,687	5,899	17,082	7,754	3,877	6,203	17,782	8,072	4,036	6,458
Nigeria	27	49,411	8,619	4,309	6,895	51,963	9,064	4,532	7,251	54,095	9,436	4,718	7,549
Rwanda	37	7,689	2,018	1,009	1,614	8,086	2,122	1,061	1,698	8,418	2,209	1,105	1,767
South Africa	60	275,172	117,107	58,553	93,685	289,382	123,154	61,577	98,523	301,256	128,208	64,104	102,566
Tanzania	34	77,141	18,603	9,302	14,883	81,124	19,564	9,782	15,651	84,453	20,367	10,183	16,293
Uganda	24	52,055	8,071	4,036	6,457	54,743	8,488	4,244	6,790	56,990	8,836	4,418	7,069
Viet Nam	2	139,761	1,691	846	1,353	134,706	1,630	815	1,304	127,653	1,545	772	1,236
Zambia	62	69,356	30,500	15,250	24,400	72,938	32,075	16,038	25,660	75,930	33,391	16,696	26,713

Appendix 6   FY06 COP ACQUISITION AND ASSISTANCE GUIDANCE

Background:

One follow-up action to the November 2004 Emergency Plan Management Workshop was for OGAC to provide the field with additional acquisition and assistance guidance. This paper provides general guidance for integrating new partners into the Emergency Plan; describes procedures for OGAC's review and approval of program activities where partners were not identified at the time of COP approval; and provides guidance on construction.

Increasing Local Partners:

One of the principles established in the Emergency Plan's Five Year Strategy is to "encourage and strengthen faith-based (FBOs) and community-based organizations (CBOs)." In order to meet Emergency Plan targets and do so on a sustainable basis, it is important to utilize organizations that have close and multi-dimensional ties to population groups, and have, or can develop networks in these countries that can be sustained over long periods of time.

OGAC has created the Community and Faith-Based Organization Integration Work Group (C/FBO) to assist countries in integrating new partners in the 06 COP process. A member of this work group will be assigned to each core team as a resource and point of contact.

Objectives:

As you continue to design FY 2005 programs and acquisition and assistance (A&A) plans and begin to formulate FY 2006 plans, please remember the following objectives:

1. Add new organizations to implement all components of the Emergency Plan and ensure that non-local organizations build institutional capacity of indigenous organizations;
2. Assure within all solicitations a level playing field for all potential bidders, including those with limited previous experience working with the USG;
3. Promote the use of indigenous organizations as implementing organizations;
4. Avoid duplication of resources programmed by different USG agencies to the same implementing organization for the same purposes, for example two USG agencies funding the same partner to provide assistance to orphans or anti-retroviral therapy; and
5. In the assistance arena, to promote the most efficient use of funding, limit the amount of funding for any single organization (as prime or sub) to less than 10 percent of the total COP budget for that year. Exceptions can be made for organizations that are acting as grant making and administration arms of the Emergency Plan and are building local sustainable capacity, for government ministries, or for organizations that are major purchasers of pharmaceuticals and other commodities.

Best Practices:

This guidance focuses on identifying organizations that already reach populations not served, have expertise in the program area, and could partner with the USG with some technical assistance and capacity building.

Experience during the first year of the Emergency Plan has yielded examples of creative program designs that successfully integrate FBOs, CBOs and indigenous organizations into Country Operational Plans.

- Some Annual Program Statements (APSs) were directed entirely at new partners, or set aside a portion of funding for new partners that are indigenous with an existing in-country presence or relationship.
- The language used in solicitation requests, such as Requests for Application (RFAs) and APSs, is critical in determining what types of organizations respond. Some word choices encourage the participation of FBOs, CBOs and indigenous organizations while other word choices discourage participation. A best practice is to issue a draft solicitation for comment or hold an in-country pre-bidders conference to determine if there are impediments to participation by FBOs/CBOs. Please provide any examples of problems faced and overcome to OGAC.
- The dollar values identified in solicitations for size of grants may also influence which organizations apply because they are indicators that help local organizations decide if it is feasible to prepare an application. Statements indicating dollar value awards "up to $5 million" can discourage local organizations because they are often viewed as "set-asides" for international organizations. Additional language, such as "small awards to local organizations will be a priority" may be helpful.
- Where local organizations are strong, umbrella grant programs have been designed to hire a strong local or international organization whose role is to run a grant making and administration program, using a relatively small percentage of the funds (usually around 7%) in the overall grant for these purposes.
- Where local organizations are weak, umbrella grant programs have been designed that include significant technical assistance, either as part of the responsibilities of the grant making organization or as a separate organization. The best examples again spend a relatively small proportion of the overall grant (typically 20% to 30%) on these services and are quite specific as to the responsibilities of the prime in strengthening local partners. Such awards are expected to move to the 7% range over time as the technical capacity of local partners is strengthened. OGAC is working on language to be added to grants that set out benchmarks in this area and indicators to track performance by larger partners and umbrella organizations. Once approved, a pilot of these indicators will take place during the next few months to ensure the quality and efficacy of the measures prior to wider distribution.
- In the acquisition arena, if an international organization is essential to provide technical leadership and oversight, use all available tools in award evaluation criteria and performance assessments to encourage use of local partners. To stimulate broader participation in a contract, the award evaluation criteria can include points for including indigenous partners as sub-contractors or implementing partners. The evaluation of how broadly and effectively a contractor utilized and included new partners during the performance assessment of that contractor has also been effective when done rigorously. OGAC is also developing standardized sustainable capacity building performance indicators that will be available later this year.

OGAC recognizes that some of these practices will increase demands on A&A and other staff. We have therefore provided funding to our USG implementing agencies to allow them to increase human capacity in the field and at headquarters (including a Twinning Center that can help support local organizations). We are open to and supportive of any innovative approaches that might be taken to address this issue.

OGAC or HQ Involvement

Consistent with its coordinating responsibilities, OGAC will, from time to time, request information or provide further guidance during the A&A process. We instituted the following procedures for FY 2005:

- During the review of Country Operational Plans (COPs), OGAC will identify activities that will be subject to further monitoring during the A&A process.
- Where additional monitoring is required, OGAC will request the HQ of the implementing agency to review the solicitation document before it is released and to take any additional steps it feels necessary to ensure that Emergency Plan objectives are being pursued and that the solicitation will have a high probability of being successful. The agency involved may call upon the expertise of other Emergency Plan agencies for help through its Principal or through the PAWG.
- On occasion, OGAC may request to be the Source Selection Official for the action. These actions will be clearly designated as early in the planning process as possible.

FYI: For the 2005 COPs, a total of seven assistance actions were identified for monitoring in four countries. All were Abstinence/Be Faithful or social marketing programs.

These procedures will be evaluated before the FY 2006 COPs are submitted.

Construction:

We have not been able to develop clear operational guidance with respect to construction. DoD's Defense Security Cooperation Agency has informed the Coordinator's Office that it is unable to accept Emergency Plan funds, as was originally planned, to carry-out the construction of facilities such as laboratories. DOD is able to continue construction activities that are funded out of DOD's humanitarian assistance. HHS is currently reviewing its policies as to whether it can accept funding and utilize the Frankfort Regional Procurement Support Office (RPSO) of the Department of State to supervise construction activities. If you have identified ways of financing and supervising construction activities, please inform the Coordinator's Office so that we can share solutions with others. Posts may wish to consider convincing host governments to utilize other donor resources, such as those of the World Bank, to finance and carry-out construction activities.

Listing Partners:

Do not list partners on Table 3 of the COP until they have been formally selected through normal A&A processes, such as Annual Program Statements, Requests for Application, or Requests for Proposals. If a partner has not been formally selected, list the partner as To Be Determined (TBD).

Appendix 7   FY06 BUDGET ALLOCATION BY COUNTRY

Below is a table providing budget planning numbers for focus country FY06 COP. Since we do not know what our final appropriations will be for FY06, we are asking you to plan at two levels: the COP planning level (including both GHAI and GAP funding and titled the "FY06 COP sub-total" on the table) and a "potential total" that includes a plus up in funding in the event we receive an appropriation at the requested level. Instructions on how to identify those components of your program that would receive a plus-up and how to rank the plus-ups in priority order are included in page 29 and Appendix 9. We are including the potential plus up requests at this time in order to avoid additional work to the field later, should these funds become available.

Focus Countries

Country	GAC (GHAI)	Base HHS/CDC (GAP)	FY06 COP Sub-Total	5% (Ceiling for Unallocated)*	Potential Plus-Up	Total (including potential plus-up)
Botswana	39,500,000	7,547,000	47,047,000	1,975,000	1,500,000	48,547,000
Cote d'Ivoire	28,137,000	5,253,000	33,390,000	1,406,850	2,000,000	35,390,000
Ethiopia	95,970,000	5,800,000	101,770,000	4,798,500	13,530,000	115,300,000
Guyana	16,100,000	1,000,000	17,100,000	805,000	1,900,000	19,000,000
Haiti	47,300,000	1,000,000	48,300,000	4,730,000	1,200,000	49,500,000
Kenya	144,143,000	8,121,000	152,264,000	7,207,150	25,807,000	178,071,000
Mozambique	63,166,000	2,337,000	65,503,000	3,158,300	12,834,000	78,337,000
Namibia	47,000,000	1,500,000	48,500,000	2,350,000	0	48,500,000
Nigeria	111,744,000	3,056,000	114,800,000	5,587,200	22,756,000	137,556,000
Rwanda	52,837,000	1,135,000	53,972,000	2,641,850	2,663,000	56,635,000
South Africa	154,022,100	4,818,000	158,840,100	7,701,105	31,530,900	190,371,000
Tanzania	92,312,000	3,883,000	96,195,000	4,615,600	10,688,000	106,883,000
Uganda	134,296,000	8,040,000	142,336,000	6,714,800	4,704,000	147,040,000
Viet Nam	31,214,000	2,855,000	34,069,000	1,560,700	3,786,000	37,855,000
Zambia	108,709,000	2,914,000	111,623,000	5,435,450	1,291,000	112,914,000
Totals	1,166,450,100	59,259,000	1,225,709,100	60,687,505	136,189,900	1,361,899,000

*Haiti has a 10% ceiling for unallocated.

[This table will be provided as soon as it is complete.]

5 New Countries

Country	Base HHS/CDC GAP	USAID CSH	State/ USAID FSA	State/ USAID ESF	State, USAID, HHS, DOD, DOL, Peace Corps GAC (GHAI)	FY06 Total	5% (Ceiling for Unallocated)
Cambodia			■				
India			■				
Malawi			■	■			
Russia				■			
Zimbabwe			■	■			
Totals							

Appendix 8   TRACK 1 FY06 BUDGET ALLOCATIONS BY COUNTRY AND PROGRAM AREA

FY 06 TRACK 1 ART BUDGET GUIDANCE

In FY06, central funding for track 1 ART grantees will be essentially straight-lined at FY05 central funding levels, not including any rapid expansion funds or COP funds transferred to track 1 grantees in FY05. This has been done to ensure that track 1 grantee activities are fully integrated into host country and embassy plans.

FY06 country budgets must cover:

- The continuing treatment costs of anyone already on treatment using track 1 resources that exceeds those costs that can be covered by central track 1 funding. See the table below for track 1 country allocations for all central programs, including ART.
- The full cost of any expansion of treatment using track 1 grantees.

Note that posts are not required to use track 1 grantees if they are not performing. However, if posts wish to switch treatment provider from a track 1 grantee to another provider, the post must ensure that all patients formerly treated by a track 1 grantee continue to receive treatment without a gap in service. Please be sure to include your core team leader and the Track 1 program manager for your country in these discussions.

If you have not already done so, please meet with your track 1 ART grantees to begin to determine their funding needs in FY06. Note that a key issue for the track 1 grantees is that OGAC has not provided sufficient funding centrally to cover the entire cost of maintaining people on treatment that track 1 grantees put on treatment in FY05. The costs that cannot be covered from central funding must come from the COP budget. A second key issue is that the track 1 grantees will likely need funding early in FY06 to order drugs for delivery by March 2006 to avoid shortages. We are trying to address this issue centrally by determining track 1 urgent drug procurement needs and notifying for this early in FY06. However, now that almost a third of the track 1 grantee budgets come from COP budgets, track 1 grantees may request posts to include funding for procurement as an "early funding request" (See instructions for table 3.1 – Funding Mechanisms and Source Table, Early Funding Requested). These requests will receive priority attention.

This appendix provides Track 1 FY06 Budget Allocations by Country and Program Area. Since the COPR was not structured to allow entry of Track 1 budget levels for central mechanisms (funded by headquarters budgets), we are providing a separate Excel spreadsheet for your country, which will contain all the information in the table below. You will then need to copy the "Total" column from Table 4 (Summary Budget Table) into the spreadsheet. All formulas will be entered such that the spreadsheet will automatically calculate for you:
- AB: AB resources as a percent of resources for all prevention of sexual transmission of HIV (66% budgetary requirement); and ii) Resources for prevention of sexual transmission of HIV as a percent of the overall prevention budget (50% budgetary requirement)

- OVC: OVC resources are 10 percent of resources for prevention, care and treatment resources.
- Treatment: Treatment resources are 55 percent of prevention, care and treatment resources.

This table is provided to assist countries in planning. Track 1 funding provided from Headquarters should not be included in your country budget and should not appear in the COP. You should have received additional information from your Core Team Leader with specific funding levels for the specific Track 1 partners working in your country.

Track 1 FY06 Budget Allocations by Country & Program Area

Country	ARV	Blood Safety	Injection Safety	OVC	AB	TOTAL
Botswana	2,200,000	3,100,000	2,115,000	211,754	177,370	7,804,124
Cote d'Ivoire	6,722,257	4,100,000	2,115,000	309,302	225,743	13,472,302
Ethiopia	0	3,100,000	3,032,417	2,077,508	2,097,028	10,306,953
Guyana	566,685	1,900,000	1,222,566	0	270,750	3,960,001
Haiti	1,882,938	2,800,000	2,115,000	804,068	1,430,507	9,032,513
Kenya	9,414,373	4,100,000	2,115,000	3,427,168	3,864,496	22,921,037
Mozambique	4,500,000	2,130,000	1,792,993	3,045,083	1,963,234	13,431,310
Namibia	0	1,733,000	1,229,031	1,118,384	321,468	4,401,883
Nigeria	15,669,771	2,220,000	3,781,910	612,844	540,828	22,825,353
Rwanda	5,560,366	3,267,000	2,115,000	1,412,298	636,130	12,990,794
South Africa	13,629,974	4,100,000	2,115,000	1,756,359	1,394,196	22,995,529
Tanzania	19,542,378	4,100,000	2,115,000	1,506,050	2,381,557	29,644,985
Uganda	5,317,485	4,100,000	2,392,584	3,116,570	1,645,624	16,572,263
Viet Nam	0	0	0	0	0	0
Zambia	20,459,163	3,600,000	1,948,499	4,255,011	1,295,733	31,558,406
Totals	105,465,390	44,350,000	30,205,000	23,652,399	18,244,664	221,917,453

Appendix 9   TEMPLATE FOR POTENTIAL PLUS-UP FUNDS

Use this table if you are adding funding to an **existing** FY06 COP **funding mechanism/source** and an **existing activity within a program area**.

PLUS –UP FUNDING TABLE				
FY06 COP Existing Funding Mech/Source and Existing Activity within Program Area				
Priority Rank	**Funding Mech ID (Table 3.1)**	**Activity within Program Area ID (Table 3.3)**	**Plus Up Funds Requested**	**Additional Results/Targets to be achieved (program area indicators)**

FY06 COP Existing Funding Mech/Source and Existing Activity within Program Area: Narrative Rationale		
Fund Mech & Source ID Table 3.1	Activity Within Program Area ID Table 3.3	Narrative:
Fund Mech & Source ID Table 3.1	Activity Within Program Area ID Table 3.3	Narrative:
Fund Mech & Source ID Table 3.1	Activity Within Program Area ID Table 3.3	Narrative:
Fund Mech & Source ID Table 3.1	Activity Within Program Area ID Table 3.3	Narrative:

Use this table if you are adding funding to an **existing** FY06 COP **funding mechanism/source** with a **new activity within a program area**.

PLUS –UP FUNDING TABLE				
FY06 COP Existing Funding Mechanism/Source Only				
Priority Rank	**Funding Mech ID (Table 3.1)**	**Program Area in which new activity defined**	**Plus Up Funds Requested**	**Targets (use indicators for program area)**

FY06 COP Existing Funding Mechanism/Source Only Narrative Rationale		
Fund Mech & Source ID Table 3.1	Program Area in Which New Activity Defined	Narrative:
Fund Mech & Source ID Table 3.1	Program Area in Which New Activity Defined	Narrative:
Fund Mech & Source ID Table 3.1	Program Area in Which New Activity Defined	Narrative:
Fund Mech & Source ID Table 3.1	Program Area in Which New Activity Defined	Narrative:

Use this table if you are putting funding into a **new** FY06 COP **funding mechanism/source** and a **new activity within a program area**.

PLUS –UP FUNDING TABLE						
FY06 COP New Funding Mech/Source and New Activity within Program Area						
Priority Rank	**Define Funding Mech /Source**			**Program Area in which new activity defined**	**Plus Up Funds Requested**	**Targets (use indicators for program area)**
	Funding Mech Type	**USG Agency**	**Prime Partner**			

FY06 COP New Funding Mechanism/Source and New Activity by Program Area Narrative Rationale		
New Fund Mech And Source Info (copy from above)	Program Area in Which New Activity Defined	Narrative:
New Fund Mech And Source Info (copy from above)	Program Area in Which New Activity Defined	Narrative:

Appendix 10   LIST OF HQ MECHANISMS BY AGENCY

HHS

HHS Operating Division	Mechanism Type	Funding Mechanism Name	Prime Partner Name
Cooperative Agreements			
HHS/HRSA	HQ	International Training ad Education Center on HIV/AIDS (I-TECH)	University of Washington
HHS/HRSA	HQ	Technical Assistance/Leadership	National Association of People Living With AIDS (NAPWA)
HHS/HRSA	Central or HQ	Twinning	American International Health Alliance (AIHA)
HHS/HRSA	Central or HQ	Track 1 ARV	Catholic Relief Service (CRS)
HHS/HRSA	Central or HQ	Track 1 ARV	Harvard University School of Public Health
HHS/CDC	Central or HQ	Track 1 ARV	EGPAF
HHS/CDC	Central or HQ	Track 1 ARV	Columbia University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Baylor University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Columbia University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Harvard University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Howard University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	JHPIEGO
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Tulane University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of California San Francisco
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of Medicine and Dentistry New Jersey (FXB)
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of North Carolina
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of Maryland
HHS/CDC	HQ	Technical Assistance	National Association of State & Territorial AIDS Directors (NASTAD)
HHS/CDC	HQ	Technical Assistance	Association of Public Health Laboratories (APHL)
HHS/CDC	HQ	Technical Assistance	United Nations Programme on HIV/AIDS (UNAIDS)
HHS/CDC	HQ	Technical Assistance	American Schools of Public Health (ASPH)
HHS/CDC	HQ	Technical Assistance	World Health Organization (WHO)
HHS/CDC	HQ	Technical Assistance	American Society for Clinical Pathology (ASCP)
HHS/CDC	HQ	Technical Assistance	American Society for Microbiology (ASM)

HHS Operating Division	Mechanism Type	Funding Mechanism Name	Prime Partner Name
HHS/CDC	HQ	Technical Assistance	Clinical & Lab Standards Institute (CLSI)
Contracts			
HHS/CDC	HQ	Technical Assistance	MACRO
HHS/CDC	HQ	Technical Assistance	Danya International (NPIN)
	HQ	Information Technology Support Contract (CITS)	Must be competed among the following contractors: Northrop-Grumman and Lockheed Martin
HHS/CDC	HQ	Logistical and Travel Support	Social Scientific Systems, Inc (SSSI)
HHS/CDC	HQ	Lab Supplies	Crown Agents
HHS/CDC	HQ	GAP Program Support and Technical Assistance Contract (GAP 6)	Must be competed among the following contractors: AED, EnCompass, FHI, JHPIEGO, John Snow Inc, & SSSI

USAID

Please see the *2005 Users' Guide to USAID/Washington Population, HIV/AIDS, Health and Nutrition Programs* (http://www.usaid.gov/our_work/global_health/home/Resources/users_guide.html) for this information. Contact Wyman Stone (wstone@usaid.gov) with any questions.

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Appendix 11   HELPFUL HINTS

CDC as prime partner for a funding mechanism
> CDC should only be the prime partner for a funding mechanism in three instances:
> 1. management & staffing costs
> 2. technical assistance that CDC in-country provides directly
> 3. technical assistance that CDC HQ provides directly
>
> If funding will eventually be obligated to another organization, then CDC should **NOT** be the prime partner. Additionally, there should NEVER be sub-partners under an activity where CDC is the prime partner.
>
> For more assistance with this issue, please contact Lynn Mercer (email lzm2@cdc.gov) at CDC HQ.

Partners/Organizations
> Please make sure to do a search of the organizations already listed in the data system before you add an organization. In order to make the listing of organizations useful, we need to ensure there are not duplicate entries in the data system and that project names are not used as organization names. When you search for partner organizations, please try several variations of the partner name, if you do not find it the first time.
>
> Recommendation: Before you begin to do data entry into the COPRS data system, print out the full list of partners/organizations. This can be found in the *Reports* section, "All Partner Names Report". Then look through this report to ensure that all of the partners/organizations you need for your COP data entry are already included in this list. For any partners/organizations that you will need that are not included in list, use the Organization Template that was send in the News To The Field Email on June 16th to enter the correct information. Then send the list to Sarah Gorrell (gorrellse@state.gov). Please remember the deadline for receiving organizations is August 26th for focus countries and October 31st for the 5 new countries.

When do we enter SI activities in the Strategic Information Program Area 13 (budget code HVSI), and when do we enter SI activities under other program areas within the emphasis area called strategic information?
> **The answer to this question depends upon the scope**, **scale and funding level of the SI activity**. Large dollar value SI funding mechanisms that support the collection, analysis and dissemination of HIV/AIDS behavioral and biological surveillance and monitoring information; facility surveys; support for national or USG-wide program monitoring systems and/ HMIS; assistance to countries in the establishment of same data collection methods and capacity building; large targeted evaluations, including Emergency Plan program efficiency and effectiveness or impact studies, should be included under the SI Program Area 13.
>
> Conversely, if the SI activity is relatively small in scope and cost, and if it is an integral component activity of a prevention, care or treatment funding mechanism, it should be included under the appropriate program area and its costs attributed to the emphasis area called strategic information. For example, suppose you are supporting PMTCT service delivery in 20 sites through a funding mechanism with prime partner "PMTCT Partner". A component activity of this grant is that PMTCT Partner is providing TA to set up facility-based health management information systems in the 20 PMTCT sites. This activity could

be included in the PMTCT program area, when the funding mechanism is entered, and the costs for the facility HMIS technical assistance would be attributed to the emphasis area called strategic information.

When do USG and/or project/program staff costs get entered in program area 15 (management and staffing) and when do they get entered in other program areas?

Program area 15 (management and staffing) is the program area where countries are to justify the management and staffing costs for each agency. One important determination is whether the fully-loaded cost of a particular position should be allocated to program area 15 or one of the other program areas. Using the categories in Appendix 17, technical leadership/management positions, technical advisor/program managers, contracting staff, financial/budget staff and administrative/support staff should be allocated to program area 15. Technical advisors/non management and staff, who spend most of their time implementing programs in technical areas, as well as their administrative support staff, should be allocated to the other 14 program areas. However, if a position is supporting more than three program areas, allocated those costs to program area 15.

One of the emphasis areas in the drop down list in Table 3.3 is "HR", human resources. Should the costs of all project staff be allocated to this emphasis area?

No. The "HR" emphasis area that is listed in the emphasis area drop-down list is specifically defined to reflect activities that "...help meet immediate and short-term workforce requirements through innovative approaches to recruitment, retention, deployment and rewarding of quality performance of health care workers and managers...". Included in this category is the direct payment of salaries for health care workers. (Please see Appendix 14 for complete definitions of the COP emphasis areas.) This category is intended to capture health care workforce expenditures, not the costs of ALL project personnel.

Connectivity

If you are still frustrated by slow internet connections, you might consider investing some of your FY06 funding in upgrading your system. If you would like to find out more about how to improve internet connectivity in your country, contact Lyle Holden (lholden@s-3.com).

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Appendix 12   PROGRAM AREA/BUDGET CODING CATEGORIES

PREVENTION

1. PMTCT (MTCT) – activities aimed at preventing mother-to-child HIV transmission including counseling and testing for pregnant women, ARV prophylaxis for HIV-infected pregnant women and newborns, counseling and support for maternal nutrition and safe infant feeding practices. PMTCT-plus ARV-treatment activities should be coded under HTXD and HTXS.

2. Abstinence/be faithful (HVAB) – activities (including training) to promote abstinence, fidelity, delay of sexual activity, partner-reduction messages and related social and community norms

3. Medical transmission/blood safety (HMBL) – activities supporting a nationally coordinated blood program, which includes policies; infrastructure, equipment and supplies; donor-recruitment activities; blood collection, distribution, testing and transfusion; training; and management to ensure a safe and adequate blood supply.

4. Medical transmission/injection safety (HMIN) – policies, training, waste-management systems, advocacy and other activities to promote (medical) injection safety, including distribution/supply chain, cost and appropriate disposal of injection equipment and other related equipment and supplies.

5. Other prevention activities (HVOP) – other activities aimed at preventing HIV transmission including purchase and promotion of condoms, STI management (if not in palliative care settings/context), messages/programs to reduce injecting drug use and related risks.

CARE

6. Palliative Care: Basic health care and support (HBHC) – all clinic-based and home-/community-based activities for HIV-infected adults and children and their families aimed at optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring, related laboratory services and management of opportunistic infections (excluding TB) and other HIV/AIDS-related complications (including pharmaceuticals); and culturally-appropriate end-of-life care. HBHC also includes clinic-based and home-/community-based support; social and material support such as nutrition support, legal aid and housing; and training and support of caregivers. Clinic-based and home-/community-based care and support activities for HIV-positive children within programs for orphans and other vulnerable children affected by HIV/AIDS fall under HKID. ARV treatment should be coded under HTXD and HTXS.

7. Palliative Care: TB/HIV (HVTB) – exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis in HIV basic health care settings (including pharmaceuticals); as well as screening and referral for HIV testing, and clinical care related to TB clinical settings. If TB programs provide other basic health care and support services such as clinical or psychosocial services, these services would be coded under HBHC. If TB programs expand to provide clients with ART, such services would fall under HTXD and HTXS. Note: General TB treatment, prevention and related programming must be funded with CSH/Infectious Diseases funds directed for TB, not with HIV/AIDS funds.

8. Orphans and Vulnerable Children (HKID) – activities aimed at improving the lives of orphans and other vulnerable children and families affected by HIV/AIDS. The emphasis is on strengthening communities to meet the needs of orphans and other vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents to meet their own needs, creating a supportive social and policy environment, etc. Activities could include training caregivers, increasing access to education, economic support, targeted food and nutrition support, legal aid, etc. Institutional responses would also be included. ARV treatment of children is excluded from this category and should be coded under HTXD and HTXS. Palliative care, including basic health care and support and TB/HIV prevention, management and treatment, as well as their related laboratory services and pharmaceuticals, when delivered within programs for orphans and other vulnerable children affected by HIV/AIDS, should be coded under this category (HKID). Other health care associated with the continuum of HIV/AIDS illness, including HIV/TB services, when delivered outside a program for orphans and other vulnerable children affected by HIV/AIDS, should be coded under HBHC or HVTB.

9. Counseling and testing (HVCT) – includes activities in which both HIV counseling and testing are provided for those who seek to know their HIV status (as in traditional VCT) or as indicated in other contexts (e.g., STI clinics). Counseling and testing in the context of preventing mother-to-child transmission is coded under MTCT.

TREATMENT

10. HIV/AIDS treatment/ARV drugs (HTXD) – including distribution/supply chain/logistics, pharmaceutical management and cost of ARV drugs.

11. HIV/AIDS treatment/ARV services (HTXS) – including infrastructure, training clinicians and other providers, exams, clinical monitoring, related laboratory services and community-adherence activities. Clinical monitoring and management of opportunistic infections is classified under palliative care (HBHC or HVTB).
12. Laboratory infrastructure (HLAB) – development and strengthening of laboratory facilities to support HIV/AIDS-related activities including purchase of equipment and commodities, provision of quality assurance, staff training and other technical assistance. Specific laboratory services supporting testing (e.g., under HVCT, MTCT or HMBL), palliative care (HBHC and HVTB) and treatment (HTXS) should be included under the codes for those activities.

OTHER

13. Strategic information (HVSI) – development of improved tools and models for collecting, analyzing and disseminating HIV/AIDS behavioral and biological surveillance and monitoring information; facility surveys; other monitoring and health management information systems; assisting countries to establish and/or strengthen such systems; targeted program evaluations (including operations research); developing and disseminating best practices to improve program efficiency and effectiveness; planning/evaluating national prevention, care and treatment efforts; analysis and quality assurance of demographic and health data related to HIV/AIDS; testing implementation models, e.g., to support the development or implementation of Global Fund proposals. Related training, supplies and equipment are included.
14. Other/policy analysis and system strengthening (OHPS) – other HIV/AIDS-related activities to support national prevention, care and treatment efforts. This includes strengthening national and organizational policies and systems to address human resource capacity development, stigma and discrimination, and gender issues; and other cross-cutting activities to combat HIV/AIDS including activities to support the implementation of Global Fund programs.
15. Management and staffing (HVMS) – costs of supporting USG mission staff to manage, support and administer HIV/AIDS programs including related training, salaries, travel, housing and other personnel-related expenses. Implementing agency/grantee staffing costs are coded under the appropriate functional category rather than under HVMS.

Appendix 13   REQUIRED INDICATORS/TARGETS BY PROGRAM AREA

Prevention of Mother-to-Child Transmission

Number of service outlets providing the minimum package of PMTCT services according to national and international standards

Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results

Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting

Number of health workers trained in the provision of PMTCT services according to national and international standards

Prevention/Abstinence and Being Faithful

Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful

Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of the total reached with AB)

Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful

Prevention/Medical Transmission/Blood safety

Number of service outlets carrying out blood safety activities

Number of individuals trained in blood safety

Prevention/Medical Transmission/Injection Safety

Number of individuals trained in injection safety

Prevention/Other

Number of targeted condom service outlets

Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful

Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful

Palliative Care: Basic Health Care & Support

Number of service outlets providing HIV-related palliative care (excluding TB/HIV)

Number of individuals provided with HIV-related palliative care (excluding TB/HIV)

Number of individuals trained to provide HIV palliative care (excluding TB/HIV)

Palliative Care: TB/HIV

Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting

Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease

Number of HIV-infected clients given TB preventive therapy

Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed)

Orphans and Vulnerable Children

Number of OVC served by OVC programs

Number of providers/caretakers trained in caring for OVC

Counseling and Testing

Number of service outlets providing counseling and testing according to national and international standards

Number of individuals who received counseling and testing for HIV and received their test results

Number of individuals trained in counseling and testing according to national and international standards

HIV/AIDS Treatment/ARV Services

Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)

Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)

Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)

Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)

Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)

Laboratory Infrastructure

Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests

Number of individuals trained in the provision of laboratory-related activities

Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring

Strategic Information

Number of local organizations provided with technical assistance for strategic information activities

Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)

Other/policy analysis and system strengthening

Number of local organization provided with technical assistance for HIV-related policy development

Number of local organization provided with technical assistance for HIV-related institutional capacity building

Number of individuals trained in HIV-related policy development

Number of individuals trained in HIV-related institutional capacity building

Number of individuals trained in HIV-related stigma and discrimination reduction

Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment

Appendix 14   EMPHASIS AREAS

Emphasis areas for Program Areas 1 thru 12 and 14

- **Commodity Procurement**
  This category is limited to the actual purchase of pharmaceuticals, diagnostics, medical equipment, medical commodities and supplies needed to provide care and treatment of persons with HIV/AIDS and related infections. This includes the actual ordering, purchase, shipment and delivery of the full range of HIV/AIDS related pharmaceuticals, diagnostics and other medical commodities.

- **Community Mobilization/Participation**
  Activities that create community commitment and involvement in achieving Emergency Plan goals. This includes, but is not limited to: involvement of community groups (for example religious leadership or PLWHAs) in program planning and mobilization of community resources, peer education, education of local media and support groups.

- **Development of Network/Linkages/Referral Systems**
  Activities that support the development and implementation of linkages and coordination between health service delivery institutions, program areas, and geographical areas, both vertically and horizontally, to increase efficiency and eliminate duplication. This includes geographical expansion and strengthening of coverage of organizations that own, operate and manage health service delivery networks.

- **Health Care Financing**
  Activities designed to broaden access to HIV/AIDS related services through mechanisms that ensure stable and effective short and long term health care financing. Examples include: medical aid (health insurance) schemes, community-based health care financing, national health accounts and franchising schemes to provide free or discounted TB, OI and ARV drugs.

- **Human Resources**
  Activities that help meet immediate and short-term workforce requirements through innovative approaches to recruitment, retention, deployment and rewarding of quality performance of health care workers and managers. In addition, long-term human resource requirements should be addressed through workforce assessments and policy and planning activities. Included in this category is the direct payment of salaries for health care workers, excluding government health care workers, for whom the USG cannot directly pay salaries.

- **Information, Education and Communication**
  Activities involving the development, dissemination, and evaluation of linguistically, culturally, and age appropriate materials supporting Emergency Plan Goals. This could include, but is not limited to, curricula and training manuals, job aids, brochures, pamphlets, handbooks, posters, newspaper or magazine articles, comic books, TV or radio shows or spots, songs, dramas, puppet shows or interactive theatre.

- **Infrastructure**
  Activities that involve construction, renovation, leasing, procurement (equipment, supplies, furniture, vehicles), overhead and/or installation needed for the implementation of Emergency Plan Programs.

- **Linkages with Other Sectors and Initiatives**
  This category includes HIV activities that are programmed through/linked with other sectors and Presidential Initiatives, for example in education, food, microfinance, democracy and governance etc. This could include, for example school fees and uniforms for HIV OVCs, microcredit programs for PLWHAs, nutritional supplements for PLWHAs and activities that support the rights of PLWHAs. Ideally activities in this category will reflect co-funding from resources from other sectors, for example USDA food monetization programs, the Africa Education Initiative and other health programs such as family planning, child survival, safe motherhood, malaria and TB.

- **Local Organization Capacity Development**
  Strengthening the ability of key local institution's to implement HIV/AIDS programs efficiently with diminishing reliance, over time, on external technical assistance. This includes activities to improve the financial management, human resource management, MIS, quality assurance, strategic planning, and leadership and coordination of partner organizations.

- **Logistics**
  Activities that involve the support systems for pharmaceuticals, diagnostics, medical equipment, medical commodities and supplies needed to provide care and treatment of persons with HIV/AIDS and related infections. This includes the design, development and implementation of improved systems for forecasting,

procurement, storage, distribution, and performance monitoring of HIV/AIDS pharmaceuticals, commodities and supplies.

- **Needs Assessment**
Activities designed to identify baseline information and provide recommended actions for program implementation and/or progress.

- **Policy and Guidelines**
Activities that involve the development, dissemination and implementation of policies, guidelines and protocols for treatment, care, prevention and strategic information. This may range from high level policies such as those relating to stigma, gender and other issues as they affect care and prevention, through specialized areas such as, scientific protocols, counseling or nutritional guidelines, administrative procedures, etc.

- **Quality Assurance and Supportive Supervision**
Activities that assure the development, implementation and/or maintenance of proper standards for the delivery of services under the Emergency Plan, including: use of best practices and evidence-based approaches. In addition, this should include supportive supervision (monitoring, guidance, oversight and mentoring through site visits, technical assistance and performance evaluation) and periodic review by regulatory bodies and funding entities.

- **Strategic Information (M&E, IT, Reporting)**
Activities designed to ascertain direction and ultimate achievement of Emergency Plan goals, including: measurement of program progress; provision of feedback for accountability and quality; surveillance; provision of targeted programmatic evaluation; and, implementation/upgrade of information management systems.

- **Training**
Activities that impart skills, knowledge, and attitudes to individuals, groups or organizations [HCWs, PLWHAs, women's groups, laboratory personnel, community leaders, political leaders], to enhance their ability to provide quality HIV/AIDS services that are responsive to clients' needs. This includes in-service training and continuing education delivered through a variety of modalities such as workshops, distance learning, on-the-job training, mentoring, etc. Support for building specific skill areas should also be included here, for example, strengthening interpersonal communication, improving laboratory skills, nutritional education for PLWHAs and their families, etc. Activities to strengthen or expand pre-service education, such as curriculum development or faculty training, are also included in this category.

- **Workplace Programs**
Activities, which promote private business, public employers, unions, and professional associations (teachers, farmers, fishermen, coffee growers etc.) to provide HIV/AIDS care, treatment and prevention for their members, employees and family members.

Emphasis Areas for Program Area 13: Strategic Information

- **AIS, DHS, BSS or other population survey**
Funds used to support any population-based survey that collects behavioral data, HIV service data, and HIV prevalence/incidence data.

- **Facility survey**
Funds used to support any facility-targeted data collection using survey methods. Examples include Service Availability Mapping (SAM), Service Provision Assessment (SPA), and Facility Audit for Service Quality.

- **Health Management Information Systems (HMIS)**
Funds used to establish or support the system necessary to collect, report, analyze, and use routine patient or facility data. This can include but is not limited to consultation/technical assistance, policy development, system assessment, requirements gathering, consensus workshops, form design and distribution, data reporting and flow, software design, training clinic and district staff, hiring data clerks, data entry, data analysis and dissemination, data management and quality assurance.

- **HIV Surveillance Systems**
Funds used to establish or maintain the infrastructure necessary to support ongoing HIV surveillance activities. This can include but is not limited to laboratory capacity for serological diagnosis of HIV, ANC sentinel surveys, assessments of AIDS case reporting systems, STI surveillance, TB drug resistance surveillance, ARV drug resistance surveillance, HIV incidence pilots, and data analysis.

- **Information Technology (IT) and Communications Infrastructure**
Funds used to establish or support the infrastructure necessary to support routine data collection and use at every level of the Emergency Plan, or to support routine IT-related operation of USG facilities. This can include but is not limited to hardware, software, local/wide area networks, internet connectivity, software

development and maintenance, trainings for hardware or software use, user support desks and documentation, system security.

- **Monitoring**, **evaluation**, **or reporting (or program level data collection)**
  Funds used to establish or support the system(s) necessary to collect, analyze and use routine program data that is not facility based, for example OVC, community based care, or BCC interventions. This can include but is not limited to assessments, consensus workshops, form design, data flow design, training program staff.
- **Proposed staff for SI**
  Funds used to hire USG staff dedicated to Strategic Information.
- **Targeted evaluation**
  Funds used to support a study that answers a research or evaluation question. Some indicators that the study should be considered a targeted evaluation are: PEPFAR program is the study site; Clients served by PEPFAR program are the study population; Study attempts to explain if, how, or why a PEPFAR program is working; Study attempts to demonstrate the replicability of a PEPFAR program; Study attempts to determine the extent to which patient expectations, professional health standards, or other quality criteria are met through services delivered at a PEPFAR site; Study attempts to establish whether the PEPFAR program costs yield desired results.
- **USG database and reporting system**
  Funds used to establish or maintain a system that supports planning and reporting for all USG activities. HIV/AIDS programs are encouraged to implement country-specific solutions for their program data collection and management needs.
- **Other SI Activities**

Appendix 15   KEY LEGISLATIVE ISSUES

Gender

Activities aimed at addressing the norms of women's and men's behaviors and inequalities between men and women that increase the vulnerability to and impact of HIV/AIDS. There are 5 specific subcategories for gender:

1. Increasing gender equity in HIV/AIDS programs – activities include: collecting data to show breakdown of women and men receiving prevention activities, treatment, and care services; developing strategies to ensure that an equitable number of women are receiving treatment; developing and supporting strategies to reach equitable number of women and men, such as community education to support treatment for women, comprehensive workplace policies, and costing schemes that account for economic constraints; mitigating burden of care on women and girls by linking care programs with community efforts that provide resources such as food/school expenses, household help, farm labor and child care; developing/supporting policies to increase access to information, services, and care for women and girls; partnering with women's organizations in the design and implementation of programs and policies.

2. Male norms and behaviors – activities include: supporting counseling, peer education and community interventions with messages that challenge norms about masculinity, the acceptance of early sexual activity and multiple sexual partners for boys and men, and transactional sex.

3. Reducing violence and coercion – activities include: mobilizing communities to address norms/behaviors re to cross-generational and transactional sex; supporting workplace and school-based programs for the prevention of violence; training health care providers and peer educators to identify, counsel and refer victims of sexual abuse and violence; within PMTCT/VCT programming, providing training on couple counseling, risk assessment, and stigma reduction; supporting women to mitigate potential violence or other negative outcomes of disclosure; supporting activities and policies to strengthen sanctions against sexual and physical violence.

4. Increasing women's access to income and productive resources – activities include: linking care and support programs to income generation activities and microfinance programs for women; supporting initiatives to ensure that children and adolescents, especially girls, stay in school and are trained in vocational skills; working with governments to develop policies that increase women's access to economic resources.

5. Increasing women's legal rights – activities include: working with governments and NGOs to eliminate gender inequalities in the civil and criminal code; working with governments and NGOs to promote and enforce inheritance rights; linking HIV programs with community efforts to provide children and families with legal assistance to protect property rights and ensure protection from abuse.

For additional guidance about Gender, please contact Daniela Ligiero at OGAC (ligieroDP@state.gov).

Wrap Arounds

Activities aimed at supporting linkages between HIV/AIDS and other sectors. These activities would reflect some co-funding by sources other than HIV/AIDS funding. There are 4 subcategories for wrap arounds:
1. Food – activities related to increasing food and nutritional resources for HIV affected and infected individuals.
2. Microfinance/Microcredit – activities related to increasing access for HIV affected and infected individuals to income generation.
3. Education – activities related to increasing the educational access of OVCs or other HIV affected and infected individuals.
4. Democracy & Government – activities related to increasing HIV affected and infected individuals access to and participation in government.
5. Other – example, refugees, gender, reproductive health, etc.

Stigma and Discrimination

All activities that work to reduce either the stigma associated with HIV status, or that work to reduce the discrimination faced by individuals with HIV or AIDS and their family members.

Twinning

All activities that use Emergency Plan funds to support on-going or new formal partnerships to strengthen capacity of organizations, called twinning partnerships, whether through the Twinning Center; through south-south partnerships; or through individual projects/programs - should be tagged as "twinning".

Twinning partnerships are considered to be substantive, long-term, formal partnerships and, if facilitated by the Twinning Center, that are accompanied by a signed agreement among the US team, the MOH and the twinning organization and contribute to building sustainable capacity building. Twinning is not just collaboration or a contractual relationship between two parties where technical assistance is provided.

If you want a Twinning Partnership your budget allocation should include only travel and logistics for the US twin and if needed for the in-country twin. US twinning organizations work on a voluntary basis and therefore do not require large overhead or salary.

A twinning partnership also makes use of volunteers who will work within the partnership. That is, volunteers from the United States, which will be identified and recruited from various sources and placed by the Twinning Center, will be used by the partnerships for enhancement of service delivery, on-site training, systems development, and in other ways to enhance the ability of country institutions to provide services. For further information on making twinning arrangements, contact Robert Soliz (rsoliz@hrsa.gov).

Volunteers

This relates exclusively to US-based volunteers. In addition to activities for which there is involvement of Peace Corps volunteers, activities that use Emergency Plan funds to support the recruitment and placement of US-based volunteers within twinning partnerships or for other short-term technical assistance programs, should be checked as "volunteer" activities. Activities that use local volunteers (i.e., community-based volunteers) should not be tagged under this label. This distinction is not being made due to any disparagement of local or community-based volunteers. However, the intention of the legislation was to increase the use of US-based volunteers and/or resources in addressing many of the short-

term human capacity issues in the focus countries. Therefore, we are required to capture the information on US-based volunteers only.

Appendix 16   TARGET POPULATIONS

General population

□ Infants
□ Children and youth (non-OVC)
   □ Girls
   □ Boys
   □ Primary school students
   □ Secondary school students
   □ University students
□ Adults
   □ Men (including men of reproductive age)
   □ Women (including women of reproductive age)
□ Family planning clients
□ Pregnant women

People affected by HIV/AIDS

□ Orphans and Vulnerable Children
□ People living with HIV/AIDS
   □ HIV positive pregnant women
□ HIV/AIDS-affected families
□ HIV positive infants (0-5 years)
□ HIV positive children (6-14 years)
□ Caregivers (of OVC and PLWHAs)
□ Widows/widowers

Special populations

□ Disabled populations
□ Most at risk populations
   □ Commercial sex workers
   □ Discordant couples
   □ Injecting drug users
   □ Men who have sex with men
   □ Military personnel
   □ Mobile populations
      □ Migrants/migrant workers
      □ Refugees/ internally displaced persons
      □ Truck drivers
   □ Out-of-school youth
   □ Partners/clients of CSW
   □ Prisoners
   □ Seafarers/port and dock workers
   □ Street youth
   □ Transgender individuals

USG staff

□ USG in-country staff
□ USG headquarters staff

Community

□ Business Community/private sector
   □ Factory workers
□ Brothel owners
□ Community leaders
□ Religious leaders
□ Program managers
□ Volunteers

Host country government workers

□ Host country government workers
   □ Policy makers
   □ Teachers
   □ National AIDS control program staff
   □ Other MOH staff (excluding NACP staff and health care workers described below)

Health care providers

□ Public health care workers
   □ Doctors
   □ Laboratory Workers
   □ Nurses
   □ Pharmacists
   □ Traditional Birth Attendants
   □ Traditional healers
   □ Other health care workers
□ Private Health care workers
   □ Doctors
   □ Laboratory Workers
   □ Nurses
   □ Pharmacists
   □ Traditional Birth Attendants
   □ Traditional healers
   □ Other health care workers

Groups/Organizations

□ Community-based organizations
□ Faith-based organizations
□ Non-governmental organizations/private voluntary organizations
□ Implementing organizations (not listed above)
□ Country coordinating mechanisms
□ International counterpart organizations

Appendix 17   STAFFING MATRIX

EXISTING STAFF (Positions as of September 30, 2005)									
	USDH/FTE			FSN/PSC/ LES	USPSC/ Contractors	Number of OE Funded Staff	Number of Program Funded Staff	TOTAL NUMBER STAFF	Of Total – Number Working 100% on EP
	Number of OE Funded	Number of Program Funded	Total Number of USDH/FTE	Number	Number				
	a	b	a+b	c	d	e	f	e+f	
1. Technical Leadership/ Management									
2. Technical Advisors – Non M&S Staff									
3. Technical Advisors/ Program Managers									
4. Contracting Staff									
5. Financial/ Budget Staff									
6. Administrative/ Support Staff									
NEW STAFF (Positions Requested for FY 2006)									
	USDH/FTE			FSN/PSC/ LES	USPSC/ Contractors	Number of OE Funded Staff	Number of Program Funded Staff	TOTAL NUMBER STAFF	Of Total – Number Working 100% on EP
	Number of OE Funded	Number of Program Funded	Total Number of USDH/FTE	Number	Number				
1. Technical Leadership/ Management									
2. Technical Advisors – Non M&S Staff									
3. Technical Advisors/ Program Managers									
4. Contracting Staff									
5. Financial/ Budget Staff									
6. Administrative/ Support Staff									

Staffing Table

The table is divided into rows by type of staff position: existing vs. new staff. Please specify the number of positions in the appropriate columns. No person/position is to be counted more than once and one person/position cannot count as more than 100% time. Only include positions that devote more than 50 percent of their time to the Emergency Plan. More instructions are included below along with definitions.

Existing Staff: Please include all existing staff, <u>which includes approved vacant positions</u> as of September 30, 2005.

New Staff: Please include any requested new staff positions for FY 2006. In addition, for USAID include those positions that should be financed from the COP budget, specifically those positions previously funded by USAID/Washington including:
- the five positions that have been previously funded by program to OE funds; i.e., Holly Fluty Dempsey (Ethiopia), Polly Dunford (Nigeria), Linda Lou Kelley (Mozambique), Marie McLeod (South Africa), and Rene Burger (Tanzania); and
- the 29 field positions, as referenced in the following cable from Ambassador Tobias: UNCLAS STATE 026657, (further guidance/ instructions on these 29 positions will be forthcoming from USAID/Washington).

Staffing Categories

Technical Leadership/Management: Include in this row those positions that head up the health/HIV team within the agency; e.g., Health Officer, 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 overseas all USG 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. DH Foreign Service officer filling an HIV/AIDS advisor position and thereby leading an HIV/AIDS team would also be placed in this category.

Technical Advisors—Non Management and Staff: Include the technical staff within the health/ HIV team who spend most of their time implementing programs in technical areas. These are the positions allocated to specific program areas such as laboratory. These positions are not financed out of the Management and Staffing budget.

Technical Advisors / Program Managers: Include the technical staff within the health/HIV team who spend most of their time managing programs or who work in more than two program areas, e.g. Cognizant Technical Officers (CTOs), or Project Officers (POs). These positions are financed out of the Management and Staffing budget.

Contracting: Contracting staff includes contracting officers as well as other staff who support a contracting officer or office. A contracting officer is a person representing the U.S. Government through the exercise of his/her delegated authority to enter into, administer and/or terminate contracts and make related determinations and findings. Contracting Officers usually support an entire agency in country or will support an entire

regional portfolio. If the agency utilizes the contracting officer services of another agency, include the position only in the other agency's table.

Financial / Budget: These positions include the "accountant" and "budget person" for the agency. These staff support financial and budget analysis and financial operations functions.

Administrative / Support: Include any secretarial, programmatic support positions within the health/HIV team, and other support positions (e.g., non-health/ non-HIV HIV staff which could include drivers who provide support to the health/HIV team). Only include those staff working most of their time supporting the Emergency Plan.

US Direct Hire (USDH) / Full Time Equivalent (FTE): USDH/ FTE are US citizens employed under the general schedule (Civil Service) and excepted service (non-career, Foreign Service Limited or Foreign Service).

OE funded: Refers to Operating Expense funds. These are funds that can only be used to pay for an agency's administrative expenses (i.e., rent, staff salaries, etc). Not all agencies pay for U.S. direct hires out of OE funds. Some agencies will list <u>most</u> of their U.S. direct hire staff in this row (i.e., USAID—with the exception of FSLs and the staff positions previously paid for by USAID/Washington listed above), other agencies will list no staff here (i.e., CDC), but will instead list staff under USDH/ FTE, number of program funded column.

Program funded: These are funded positions that are paid for from a specific program appropriation, for example GHAI (Global HIV/AIDS Initiative), GAP (Global AIDS Program) or CSH (Child Survival and Health).

FSN—Foreign Service National,
LES—Locally Employed Staff, **and**
Locally hired PSC: These are positions are typically filled by non-U.S. citizens and can include persons from the host country or third country nationals. These positions can be classified as either direct hire FSN, PSC, or LES. They can be funded either out of OE or Program funds. Please include the total number of staff who are FSN, locally hired PSC, and LES.

USPSC / Contractors: US Personal Services Contractors (USPSC) are filled by US Citizens and can be funded either out of OE or program funds. Please include the total number of staff who are USPSC or Contractors in this column.

Number of OE Funded Staff: This column should include the total number of OE funded staff from the USDH/FTE, FSN/PSC/LES and USPSC/ Contractors.

Number of Program Funded Staff: This column should include the total number of program funded staff from the USDH/FTE, FSN/PSC/LES, and USPSC/Contractors.

Total Number of Staff: This number is to include all positions that will exist as of September 30, 2005. Each part-time position is counted as one. Only include positions that devote more than 50 percent of their time to the Emergency Plan.

Of Total—Percentage Working 100 percent on the Emergency Plan: Of the Total Number of Staff, please indicate the number of staff who work full-time on the Emergency Plan.

Appendix 18   MANAGEMENT & STAFFING BUDGET TABLE

AGENCY:

	GHAI	GAP	**TOTAL**
Personnel, office rent, etc			
PEPFAR ICASS Code			
Capital Security Sharing			
IRM tax (USAID only)			
TOTAL			

Appendix 19   LIST OF ITEMS FLAGGED BY THE QUALITY ASSURANCE REPORT

Country Contacts
- Do you have contacts for all 5 required USG Agencies – US Embassy, HHS/CDC, USAID, DoD, Peace Corps?

Executive Summary
- Has the Executive Summary been uploaded?

Table 1
- Has the question been answered?
- If yes, has narrative been included?

Table 2
- Are targets included for all indicators, both direct and indirect?

Table 3.1
- Is the unallocated funding requested less then 5% of GHAI funding?
- Is the total funding requested for each funding source within the allowed ceiling?

Table 3.2
- Does funding for a specific sub-partner exceed funding requested for the prime partner?
- Is there at least one program area box checked for each sub-partner?

Table 3.3
- Is the AB funding greater than or equal to 66% of Sexual Prevention (AB + Other Prevention)?
- Is the OVC funding greater than or equal to 10% of the Prevention, Care & Treatment total?
- Is the M&S funding greater than 7% of the total budget?
- Does each of the required indicators have a target?
- Was each item that was imported from the FY05 COP updated?

Table 5
- Is there an answer to each of the questions included in Table 5?

Appendix 20   TIMELINE FOR FY06 COP PROCESS

Activity	Timing
All Countries	
Final COP Guidance and Partner Data Collection Sheets Distributed	Week of June 20th
Partnership Consultations on COP Activities	April – August
Pilot Testing of Enhanced COPRS	June 20th – 24th
FY06 COP Training for Core Team Members – DC	June 27th – 28th July 19th – 20th
Regional & In-Country Training for Enhanced COPRS	July 5th – August 26th
Technical Assistance – TWGs	April 1st – August 12th
Technical Assistance – Program	July 1st – September 23rd
MOAs Prepared to Transfer Funding from 1st Congressional Notification	November 14th – December 2nd
Transfer Early Request Funding	December 5th
Preparation of 2nd Congressional Notification with COP Approved Funding	January 2nd – January 20th, 2006
FY07 Congressional Budget Justification Sent to Congress	January 13th, 2006
2nd Congressional Notification Sent to Congress	January 27th, 2006
MOAs Prepared to Transfer Funding from 2nd Congressional Notification	February 6th – February 24th, 2006
Transfer Approved COP Funding	February 28th, 2006
Preparation of 3rd Congressional Notification with Remaining Funding	March 20th – April 14th, 2006
3rd Congressional Notification Sent to Congress	April 21st, 2006
MOAs Prepared to Transfer Funding from 3rd Congressional Notification	May 8th – May 19th, 2006
Transfer Funding from 3rd CN	May 22nd, 2006
15 Focus Countries	
COPRS Data System Live for Data Entry – Focus Countries	**beginning July 25th**
Host Government Review and Approval	September 19th – September 29th
COP DUE TO OGAC – FOCUS COUNTRIES	**September 30th**
Data Cleaning and Feedback	October 3rd – October 14th
Distribute Documents to Reviewers	October 6th – October 14th
Preparation of 1st Congressional Notification with Early Funding Requests	October 1st – October 15th
Technical Reviews	October 17th – October 27th

Activity	Timing
Technical Reviews due to Programmatic Reviewers	October 28th
1st Congressional Notification Sent to Congress	October 28th
Programmatic Reviews	October 31st – November 4th
Prepare for Principals Review	November 7th – November 18th
Principals Reviews	November 21st – November 22nd
Approval of Memo's	November 23rd – December 15th
Send Memo's to Field	January 3rd, 2006
Deadline for Yellow-Lighted and Unallocated Funds to be Finalized	February 28th, 2006
5 New Countries	
COPRS Data System Live for Data Entry – 5 New Countries	**Beginning August 15th**
COP DUE TO OGAC – 5 NEW COUNTRIES	**December 1st**
Data Cleaning and Feedback	December 2nd – December 16th
Distribute Documents to Reviewers	December 7th – December 16th
Reviews	December 19th – December 30th
Prepare for Principals Review	January 2nd – January 13th, 2006
Principals Reviews	January 17th – January 18th, 2006
Prepare Feedback for Countries	January 19th – January 24th, 2006
Feedback to Countries	January 25th – February 3rd, 2006
Submission of Revised COPS	February 6th, 2006
Approval of Memo's	February 6th – February 17th, 2006
Send Memo's to Field	February 21st, 2006
Deadline for Yellow-Lighted and Unallocated Funds to be Finalized	March 15th, 2006

Exact dates may shift as necessary. This timeline is provided for illustrative purposes.

Appendix 21   PROCESS FOR POST SUBMISSION CHANGES TO THE COP

After formal submission, all in-country write privileges to the COP will be suspended. In-country individuals will still have access to view the COP and print reports.

It is anticipated that changes to the COP will be necessary after the formal submission takes place. These changes will happen in several phases.

First, there will be a week of COP cleaning as soon as submission takes place. The cleaning process will be headed up by the SI Unit at OGAC. This process involves reviewing the COP for common errors and consistency with the written guidance. There should be one or two people identified in each country to work with the SI Unit on any requested changes during the cleaning period.

Second, there will be discussions between the countries and the Programmatic Review teams. These discussions will be headed up by the Core Team Leaders. Any changes that need to take place will be done in consultation with the Core Team Leaders. In-country individuals will be granted write access on an as needed basis depending upon the scope of the changes required.

Third, changes that are needed after the COPs have been approved will happen in two ways. For activities that are not approved in the initial round (i.e., yellow lighted and unallocated activities), in-country individuals will have the opportunity to make changes. The approximate timing for this change period is shown in Appendix 20. For changes to activities that are approved in the first round, or in subsequent rounds, requests will need to go through your Core Team Leader. We are working on the exact process for submitting changes and will send out the final process in a news to the field email in October.

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Appendix 22   LIST OF ALL CELL NAMES AND VARIABLES

Country Contacts

Contact Type		First Name
	U.S. Embassy Contact	*Assorted*

Contact Type | **First Name**

Required
- U.S. Embassy Contact
- HHS/CDC In-Country Contact
- USAID In-Country Contact
- DOD In-Country Contact
- Peace Corps In-Country Contact

Optional
- HHS/HRSA In-Country Contact
- HHS/NIH In-Country Contact
- HHS/OS In-Country Contact
- DOL In-Country Contact
- MOH Contact
- State/PRM In-Country Contact

First Name
   Assorted

Last Name
   Assorted

Title
   Assorted

E-mail
   Assorted

Executive Summary

   N/A

Table 1

Will you be submitting changes to your country's 5-Year Strategy this year?
   Yes
   No

Please briefly describe the changes which you will be submitting.
   Assorted

Table 2

   N/A

Table 3.1

Funding Mechanism Type
   Central
   HQ
   Local
   Unallocated

USG Agency
   DoD
   DoL
   HHS/CDC
   HHS/HRSA
   HHS/NIH
   HHS/OS
   HHS/SAMHSA
   Peace Corps
   State
   USAID

Funding Source

DoD
   GAC (GHAI account)
   N/A
DoL
   GAC (GHAI account)
   N/A
HHS/CDC
   GAC (GHAI account)
   Base (GAP account)
   N/A
HHS/HRSA
   GAC (GHAI account)
   N/A
HHS/NIH
   GAC (GHAI account)
   N/A
HHS/OS
   GAC (GHAI account)
   N/A

HHS/SAMHSA
    GAC (GHAI account)
    N/A
Peace Corps
    GAC (GHAI account)
    N/A
State
    GAC (GHAI account)
    N/A
USAID
    GAC (GHAI account)
    CSH account *(for 5 new countries only)*
    ESF account *(Cambodia and India only)*
    FSA account *(Russia only)*
    N/A

Prime Partner Name

Table 3.2

Sub Partner Name
    Numerous variables
    TBD

Sub Partner Type
    FBO
    NGO
    Host Country Government Agency
    Private Contractor
    University
    Multi-lateral Agency
    Other USG Agency
    Own Agency
    Parastatal

Local Partner
    Yes
    No

Table 3.3

USG Agency/Prime Partner/Mechanism/Funding Source
    Drop down list of Table 3.1 Funding Mechanisms

Planned Funding
    Assorted

Activity Narrative
    Assorted

Indicators/Targets

Numerous variables
TBD

Prime Partner Type
    FBO
    NGO
    Host Country Government Agency
    Private Contractor
    University
    Multi-lateral Agency
    Other USG Agency
    Own Agency
    Parastatal

Local Partner
    Yes
    No

Sub Partner Program Areas
    PMTCT
    Abstinence & Be Faithful
    Blood Safety
    Injection Safety
    Other Prevention
    Palliative Care: Basic Health Care & Support
    Palliative Care: TB/HIV
    OVC
    Counseling & Testing
    HIV Treatment: ARV Drugs
    HIV Treatment: ARV Services
    Laboratory Infrastructure
    Strategic Information
    Other/Policy Analysis & System Strengthening

Varies by program area (see Appendix 13 for list)

Emphasis Areas (tables 3.3.1 – 3.3.12 & 3.3.14)
    Community Mobilization/Participation
    Commodity Procurement
    Development of Network/ Linkages/Referral Systems
    Health Care Financing
    Human Resources
    Information Education, and Communication

Infrastructure
Linkages with Other Sectors and
    Initiatives
Local Organization Capacity
    Development
Logistics
Needs Assessment
Policy and Guidelines
Quality Assurance and Supportive
    Supervision
Strategic Information
Training
Workplace Programs

Emphasis Areas (table 3.3.13)
AIS, DHS, BSS or other population
survey
Facility survey
Facility based information system or
HMIS
HIV Surveillance Systems
IT
Monitoring, evaluation, or reporting (or
program level data collection)
Proposed staff for SI
Targeted evaluation
USG database and reporting system
Other SI Activities

Key Legislative Issues
Gender
    Addressing male norms and
        behaviors
    Increasing gender equity in
        HIV/AIDS programs
    Increasing women's access to
        income and productive
        resources
    Increasing women's legal protection
    Reducing violence and coercion
Stigma and Discrimination
Twinning
Volunteers
Wrap Arounds
    Food
    Microfinance/Microcredit
    Education
    Democracy & Governance
    Other

Target Populations
General population
    Infants

Children and youth (non-OVC)
    Girls
    Boys
    Primary school students
    Secondary school students
    University students
Adults
    Men (including men of
        reproductive age)
    Women (including women of
        reproductive age)
Family planning clients
Pregnant women
People affected by HIV/AIDS
    Orphans and Vulnerable Children
    People living with HIV/AIDS
        HIV positive pregnant women
    HIV/AIDS-affected families
    HIV positive infants (0-5 years)
    HIV positive children (6-14 years)
    Caregivers (of OVC and PLWHAs)
    Widows/widowers
Special populations
    Disabled populations
    Most at risk populations
        Commercial sex workers
        Discordant couples
        Injecting drug users
        Men who have sex with men
        Military Personnel
        Mobile populations
            Migrants/migrant workers
            Refugees/ internally
                displaced persons
            Truck drivers
        Out-of-school youth
        Partners/clients of CSW
        Prisoners
        Transgender individuals
        Seafarers/port and dock
            workers
        Street youth
USG staff
    USG in-country staff
    USG headquarters staff
Community
    Business Community/private sector
        Factory workers
    Brothel owners
    Community leaders
    Religious leaders
    Program managers
    Volunteers

Host country government workers
    Host country government workers
        Policy makers
        Teachers
        National AIDS control program
            staff
        Other MOH staff (excluding
            NACP staff and health care
            workers described below)
Health care providers
    Public health care workers
        Doctors
        Laboratory Workers
        Nurses
        Pharmacists
        Traditional Birth Attendants
        Traditional healers
        Other health care workers
    Private Health care workers

Doctors
Laboratory Workers
Nurses
Pharmacists
Traditional Birth Attendants
Traditional healers
Other health care workers
Groups/Organizations
    Community-based organizations
    Faith-based organizations
    Non-governmental
        organizations/private voluntary
        organizations
    Implementing organizations (not
        listed above)
    Country coordinating mechanisms
    International counterpart
        organizations

Coverage Area
    Varies by country

Table 5
_____
    N/A

Appendix 23   RELATIONSHIP MAP OF TABLE 3

The diagram here is provided in an attempt to show the relationships between information in Table 3. It outlines how the pieces of information requested in Table 3.3 relate to each other and how Table 3.1 and Table 3.2 link to Table 3.3.
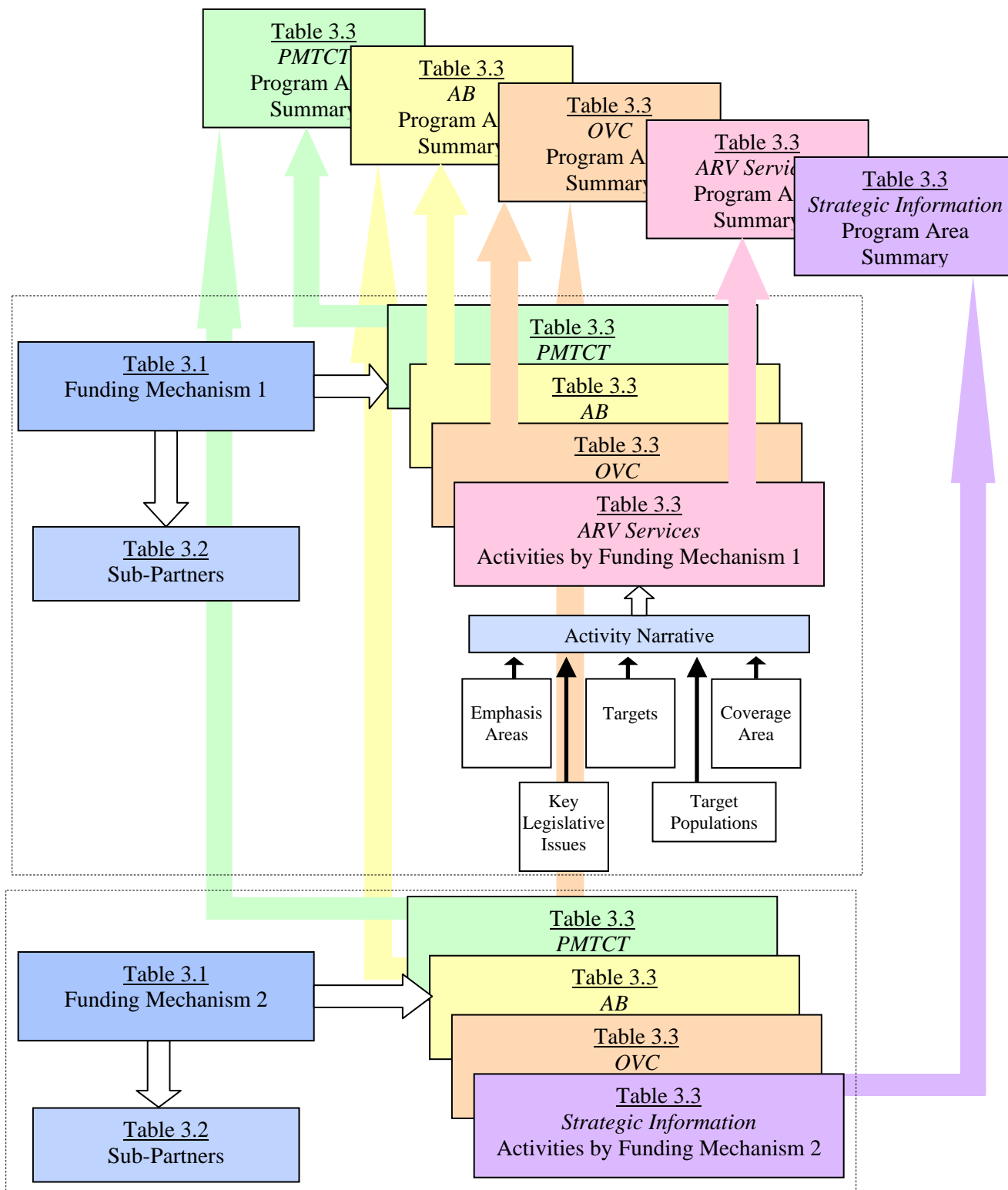
Appendix 24   AVAILABLE REPORTS FROM COPRS

- Quality Assurance Report – This report checks for a predefined list of errors in the COP.

COP Reports
- COP Template – This gives you a Word version of the COP tables that can be used for data collection.
- Partner Data Entry Forms – These forms can be used to collect data from partners.
- Populated Printable COP – This print out provides the full version of what has been entered into the data system to date. It can be converted to Word, RTF or PDF files. It will run the live, "up to the minute" data.
- Inputted COP without Budget Amounts – This print out provides the full version of what has been entered into the data system to date, without budget numbers included. It can be converted to Word, RTF or PDF files. It runs the live, "up to the minute" data.
- COPs by Section
- COP Report by Funding Mechanism – This will give you all the information from Table 3 for a specific "funding mechanism". This will include sub-partner data entered into Table 3.2 and activity information entered into Table 3.3.

Budget Reports
- Summary Budget Report (Table 4)
- Budget Summary – This table shows the amount of funding requested, by USG Agency and by Funding Source, for the selected country.
- Budget Request by Program Area – This table shows the total amount requested for each program area and the percentage of Total funds for that program area, for the selected country.
- Budget request and % of budget for management by country – This table shows the requested amount of the budget for the Management and Staffing program area and the percentage of the Total budget for Management and Staffing.
- Request by Funding Source – This table shows the requested amount by funding source, for the selected country.
- Amounts of request by USG agency and country – This table shows the requested amount by USG Agency and Country.
- Request by Partner Type, by country: All, Prime, Sub – This table shows the requested amount by Partner type, for the selected country.

Program Summary Reports
- Estimated 2006 progress toward 2008 treatment target by country – This table shows the 2006 total treatment target, the 2008 treatment target and the percent of the 2008 target that will be reached by the end of FY07, by country.
- Estimated 2006 progress toward 2008 care target by country – This table shows the 2006 total care target, the 2008 care target and the percent of the 2008 target that will be reached by the end of FY07, by country.
- Summary Program Level Targets Report – This report will let you print out the summary program level targets for each program areas.
- Amount of request by partner and country – This table shows the requested amount for each prime partner, for the selected country.

- Program Areas for Sub-Partners – This report gives a listing of each program area and all sub-partners working in that program area.
- Partner Summary – This table shows various partner data for the selected country, including total number of partners, number of prime partners, number of sub-partners, number of new partners, number of FBO partners, number of local partners, etc.

Ad Hoc Searches
- Partners by budget
- Activity Narratives by funding mechanism and prime partner
- Activity Approval Status Report – This report allows the user to view all or select activities, by approval status with several sort options (by USG Agency, by program area, by funding mechanism).
- COP Comment Report – This report will print out all of the Comments that have been added to the COP.
- Early Funding Request Report – This report will print out all of the activities which have been selected for early funding, with amounts and descriptions.

Miscellaneous Reports
- Printable COP Annex 2: Partner Names (online report) – This report prints a list of ALL active partners listed in the COPRS system. This is NOT a report of partners receiving funding in any time period.
- List of Sub-Partners, with Funding Amounts, by Sub-Partner or by Prime Partner – This table gives a listing of all of the sub-partners, with funding amounts. You can choose to have the list sorted either by Sub-Partner (which will show you when sub-partners are being funded under several funding mechanisms/prime partners) or by Prime Partner (which will show you all of the sub-partners funded under a specific funding mechanism/prime partner).
- Country-Specific Emergency Plan Targets for Total USG Support – This table gives a comparison of FY2004 targets, FY2005 targets, FY2006 targets and the increase each year.
- Program Level Targets Summary Report – This report summarizes the targets for each activity in each program area, or for each program area by USG agency, or for each prime partner by program area.
- Summary Program Area Report – This report has each activity (with just funding mechanism name, prime partner, and amount) within each program area by each agency or by program area.
- Coverage Area Report – This report lists each province/state in the country and all activities by funding mechanism (with funding mechanism name, USG Agency, prime partner and amount) selected as working in that coverage area.

Appendix 25   EXAMPLES

Appendix 25.1   CONGRESSIONAL NOTIFICATION FORMAT

ETHIAMIBIA

Project Title: **Ethiamibia FY 2006 Country Operational Plan (COP)**

Budget Summary:

Receiving Agency	Funding Sources		
	GAP*	GHAI	TOTAL
HHS	1,500,000	13,076,272	14,576,272
USAID	0	19,318,725	19,318,725
DOD	0	1,137,278	1,137,278
State	0	97,841	97,841
Peace Corps	0	559,672	559,672
TOTAL REQUEST	1,500,000	34,189,788	35,689,788

*The Global AIDS Program of HHS/CDC

HIV/AIDS Epidemic in Ethiamibia:
- HIV Prevalence in Pregnant Women: 22% (2002 National HIV Sentinel Survey)
- Estimated Number of HIV-infected People: 230,000 (UNAIDS 2004)
- Estimated Number of Individuals on Anti-Retroviral Therapy: 4,000 (in public facilities); 3,000 (in private sector)
- Estimated Number of AIDS Orphans: 93,000 (estimates from MWACW)

Targets to Achieve 2-7-10 Goals:

Ethiamibia	Individuals Receiving Care and Support	Individuals Receiving ART
End of FY 2004*	33,000	4,000
End of FY 2005		
End of FY 2006	93,710	7,750
End of FY 2008	115,000	23,000

*"Bringing Hope and Saving Lives: Building Sustainable HIV/AIDS Treatment"
The President's Emergency Plan for AIDS Relief Report on Current Activities Underway to Expand Treatment for HIV/AIDS
Submitted by the Office of the U.S. Global AIDS Coordinator, U.S. Department of State, August 2004

Program Description:

Ethiamibia is facing its most critical health, development and humanitarian crisis to date. An estimated 15.6% of the adult population is infected with HIV (18% of adult women and 13% of adult males); 920,000 Ethiamibian adults and 90,000 children are living with HIV/AIDS in a total population of 10 million people. The repercussions of the HIV/AIDS epidemic continue to loom over the nation with 750,000 individuals having died from AIDS to date, leaving behind an

estimated 630,000 orphans, and the continuing loss of 89,000 persons from AIDS every year (UNAIDS, 2004).

Although Ethiamibia's HIV/AIDS epidemic is mostly transmitted through heterosexual contact and from mother to child, there are clearly identifiable high-risk groups that warrant special attention: commercial sex workers and their clients and partners; uniformed personnel including military and police forces; long distance truck drivers; bus drivers; fish camp traders; migrant workers; and discordant couples. Discordant couples, where one partner is sero-positive and the other is sero-negative, are estimated to make up 21% of all married couples. Deployments and long separations from their families place members of the Ethiamibian Defense Force (EDF) at high risk for exposure to HIV. Orphans and Vulnerable Children (OVCs) are particularly vulnerable to property-grabbing, homelessness, sexual exploitation, violence, abuse, and a life of abject poverty. Youth are another high-risk group, with 11.2% of females aged 15-24 years and 3.0% of males in the same age group being HIV positive, resulting from an early age of sexual debut (mean age of 17.0 years) and multiple sexual partners. Since 1985, the number of TB cases has increased dramatically. It is estimated that over 50% of TB/HIV cases are co-infected.

Emergency Plan funding will be focused on the following programmatic areas to achieve the 2-7-10 targets:

Prevention: $10,442,128

Prevention activities in Ethiamibia include prevention of mother-to-child transmission (PMTCT), abstinence and faithfulness programs, blood and injection safety, and other behavioral prevention initiatives, including those that focus on high-risk populations. In FY 2006, USG will partner with GOE to strengthen the scope, quality and sustainability of PMTCT services. The USG will continue to support technical capacity-building in the MOH, support technical and managerial training for PMTCT staff (110 health workers trained by March 31, 2007) and will build the capacity of FBO/CBO/NGOs to deliver high-quality, sustainable PMTCT services, including support to 500 HIV-positive women and their children. Finally, the USG will support community mobilization and IEC activities to increase awareness of and demand for PMTCT services.

The USG will continue to support high-quality behavioral change programs, including life skills programs for school youth and media-based behavior change communication programs. In FY 2006, the USG will strengthen its ongoing activities, including training youth groups, schools and faith-based organizations for effective prevention efforts in ways to reach youth and deliver messages about abstinence, and training field officers to inform, educate, and mobilize communities. Through these efforts, the USG expects to reach 10,000 young people by March 2007.

Efforts to reduce new infections among high-risk or high-transmitter groups (such as uniformed services, mobile populations, and migrant workers), including the USG-supported national behavior change communication program and condom social marketing, will be expanded and targeted to locales where high-risk activities take place. The USG will target 8,000 individuals through these mass media prevention programs.

Finally, in order to strengthen systems for blood collection, testing, storage and handling, the USG is providing financial and technical support to strengthen GOE policies and systems, to strengthen human capacity, and to provide essential supplies and equipment for blood testing in 35 service outlets by March 2007. These activities are supported through Central Program funding.

Principal Partners: Academy for Educational Development (AED), AXIOM, Ethiamibia Defense Force, Educational Development Center, Harvard School of Public Health, John Snow Incorporated, International Training and Education Center (I-TECH), Ministry of Health (MOH), Ministry of Education (MOE), National AIDS Coordinating Agency (NACA), Safe Blood For Africa, University of Medicine and Dentistry of New Jersey, Youth Health Organization (YOHO).

Care: $13,641,316

Care activities in Ethiamibia include counseling and testing (CT), basic palliative care, support to integration of TB and HIV programs, and support for orphans and vulnerable children (OVC). The CT strategy for 2006 will include deliberate and focused policy dialogue to permit routine, informed consent testing of high-risk groups, including TB and STI patients and active duty military personnel, and will increase attention to assuring quality of all voluntary and routine CT services provided.   In FY 06, a modest increase of 20 new U.S. government-initiated CT sites is planned.   The testing will result in 246,000 new clients/patients knowing their HIV status by March 2007.

Palliative care activities will comprise delivery of a "preventive care package" of services and support base to HIV positive individuals and their families, targeted to the needs of asymptomatic, symptomatic, and chronically ill/end-of-life population segments. The health center is considered the key catalyst for care, and as such will be the focus of training, technical assistance, quality assurance, and provision of clinical equipment and supplies during the 2006 COP.   At the community level, palliative care activities will include strengthening community- and faith-based organizations to promote "positive living" and to provide psychosocial, spiritual, bed nets (where appropriate), support, nutrition, and other support to individuals and families affected by HIV and AIDS.   Stigma reduction will be addressed through information, education, and communication materials targeted to health care providers, caregivers, and communities within health networks. U.S. government efforts will reach an additional 270,575 HIV positive patients with basic palliative care by March 2007.

The U.S. government will continue its collaboration with the Ministry of Health and the World Health Organization to integrate Ethiamibia's TB and HIV/AIDS programs in 23 pilot sites by March 2007.   The pilot includes provider-initiated clinical and diagnostic HIV counseling and testing for all persons with TB as part of standard TB care; screening of all HIV-infected persons for active TB disease as part of routine quality clinical care of persons infected with HIV; and establishment of a strong patient referral system between TB and HIV programs for HIV-infected persons. Based on the results of the pilot, during the 2006 COP the partners will plan for expansion beginning in FY 2007.

In the 2006 COP, the U.S. government will continue to leverage use of P.L. 480 Title II resources to provide care and support to OVCs in high-prevalence areas within U.S. government-assisted health networks, and to provide non-food subsistence, psychosocial,

spiritual, and education/skills development support to OVCs nationwide through FBOs and NGOs in U.S. government-assisted health networks. The U.S. government and key partners will continue to provide advocacy and education to the nascent OVC Task Force to promote development of guidelines, norms, and standards for OVC care and support in Ethiamibia. Activities launched under two central programming awards launched in 2004 are expected to complement these efforts.

Principal Partners: Ethiamibia Program Funding to: CDC, DOD, USAID, U.S. Department of State Office of Population, Refugees and Migration (PRM), International Rescue Committee (IRC), Johns Hopkins University Health Communication Programs (JHU/HCP), JHPIEGO, International Training and Education Center on HIV/AIDS (ITECH), IOCC, CRS, Management Sciences for Health, Save the Children Federation.

Treatment: $5,234,035

Treatment activities in Ethiamibia include the provision of antiretroviral (ARV) drug and service programs as well as laboratory support. Since January 2002, Ethiamibia has been providing free ARV treatment to PLWHAs. This program has grown to 27 treatment sites with 25,839 patients currently on treatment, and by March 2007, this number is expected to increase to 35 sites with a total of 35,000 patients on treatment. With FY 2006 funds, the USG will work with the MOH to ensure a safe and secure supply of ARVs in the country by procuring ARV drugs, installing a security system at Central Medical Stores (CMS), training CMS staff on supply chain management and quality assurance, and training Drug Regulatory Unit staff in good manufacturing practices, inspections and pharmaco-vigilance. The USG will improve HIV/AIDS treatment for children and adults, working with international technical assistance partners focusing on development of guidelines, policies, and curricula; training; and monitoring and evaluation. Treatment activities will also be carried out through Central Program funding.

To strengthen the laboratory infrastructure in Ethiamibia , the USG will work with the MOH to ensure that laboratories have increased space, improved quality assurance, well-maintained laboratory equipment, a continuous supply of reagents and an improved standard of practice among laboratory staff. The USG will increase support from 100 individuals trained in lab activities in April 2006 to 225 trained by March 2007.

Principal partners: Associated Funds Administrators/Ethiamibia, APHL, Baylor University, Georgetown University, Harvard School of Public Health, I-TECH, Ministry of Local Government, Ministry of Health, and University of Pennsylvania.

Other Costs: $8,026,708

USG support will continue to strengthen the capability of the Ministry of Health, the National AIDS Council, and other agencies, to monitor and evaluate the progress and success of Ethiamibia's national response to HIV/AIDS and of Emergency Plan achievements. These efforts will be directed at developing and implementing routine information management systems for both program reporting and patient tracking; and at ensuring the HIV/AIDS surveillance (prevalence and behavioral), population-based surveys, targeted evaluation, and policy-related analysis essential to an effective response.

Principal Partners: Ministry of Health, National AIDS Council, Ministry of Women and Coordination of Social Action, other Government of Ethiamibia agencies, Mailman School of Public Health/Columbia University, John Snow Inc., The Futures Group International, and the University of California San Francisco.

The USG is collaborating with the Ministry of Health, WHO, and other donors on a national human capacity assessment focused on health workers. Findings will inform the priority uses of the considerable USG resources provided for training and system strengthening. To help increase the number of HIV/AIDS service providers, new initiatives will expand the number of medical students specializing in HIV/AIDS treatment and set up training programs for medical technicians. FY 2006 resources also will enable the National AIDS Council to improve its technical, programmatic, and administrative management of the increasing levels of funding being mobilized for Ethiamibia's national HIV/AIDS response.

Principal Partners: Ministry of Health, National AIDS Council, Ministry of Defense, JHPIEGO, Catholic University of Ethiamibia, and the Confederation of Ethiamibian Business Associations.

Management and staffing funds will support the in-country personnel needed for USAID, HHS, State, Defense, and Peace Corps. Funds will ensure program monitoring and accountability, ensure USG policy and technical leadership within the Ethiamibia national response, and cover compensation, logistics, and office and administrative costs.

Other Donors, Global Fund Activities, Coordination Mechanisms:

The United States is the largest bilateral donor to the Ethiamibia's health sector, having provided a total of $100 million in support in 2004, the majority of which is for HIV/AIDS prevention, care and treatment. In addition to the Global Fund, other major donors include the European Union, the United Kingdom, Belgium, Netherlands, Australia, France, Sweden and Germany. The Global Fund has approved three grants from Ethiamibia, totaling $65 million over two years for AIDS and TB programs. The primary HIV/AIDS coordinating body is the Ethiamibian National AIDS Council (ENAC). In addition to working with ENAC, the USG meets regularly with key officials of individual Ministries (Health, Social Development, Treasury, Defense, Education and Correctional Services) to ensure that USG assistance complements and supports the Ethiamibian Government's plans for prevention, care and treatment.

Appendix 25.2   FISCAL YEAR 2007 FUNDING PLANNED ACTIVITIES EXAMPLE

Fredonia FY 2007 Funding Planned Activities ($56 million)

Fredonia is experiencing one of the most severe HIV/AIDS epidemics in the world, with the third-highest HIV-prevalence in Sub-Saharan Africa. UNAIDS estimates that 28% of adults 15-49 years of age are infected with HIV. In Fredonia, approximately 110,000 adults and children with HIV/AIDS will receive antiretroviral therapy (ART) and 425,000 individuals will receive care and support by September 2007 as a result of programs funded by the Emergency Plan.

Prevention activities will be scaled-up through the media, community action forums, door-to-door campaigns, and peer educator programs for high-risk groups such as the military, prisoners, police, truckers, other mobile workers, and commercial sex workers. Community interventions and media will be used to target individuals in relationships with the message to "know your status" and "be faithful." Through grants to community-based (CBO) and faith-based organizations (FBO) that work with school health clubs, youth camps, and through community outreach, more than 3 million primary and secondary school students will be reached with abstinence messages. CBOs and non-profit organizations (NGOs) also will work to increase access to HIV prevention services by supporting programs and policies to reduce stigma and discrimination and increase advocacy for People Living with HIV/AIDS. The Emergency Plan also will continue to assist in the GOF's efforts to expand access and fully integrate high quality prevention of mother-to-child transmission (PMTCT) services into routine antenatal care.

In the area of care, earlier investments in capacity building should result in the establishment of HIV/AIDS related activities in additional rural locations. Emergency Plan funds will enable the expansion of programs offering nutritional care and other support services for people living with HIV/AIDS and their households. The GOF, CBOs and FBOs will increase the provision of health services, including diagnosis and treatment of opportunistic infections, and will help people link with ART treatment sites and other services. Emergency Plan funds will be used to expand innovative counseling and testing initiatives, such as door-to-door voluntary counseling and testing (VCT), as well as increase access to routine counseling and testing services. Support will be increased to HIV/TB centers to better integrate HIV testing and treatment programs for this high-prevalence population. TB patients who are co-infected with HIV will be provided appropriate follow up for treatment with antiretrovirals (ARVs) and distribution of the basic care package. Work with orphans and vulnerable children (OVCs) affected or infected by HIV/AIDS will accelerate and programs will expand from supporting 300,000 OVCs as of October 2006 to 425,000 by September 2007.

In 2007, the Emergency Plan will continue to provide technical assistance, training, supportive supervision, and commodities to 50 hospitals and health centers in the 15 regions of Freedonia. Support from the Emergency Plan will enable the opening in 2007 of an estimated four additional antiretroviral sites. Emergency Plan funds also will be used to develop a sustainable, government-centered antiretroviral procurement and distribution system and provide quality technical training for health care workers administering treatment. Furthermore, the Plan will

support technical assistance for monitoring for adherence, resistance, and adverse effects from therapy. The US Government will provide a projected 50% of the ARVs needed in 2007.

Financial and technical assistance will be provided to strengthen strategic information systems to monitor and evaluate the effectiveness of supported programs and to assist in building sustainable national information management. Hundreds of thousands of Fredonians will benefit from increased access to prevention, care, and treatment as a result of assistance through the Emergency Plan.

Principal partners: Elizabeth Glaser Pediatric AIDS Foundation, Drama Aid Education, Members of Provincial Executive Councils, Catholic Relief Services, National Tuberculosis Programme, Family Health International, University of California San Francisco, Rural AIDS and Development Action Program, Military Health Service, Regional Broadcasting Corporation, and National Defense Force.

Appendix 25.3   EXAMPLES FOR TABLE 3.3 – PROGRAM AREA CONTEXT

Program Area: Counseling and Testing
Budget Core: (HVCT)
Program Area Code: 06

Table 3.3.9: Program Planning Overview:

Program Area Context:
     The state of counseling and testing (C&T) services in Fredonia has come a long way in a short period of time and continues to expand. There are currently approximately 5,000 sites throughout the country which provide counseling and testing services. This number has increased from less than 1,000 sites only 4 years ago. In the last year alone, over 1,100 new counseling and testing sites were opened, providing services to an estimated 250,000 individuals. While this number is a big improvement, many of those tested were not HIV+ and ARV eligible and thus expansion and increases in C&T will focus more strategically in medical facilities among people at higher risk in order to meet our FY08 treatment targets. Many of these service sites are already integrated into the health network system, providing referrals to additional services as needed. However, we recognize that all C&T sites must ensure active referral for clients who test HIV+ and those sites that do not already refer clients through health network systems will be integrated and monitored. Additionally, many of the service sites are underutilized. Routine voluntary counseling and HIV testing in medical sites (e.g. TB clinics and in-patient medical wards) only started in FY2005. Provider initiated HIV counseling and testing in all TB clinics and other C&T sites will assist in increasing demand for C&T services which are an important priority for the coming year. These items were specifically mentioned as key components of the Fredonia 5-Year Strategy for the Emergency Plan.
     USG assistance to C&T has been substantial in Fredonia, including support for an evaluation of C&T services, development of national C&T guidelines and training curriculum, validation and support for introduction of rapid HIV tests, development of policy for and use of community (lay) counselors in health facilities. Activities have included recruitment and training, advocacy for routine testing with the right of refusal in clinical settings, strategic information support, renovations, and direct financial support to FBO/NGO community testing services. In addition, USG assistance has supported an increased attention on counseling for discordant couples to help provide ongoing prevention counseling and support. Many C&T sites have also begun to incorporate prevention for positive activities through various health education and post-test club support programs.
     There are numerous other donors who are also working in the C&T program area. The European Union began working with the Fredonia Social Marketing Association (FSMA) in 2004 in order to establish a network of six voluntary counseling and testing centers under the "Fresh Start" name. While funding from the EU will terminate in May 2006, USG support for this network has been able to leverage assistance from other development partners. DFID has committed GBP 498,088 to establish post-test clubs at five Fresh Start centers. The Gates Foundation is co-funding the Fresh Start center in Starmopolis (Eastern Lake District), supporting all costs for this center from June 2005 to September 2007. FSMA will be a sub-recipient under the Global Fund to set up a stand-alone Fresh Start center at Liber City (Northwest District) and two mobile C&T units. At the same time, the MoH is expanding capacity to increase C&T provision within the public sector at 1,600 health facilities principally

financed by the USG and the Global Fund. Within this expansion of capacity, 80% of TB patients and 50% to STD patients will receive provider initiated C&T services. As with all C&T sites in Fredonia, assurance for linking those who test HIV+ to care and support will be established along with prevention activities targeted to discordant couples and those who are HIV+.

Though there has been great progress made over the past year in C&T, there have also been barriers that have caused frustration and slower than hoped for implementation. Our new bilateral program that was planned for award in November of 2004 was delayed. This delay was caused by a contractual protest of the new award. This caused some delays in scale up of several programs, due to the need to continue working with partners who were not able to undertake the large scale up programs. This new award is now in place and the scale up of programs has begun.

Additionally, a change of staff at the MoH also caused a delay. The new staff member needed additional time to be brought up to speed on the USG efforts and our collaboration with the MoH. This change occurred in February of 2005. We have since been working very well with the new staff member and implementation of MoH activities is back on track and already has incorporated routine testing for hospitalized medical patients.

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Appendix 25.4   EXAMPLES FOR TABLE 3.3 – ACTIVITY NARRATIVE

Program Area: Counseling and Testing
Budget Core: (HVCT)
Program Area Code: 06

Table 3.3.9: Program Planning: Activities by Funding Mechanism

Mechanism/Prime Partner: USAID/HIV/AIDS Project/Partnership for a Better World
Planned Funds: $750,000

Activity Narrative:
    This activity also relates to activities in Counseling & Testing (#0631), TB/HIV (#0724) and PMTCT (#0158).
    This activity has several different components. One component is to provide comprehensive counseling and testing, through both stand-alone and integrated VCT services within hospital settings. Five mission hospitals will be supported in the provision of counseling and testing for diagnostic purposes for high numbers of in-patients and out-patients. Routine counseling and testing will be offered to the following principal target populations: pregnant women and TB patients. Additionally, VCT centers are being established at each hospital to promote self-referral for counseling and testing by the general public, including community outreach for uptake of services. This funding will go specifically to support the procurement of test kits, the renovation of the site locations at the hospitals to become VCT centers, the training of staff at the hospitals in providing counseling and testing, and the training of supervisory staff at the hospital in ensuring a minimum quality standard for services. This component of the activity will provide support for 5 service outlets, work to train 28 individuals in counseling and testing, and provide counseling and testing services to an estimated 5,000 individuals.
    The second component of this activity is support for the Fredonia City Multi Purpose Center. This Multi Purpose Center aims to provide high quality HIV testing and counseling services to the Fredonia City community; to strengthen and expand counseling and other psychological support services and to strengthen and expand testing services; and to support post test clubs that are designed to decrease stigma and discrimination experienced by PLWHA's. This funding for the Multi Purpose Center will go to principally address the following emphasis areas: staffing, infrastructure support, training VCT staff and Multi Purpose Center volunteers, sponsorship of public speaking opportunities for community educators, and outreach to the Fredonia City community and workplaces. Specific target populations of the Multi Purpose Center include the Fredonia City community: adults, boys and girls, out-of-school youth, street youth, orphans and vulnerable children and people living with HIV/AIDS. The Multi Purpose Center was designed as a place that would bring all members of the community together in order to provide services and reduce the stigma (key legislative issue) surrounding HIV/AIDS. This component of the activity will provide support for 1 service outlet, work to train 12 individuals in counseling and testing, and provide counseling and testing services to an estimated 2,500 individuals.
    The final component of this activity is a link to activity number #0631 in this program area. This partner will continue ongoing work with a USG supported training NGO which supports VCT by implementing an integrated counseling program to ensure effective VCT services through training and supervision of trainers/counselors in VCT. These two partners will work together to

continue to build the capacity of NGO/FBOs and the MOH by training staff and volunteers to meet the increasing demand for counseling services in rapidly expanding VCT services. This component of the activity will work to train 100 individuals in counseling and testing.

Appendix 26   FY06 COP REVIEW PROCESS

Appendix 26.1   STRUCTURE OF FY06 COP REVIEWS

The COP Reviews are separated into several different sections. First, there are Technical Reviews of the COPs undertaken by the Technical Working Groups. The Technical Reviews are undertaken for each technical area, with reviewers evaluating only that particular technical area for each country. Second, there is a Programmatic Review of the COPs, which is done for each country and incorporates the evaluation of each Technical Review of the COP into a comprehensive whole. Finally, there is the Principal's Review of the COPs, which is also done for each country and highlights the work of the previous two reviews.

For the Technical Reviews, a standard review form has been developed. Below is a sample evaluation form for the Care and Treatment Technical Review. Each of the Technical Reviews of the COPs will follow this format. There are Technical Review Criteria which are specific to each Technical Review. These review criteria are outlined in the next Appendix.

The Targeted Evaluation sub-committee will be conducting the review of proposed TE items in a different manner. Please see the end of Appendix 26.2 for the specific information related to TE.

**Evaluation Form for the Technical Review of the
FY2006 Country Operational Plans (COP):
HIV Care and Treatment Workgroups**

Dear Reviewer,

Mark each program area and activity using the attached matrices. In addition please note strengths and weakness below (limit 2 pages).

Country: _____

Workgroup: _____

Confidence of your technical review based on amount of information in the COP (circle one):
1----------------2------------------3----------------4--------------5 **low**   **high** (I have filled out the forms   (There was sufficient as best as possible given   information in the COP for me the limited information provided)   to adequately assess the   activities and program)

Narrative Assessment

  1) Strengths

  2) Weaknesses

  3) Issues

      A. Yellow light issues

      B. Red Light Issues

      C. Other

Part A. Activity Assessment Matrix

Fill out one table per activity. You will need to have this page copied for each activity by funding mechanism.

Activity Specific Technical Criteria	Yes	No	Can't Tell
1. The proposed specific technical activity has an achievable, measurable result.			
2. Activity is in keeping with Emergency Plan policy and strategic direction.			
3. Activity contributes to achieving the U.S. country five-year strategy.			
4. The proposed partners are appropriate and, where possible, the activity includes work with new, indigenous partners.			
5. The budget is appropriate for proposed activity.			
6. The focus of the activities is/includes direct service delivery.			
7. If not, there is sufficient description/evidence that the activities are essential to program success.			

Part B: Program Area Matrix

For this matrix, please consider the information found in the *Program Area Context* and all activities as a whole group. Fill out once.

Overall Program Assessment	**Yes**	**No**	**Can't Tell**	**Not Relevant**
1. The proposed activities reflect implementation of best practices in the technical area.				
2. The text provides reasonable rationale that the proposed activities address population/geographic areas where the programs will have major impact.				
3. The overall approach reflected in the proposed activities corresponds with the country five-year PEPFAR strategy.				
4. The text describes a plan that is consistent with the national HIV strategy, including coordination and where appropriate facilitation and implementation with other donors and the Global Fund.				
5. No critical activities are missing in this technical area. (technical areas being addressed by other donors should be described)				
6. The activities lead to achieving the results needed to meet the targets in this technical area.				
7. The implementation mechanism(s) are/is appropriate for the technical activities proposed.				
8. The technical areas adequately address gender issues.				
9. The plan appropriately leverages other U.S. Government investments including, for example, activities being conducted in other technical areas. (e.g. wraparound services, research sites)				
Overall Technical Review Criteria	**Yes**	**No**	**Can't Tell**	**Not Relevant**
1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.				
2. The proposed activities describe advancement of mechanisms for quality assurance, quality standards and quality of care within the technical programs.				
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute and provide drugs and health commodities and ensure the secure and consistent supply in 2005 and in subsequent years.				
4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services are adequate for diagnosing and treating HIV and OI's (e.g. TB) and evaluating drug toxicities.				
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected				

number of persons who will be treated and cared for each year.				
6. The proposed activities include advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART. Activities involve people living with HIV/AIDS (PLWHA) and other affected groups (ex. TB patients) when possible and appropriate.				
7. Proposed activity includes multi-disciplinary approaches to ensure adherence to ARV medications, and ensure adequate follow up and retention of patients in care.				
8. **Integration of USG plan for laboratory support of interventions into National Treatment Plan** Is the USG plan for laboratory support to interventions an integral part of the national HIV prevention and care plan?				
9. **Commodities Management** Are the systems to select, procure, store, track, distribute, provide, and maintain laboratory equipment, reagents, and other essential laboratory commodities adequate to ensure uninterrupted operations in 2005 and subsequent years?				
10. **Laboratory Standards** Are there written national laboratory policies, guidelines, and Standard Operating Procedures and are they acceptable as a tool to ensure proper diagnosis and effective patient management in 2005 and subsequent years.				
11. **Laboratory Services** Are the physical infrastructure, trained staff, and systems for specimen handling, and quality assurance for lab services acceptable for prevention activities, patient diagnosis, treatment of AIDS, TB, and OIs and for monitoring patients on therapy?				
12. **Training** Are the plans to train laboratory managers, technicians, and technologists adequate for the projected number of persons who will be diagnosed, and monitored each.				
13. **Monitoring and Evaluation** Are the plans and indicators for monitoring laboratory processes and service outcomes adequate for measuring laboratory contribution to the prevention, treatment and care objectives.				

Appendix 26.2   FY06 COP REVIEW CRITERIA

For All Technical Reviews:

Activity Specific Technical Criteria
1. The proposed specific technical activity has an achievable, measurable result.
2. Activity is in keeping with Emergency Plan policy and strategic direction.
3. Activity contributes to achieving the U.S. country five-year strategy.
4. The proposed partners are appropriate and, where possible, the activity includes work with new, indigenous partners.
6. The budget is appropriate for proposed activity.
7. The focus of the activities is/includes direct service delivery.
8. If not, there is sufficient description/evidence that the activities are essential to program success.

Program Area: Overall Program Assessment [PMTCT has slightly different criteria, see below]
1. The proposed activities reflect implementation of best practices in the technical area.
2. The text provides reasonable rationale that the proposed activities address population/geographic areas where the programs will have major impact.
3. The overall approach reflected in the proposed activities corresponds with the country five-year PEPFAR strategy.
4. The text describes a plan that is consistent with the national HIV strategy, including coordination and where appropriate facilitation and implementation with other donors and the Global Fund.
5. No critical activities are missing in this technical area. (technical areas being addressed by other donors should be described).
6. The activities lead to achieving the results needed to meet the targets in this technical area.
7. The implementation mechanism(s) are/is appropriate for the technical activities proposed.
8. The technical areas adequately address gender issues.
9. The plan appropriately leverages other U.S. Government investments including, for example, activities being conducted in other technical areas. (e.g. wraparound services, research sites).

Technical Review Area Specific:

HIV Care and Treatment
1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.
2. The proposed activities describe advancement of mechanisms for quality assurance, quality standards and quality of care within the technical programs.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute and provide drugs and health commodities and ensure the secure and consistent supply in 2005 and in subsequent years.
4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services are adequate for diagnosing and treating HIV and OI's (e.g. TB) and evaluating drug toxicities.
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected number of persons who will be treated and cared for each year.
6. The proposed activities include advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART. Activities involve people living with HIV/AIDS (PLWHA) and other affected groups (ex. TB patients) when possible and appropriate.

7. Proposed activity includes multi-disciplinary approaches to ensure adherence to ARV medications, and ensure adequate follow up and retention of patients in care.
8. Integration of USG plan for laboratory support of interventions into National Treatment Plan: Is the USG plan for laboratory support to interventions an integral part of the national HIV prevention and care plan?
9. Commodities Management: Are the systems to select, procure, store, track, distribute, provide, and maintain laboratory equipment, reagents, and other essential laboratory commodities adequate to ensure uninterrupted operations in 2005 and subsequent years?
10. Laboratory Standards: Are there written national laboratory policies, guidelines, and Standard Operating Procedures and are they acceptable as a tool to ensure proper diagnosis and effective patient management in 2005 and subsequent years.
11. Laboratory Services: Are the physical infrastructure, trained staff, and systems for specimen handling, and quality assurance for lab services acceptable for prevention activities, patient diagnosis, treatment of AIDS, TB, and OIs and for monitoring patients on therapy?
12. Training: Are the plans to train laboratory managers, technicians, and technologists adequate for the projected number of persons who will be diagnosed, and monitored each.
13. Monitoring and Evaluation: Are the plans and indicators for monitoring laboratory processes and service outcomes adequate for measuring laboratory contribution to the prevention, treatment and care objectives.

Counseling and Testing
1. The proposed activities promote the availability of routinely offered counseling and testing (CT).
2. The proposed approaches encourage polices, regulatory support, and initiatives to protect confidentiality and to combat stigma and discrimination associated with HIV infection and the disclosure of one's serostatus.
3. The proposed activities represent an expanded and strategic mix of clinical and community-based CT models.
4. The proposed CT activities are focused to reach individuals who are most likely to benefit from ARV treatment, particularly through integration with STI, TB, and hospital inpatient services.
5. The proposed activities focus efforts to make HIV testing available to those at highest risk of HIV infection (e.g. injection drug users, commercial sex workers, migrant workers, truck drivers)
6. The proposed CT activities strengthen referrals and linkages to care, treatment, and prevention activities.
7. The proposed CT activities maintain a focus on the promotion of prevention and the delivery of high quality counseling.
8. The proposed approaches to HIV CT provide support to enhance disclosure of HIV status and mitigate potential violence or other negative outcomes of disclosure.
9. The proposed approaches adequately address local human capacity, procurement, supply chain management and infrastructure needs relevant to the delivery of CT services.
10. The proposed approaches seek to stimulate demand for counseling and testing services, and to help "normalize" CT-seeking behaviors.

General Population and Youth
1. The proposed activities contribute to the establishment of national coverage with abstinence-based programs for youth 14 and under who have not initiated sexual activity.
2. The proposed activities contribute to the establishment of national coverage with a balanced ABC prevention approach for youth 15 and above and/or sexually active youth.
3. The proposed activities attempt to access youth through multiple venues including school programs, faith-based organizations, recreational activities, parents, health care services, and the workplace.
4. The proposed activities include community-based and outreach-based programming to reach out-of school youth.
5. The proposed activities address the prevention needs of girls and young women.

6. The proposed prevention activities include promotion of social norms supporting mutual faithfulness and partner reduction among sexually active adults.
7. The proposed activities include interventions that attempt to change social norms related to coercive sex, cross-generational sex, and/or transactional sex.
8. The proposed prevention/behavior change activities involve partnerships with local leadership, structures, and organizations (such as churches, local media, traditional leaders, and schools).

Human Capacity Development
1. Has an HR assessment/plan been done in this country, if so, was it taken into account in the planning?
2. If no assessment has been done previously, are there plans to do one?
3. There is an overall plan to improve human capacity that includes such aspects as:
    * In-service training
    * Pre-service training
    * Workforce planning
    * HR policy (regulatory barriers, prescribing practices, etc.)
    * Involvement of the private sector
    * Twinning
    * Volunteers
4. Is there adequate coordination of HCD activities in the COP? (e.g. across geographic areas, USG partners, USG agencies)

MARPs
1. The proposed plan includes a range of activities to address and overcome issues of discrimination that affect the delivery of prevention services for MARPS.
2. The proposed plan includes targeted activities to reach those at high risk for infection through outreach services and interpersonal approaches to behavior change,
3. The proposed activities include a range of prevention services for uniformed personnel to eliminate or reduce risky behaviors.
4. The proposed activities include a range of prevention services for prostitutes to eliminate or reduce risky behaviors.
5. The proposed activities include a range of prevention services for mobile populations to eliminate or reduce risky behaviors.
6. The proposed activities include a range of prevention services for drug users to eliminate or reduce risky behaviors.
7. The proposed plan includes activities to expand access to clinical services to those most at risk, including diagnosis of and treatment of STIs.
8. The proposed plan promotes the correct and consistent use of condoms among those most at risk for infection, and seeks to ensure the availability to high risk populations.
9. The proposed plan promotes expanded access to substance abuse and treatment services.
10. The overall approach includes programs to identify and reach HIV-infected people and their sexual partners with prevention services.
11. The proposed activities incorporate linkages to HIV treatment and care services, including HIV counseling and testing.

Orphans and Vulnerable Children
1. The proposed activities:
    * Meet the best interest of the child
    * Fit within the country context
    * Where appropriate, include leveraging of any and all relevant resources
    * Include comprehensive referrals to education, care, medical and social services
    * Include active youth participation
    * Address sustainability and scale of local systems and structures

- Address principles outlined in the Global Framework for OVC
2. The proposed activities address strengthening the capacity of families and community-members to meet the needs of OVC.
3. The proposed activities address Mobilization and support of community-based responses to make informed decisions on who is vulnerable, what services do they need, and what local resources can be leveraged to meet the needs of community identified OVC.
4. The proposed activities address strengthening government systems and structures at multiple levels to protect the most vulnerable children through:
   - Improved policy and legislation
   - Mobilization of resources to communities to ensure comprehensive service delivery
5. The proposed activities address improving access to essential services through:
   - Use of community-led targeting of OVC
   - Leveraging of other resources
   - Education, health care, psycho-social support, HIV prevention, food, social and legal protection, shelter, and economic opportunity.
6. The proposed activities facilitate a supportive social context for children and their families affected by HIV/AIDS.
7. The proposed activities reflect adequate technical and management capacity to deliver on and monitor 10% budgetary requirement for OVC programming in a consistent manner across activities.
8. The proposed activities address inter/intra-agency and cross-sector coordination to deliver comprehensive services to OVC using wrap-around programming.

Palliative Care
1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.
2. The proposed activities describe advancement of mechanisms for quality assurance and quality standards within the technical programs.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute, and provide drugs and health commodities and insure the continuous supply in 2005 and subsequent years.
4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services are adequate for diagnosing and treating HIV and OI's (e.g. TB) and evaluating drug toxicities.
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected number of persons who will be treated and cared for each year.
6. The proposed activities include advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART.
7. The proposed activities define and include a basic set of palliative care services that will be made available to all persons with HIV/AIDS.
8. The proposed activities include a preventive care package for HIV-infected adults and children, as part of the basic set of palliative care services.
9. The proposed activities define and include an approach to management of HIV-related conditions and or symptoms that is appropriate for the setting(s) in which the HIV infected persons are seen.
10. Food and nutrition has been given adequate technical and programmatic consideration.

Pediatric Technical Review
1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.

2. The proposed activities describe advancement of mechanisms for quality assurance, quality standards and quality of care within the technical programs.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute and provide drugs and health commodities and ensure the secure and consistent supply in 2005 and in subsequent years.
4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services are adequate for diagnosing and treating HIV and OI's (e.g. TB) and evaluating drug toxicities.
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected number of children who will be treated and cared for each year.
6. The proposed activities include advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART. Activities involve people living with HIV/AIDS (PLWHA) and other affected groups (ex. TB patients) when possible and appropriate.
7. Proposed activity includes multi-disciplinary approaches to ensure adherence to ARV medications, and ensure adequate follow up and retention of patients in care.
8. Integration of USG plan for laboratory support of interventions into National Treatment Plan: Is the USG plan for laboratory support to interventions an integral part of the national HIV prevention and care plan?
9. Commodities Management: Are the systems to select, procure, store, track, distribute, provide, and maintain laboratory equipment, reagents, and other essential laboratory commodities adequate to ensure uninterrupted operations in 2005 and subsequent years?
10. Laboratory Standards: Are there written national laboratory policies, guidelines, and Standard Operating Procedures and are they acceptable as a tool to ensure proper diagnosis and effective patient management in 2005 and subsequent years.
11. Laboratory Services: Are the physical infrastructure, trained staff, and systems for specimen handling, and quality assurance for lab services acceptable for prevention activities, patient diagnosis, treatment of AIDS, TB, and OIs and for monitoring children on therapy?
12. Training: Are there adequate plans in place to train a cadre of health care workers, including doctors, nurses and other health care workers, to provide pediatric treatment?
13. Monitoring and Evaluation: Are the plans and indicators for monitoring and evaluation appropriate for measuring the overall program contribution to prevention, treatment and care objectives, including service delivery, program impact, and clinical and laboratory measures for children.

Strategic Information
1. [HMIS] - The proposed activities will immediately support the collection, analysis and reporting of the M&E indicators required under the Emergency Plan.
2. [HMIS] - The proposed activities build on existing data and information system standards and build the generic health information infrastructure in the country.
3. [Surveillance] - The proposed activities are adequate to assure the ability to monitor HIV prevalence at the national level. (at minimum sentinel surveillance in ANC attendees in a generalized epidemic or in high-risk groups in a concentrated epidemics)
4. [surveillance] - The proposed activities are sufficient to assure the ability to monitor HIV related risk behaviors at the national level (either general population for generalized epidemics or high risk groups for concentrated epidemics).
5. [M&E] - The proposed activities will result in effective program monitoring (including addressing data quality and data use for program management) for all programmatic components of the USG Program.
6. [M&E] - The proposed activities include, where appropriate, targeted evaluation studies that have program relevance, are linked to innovative interventions, or help to inform effective scale-up of interventions.
7. [Human capacity development] - The proposed staffing and activities will strengthen the in-country SI capacity in terms of (1) M&E, surveillance, HIS components; (2) program/project-, facility-, and

population-based data collection and use; (3) operations research and evaluation studies; (4) coordination & collaboration.
- The proposed staffing for SI (M&E, surveillance, HIS) is adequate
- The proposed trainings/meetings/workshops are adequate

TB/HIV

1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.
2. The proposed activities describe advancement of mechanisms for quality assurance, quality standards and quality of care within the technical programs.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute and provide drugs and health commodities and ensure the secure and consistent supply in 2005 and in subsequent years.
4. The proposed activities include strengthening TB diagnostic capabilities for PLWHAs, including smear microscopy services, quality assurance, and support for national reference laboratories.
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected number of persons who will be treated and cared for each year.
6. Activities involve people living with HIV/AIDS (PLWHA) and other affected groups, including TB patients, when possible and appropriate.
7. Proposed activity includes multi-disciplinary approaches to ensure adherence to ARV medications, and ensure adequate follow up and retention of patients in care.
8. The proposed activities include providing HIV counseling and testing for all TB patients.
9. The proposed activities include screening all HIV-infected persons for active TB and a description of referral system for assuring TB suspects access to diagnosis and treatment for TB.
10. The proposed activities include working with the country's National Tuberculosis Program.
11. The proposed activities include strengthening the TB/HIV monitoring and evaluation systems.
12. The proposed activities include a description of systems for management and monitoring of TB/HIV co-infected patients across multiple health care programs.
13. The proposed activities include plans to provide cotrimoxazole prophylaxis for HIV-infected TB patients.
14. The proposed activities include cross-training health care workers on TB/HIV at all relevant administrative levels.
15. The proposed activities address short and long-term human resource needs to manage the enormous burden of HIV-infected TB patients.
16. The proposed activities describe how the USG-sponsored TB/HIV activities will work in synergy and leverage activities sponsored by other partners and large initiatives. (e.g., Global Fund, WHO, World Bank).

PMTCT
Program Area: Overall Program Assessment
1. The proposed activities reflect implementation of best practices in PMTCT, including
   - Routine offer of testing (opt-out approach)
   - Rapid testing with same day results
   - Optimal ARV prophylaxis regimen for the particular context, in keeping with WHO and national guidelines (specific regimen(s) should be delineated)
   - Linkages to care, treatment, and support (see specific items below)
2. The text provides reasonable information about the basic context in which the proposed services are being delivered, clearly stating:
   - The number of women delivering overall, and the percent delivering in facilities
   - The number and percent of HIV+ women receiving services

- The number and percent of facilities providing services
- The burden of HIV infection in various geographic areas of the country.

3. The overall approach reflected in the proposed activities corresponds with the country five-year PEPFAR strategy.
   - The national PMTCT country strategy is briefly   summarized.
4. The text describes a plan that is consistent with the national HIV strategy, including coordination and where appropriate facilitation and implementation with other donors and the Global Fund.
   - The roles and activities of the various partners and donors involved in PMTCT are described.
   - The place of PEPFAR-funded projects within the larger country PMTCT program is clearly delineated.
   - The role of the National PMTCT coordinating committee is explained if applicable.
5. No critical activities are missing in this technical area. (technical areas being addressed by other donors should be described). Critical areas include:
   - Linkages to antiretroviral treatment programs for pregnant women with WHO indications.
   - Promotion of partner counseling and testing
   - Postnatal follow-up of infants and mothers, including:
     - Promotion and support for optimal exclusive infant feeding practice.
     - Breastfeeding cessation as soon as is AFASS, along with explanation of how complementary feeding will be supported.
     - Provision of nutritional support
     - Cotrimoxazole prophylaxis for infants
     - Approach to infant diagnosis
6. The activities lead to:
   - A measurable increase in the number of pediatric infections averted.
   - An improvement in overall child survival,
   - Enrollment of HIV+ mothers in care and treatment programs
7. The management plan, specifically staffing and implementation mechanism are appropriate for the technical activities proposed.
   - Attention is given to building capacity to manage programs locally and transitioning management and supervision to the MOH as much as is feasible.
8. The technical areas adequately address the special needs of HIV+ pregnant women, including
   - Psychosocial support
   - Stigma reduction and prevention of domestic violence
9. The plan appropriately leverages other U.S. Government investments including, for example, activities being conducted in other technical areas. (e.g. wraparound services, research sites) Ex.
   - One important example of this is nutritional support for infants after early cessation (e.g. WFP)

Overall Technical Review Criteria

1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach.
   - Linkages to care and treatment services are clearly identified and contributions of PMTCT programs to indirect care and treatment targets
   - Linkages to nutritional programs for pregnant mothers.
   - Linkages of programs for infants for nutritional support replacement feeding as soon as is AFASS
   - Linkages to OVC programs
   - Linkages to other routine maternal and child health services (i.e. immunizations)
2. The proposed activities describe advancement of mechanisms for quality assurance and quality standards within the technical programs.
   - An approach to monitoring and improving different aspects of the PMTCT cascade is explained.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute, and provide drugs and health commodities and insure the continuous supply in 2005 and subsequent years
   - Where more complex PMTCT regimens are being used the supply-chain is described and is integrated with the treatment supply chain as much as is feasible.

4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services. These may specifically include:
    - Rapid testing capability
    - Capability to obtain CD4 test results for women in ANC
    - Infant diagnosis capability and CD4 % capability (see pediatric section)
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing PMTCT services.
    - The training curriculum is specified. (use of CDC generic curriculum encouraged)
    - Sub-specialized types of training, such as infant feeding counseling, are delineated.
6. The proposed activities include advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART.
    - There is a community strategy in place to increase uptake of PMTCT services.

Targeted Evaluation

Targeted evaluations (TE) answer operational questions about program implementation that are measurable, specific, and focused. Targeted evaluations are rapid studies eliciting detailed findings that inform programming decisions in the near-term. Targeted program evaluations will provide evidence-based information, beyond that derived from program monitoring and disease surveillance, to improve prevention programs, support decisions regarding clinical programs, and identify best practices for outreach to and care for those infected and affected by HIV/AIDS. The President's Emergency Plan for AIDS Relief was initiated to address specific goals in the delivery of HIV prevention, treatment, and care. The primary focus of the Emergency Plan is the implementation and sustainability of programs that provide these services. Other organizations such as the National Institutes of Health are better suited to conduct long-term studies and clinical trials. By leveraging such external efforts, the funds appropriated to the Emergency Plan are specifically used for service provision and for TE which seek to improve or enhance the services provided.

Funds can be reserved to conduct studies which help to improve the country program. When preparing FY06 submissions, TE studies should be clearly identified in COPs, as this facilitates country access to technical and coordination support from headquarters, opportunities for multi-country TE, and innovative avenues for sharing best practices. A small number of studies examining critical priorities are funded centrally and will be used to inform overall program development for the Emergency Plan. While all proposed studies cannot be funded, it is important for countries to submit ideas to Technical Working Groups, core teams, the TE Subcommittee, and OGAC leadership, when opportunities arise.

In FY 2005, OGAC began central funding for targeted evaluations that are monitoring antiretroviral treatment/clinical management, antiretroviral adherence, effectiveness of PMTCT programs, abstinence in youth, effective models of care for orphans and vulnerable children, and palliative care, as well as costs of ARV treatment. However, some new areas may also be identified and this information will be made available.

The overarching goal for Emergency Plan TE is that these studies produce results which are generalizable in nature and can contribute to sustainability of country programs. Whether funded centrally or at the country level, targeted evaluations in the Emergency Plan should be responsive to the following criteria:
- Assess or improve the quality of service provision. Quality may be defined and examined in a number of ways and may include issues such as access, efficiency of the service delivery process, cost, and doctor-patient communications.
- Examine or compare existing models of service delivery since the purpose of the Emergency Plan is to use proven methods to reach its goals. Studies that examine the feasibility of novel approaches or use a randomized clinical trial design are not considered targeted evaluations and will not be approved for Emergency Plan funding.
- Optimize use of study designs which enable comparability. This approach does not promote randomized trials, but encourages those quasi-experimental designs that utilize natural controls or other strategies that lend the greatest validity to study findings.

- Conduct TE according to rigorous scientific methodologies in the context of service provision. One advantage that the rapid scale-up of the Emergency Plan allows is that evaluators and implementers can work side-by-side to integrate evaluation activities into the program from the beginning. What this means is that, if correctly designed, targeted evaluations funded by the Emergency Plan will produce evidence that will be useful both for country programs and the Emergency Plan.
- Produce rapid results (in two years or less) that can be immediately applied to improve services.
- Include the dissemination of results and translation into programmatic improvements in the proposals as a clearly defined end-point. While publishing articles and presenting at scientific meetings is encouraged, these are not necessarily the dissemination strategies that will create mid-course corrections in Emergency Plan programs.

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