

The President's Emergency Plan for AIDS Relief

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**FY 2008**

# **COUNTRY OPERATIONAL PLAN GUIDANCE**

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## INTRODUCTION

*The President's Emergency Plan for AIDS Relief* (Emergency Plan/PEPFAR) is a landmark initiative that brings together all U.S. Government (USG) global HIV/AIDS assistance into a coordinated interagency approach to prevent new HIV infections and to treat and care for individuals living with the disease. The U.S. Global AIDS Coordinator, who is the President's representative on international HIV/AIDS issues, has "primary responsibility for the oversight and coordination of all resources and international activities of the United States Government to combat the HIV/AIDS pandemic"<sup>1</sup>

The Emergency Plan incorporates U.S. Government support to HIV/AIDS efforts through U.S. bilateral programs and U.S. contributions to multilateral initiatives. Support for multilateral initiatives includes the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund/GFATM) and UNAIDS; bilateral programs include those in the 15 PEPFAR focus countries, as well as in over 100 PEPFAR Other Bilateral Countries.

At the country level, it is essential that all USG agencies working to fight AIDS come together as one team under the leadership of the U.S. Ambassador, in partnership with host country governments and other key stakeholders, to plan, implement and monitor progress. The one USG team should be staffed to meet country-specific programmatic goals and targets. Coordination with other stakeholders, including national governments and other implementing partners, is vital to the sustainability of programs and efficient use of resources. PEPFAR is committed to support the principles of the "Three Ones" in all countries receiving support from the USG; PEPFAR activities should be aligned with the host country's national framework, national coordinating authority and national monitoring and evaluation system. Development of the Country Operational Plan is an important step in this coordinated planning and reporting process as well as the vehicle for funding approval.

The **Country Operational Plan and Reporting System (COPRS)** combines all U.S. Government agency planning and reporting on PEPFAR activities into one central data system, to facilitate country level interagency planning, monitoring and data management. COPRS is also the tool that provides information for funding review and approval and serves as the basis for Congressional notification, allocation and tracking of budget. In addition, 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). COPRS also provides an interface with the FACTS database of the Department of State's Director of Foreign Assistance (F). COPRS serves as the single means of documentation for PEPFAR funding, activities and results, and has greatly strengthened our transparency and accountability to key stakeholders.

### Why prepare a COP?

*The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy* outlines key priorities to combat the epidemic through support to focused prevention, care and treatment programs through bold leadership and support to strengthen national and community

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<sup>1</sup> U.S. Leadership Against AIDS, Tuberculosis and Malaria Act of 2003, Section 102.

responses. Building sustainability, in particular through strengthening the capacity of local organizations, is also a key theme. Development of an annual country operational plan provides an important opportunity to bring the USG country team and key host country and international partners together in a planning process that highlights areas for USG investments and support within the context of the Three Ones.

The COP itself is, essentially, a comprehensive and rigorous information system. It inventories detailed information about planned activities in a given country that are based on strategies and approaches as described in the *U.S. Five-Year Global HIV/AIDS Strategy*, additional Emergency Plan guidance and technical considerations. Such a system is essential to link resource allocation to results to demonstrate program impact and fiscal accountability. This helps to ensure support for future funding of the Emergency Plan. The COP also serves as an important tool to communicate program advances from a technical and policy standpoint. The Global AIDS Coordinator's final approval of country plans and annual budgetary decisions is based on the thorough review of information submitted through the COPRS system.

### **Which Countries Prepare an FY 2008 COP?**

All focus countries, as well as Cambodia, India, and Malawi, will prepare a COP in FY 2008. It is possible that additional countries will be asked to prepare an FY 2008 COP, pending discussions between OGAC and F.

### **Structure of the Guidance:**

- General Structure - Each table of the COP has its own section within the guidance document.
  - There are special headings for "modifications" from the FY 2007 COP and "Special Instructions for Other Bilaterals."
  - For each table there is information on the content to be included, listed under "Content," as well as data entry instructions, listed under "Data Entry."
- Key Policies – the "Overview" section has been re-named "Key Policies."
- Appendices – This year, the appendices are attached to the guidance rather than contained in a separate Resource Guide. As in previous years, these appendices contain critical information of great benefit to program planning. In addition, additional annexes (such as the list of COPRS administrators) are available on the FY 2008 COP Planning section of the Extranet. A complete list of these documents is in [Appendix 2](#).
- Additional sources of information – OGAC encourages and supports other channels of communication to strengthen COP planning, including work with core team leaders and bimonthly "phone home" calls. Based on these, OGAC will develop Questions and Answers to clarify issues in the COP, to be disseminated through News to the Field and by posting on the PEPFAR Extranet. OGAC will disseminate any COP updates in the same fashion.

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## COP FORMULATION

### Deadline

All FY 2008 COPs must be submitted to OGAC by Friday, September 28, 2007.

### Interagency Coordination

A key principle of PEPFAR is the USG interagency response, by which all USG agencies working in a host country plan, implement and monitor a unified country program as one USG team. This is critical as you formulate your country's COP. Thus, **it is essential that ALL USG Agencies working in-country be included in discussions regarding the COP.** We recognize that countries have several sources of HIV/AIDS funding; however, ALL programming decisions are to be made as a USG Team, with an emphasis on achieving Emergency Plan results. Funds directed through a particular USG agency are NOT to be programmed independently by that agency. They are part of the entire country strategy.

Not all USG agencies may have a country presence, but that should not obviate their ability to work in-country if the area of expertise of that agency would benefit the program. The COP process presents an opportunity to seek that technical expertise and support. If one or more of the five USG Agencies that must be listed in the Contact Section are not present in your country, you should be in contact with someone from the Agency Headquarters to involve them in the COP process.

All USG planning should occur within the context of the "Three Ones." As you develop your Fiscal Year (FY) 2008 COP and prepare for submission of the document to OGAC, you should include time in the schedule for active participation and review by the Host Country Government. No COP should be submitted without host country concurrence.

### Partner Performance Considerations

Country teams should regularly review partner programmatic and financial performance (pipeline analysis), especially during COP planning, to ensure the best use of resources and that partner spending is commensurate with workplans and results achievements. As part of a partner portfolio review, an interagency team should review each partner's overall performance based on clear technical targets and program indicators, as well as the partner's technical approach, program and financial management, data quality, and management and staffing. Whenever possible, information from interagency on-site reviews of USG supported partners should augment the program data.

Country teams are responsible for ensuring that funding is being spent at a pace commensurate with the requirements of the Emergency Plan. Therefore, country teams should confirm that partners do not have large pipelines before requesting additional funding. In May 2007, agencies submitted the first pipeline analysis report for non-central prime partners. The report collected obligations and outlays of FY 2005 and FY 2006 COP funding from the USG to prime partners, including obligations and outlays incurred directly by the agency, as of September 30,

2006. We expect to collect the next partner pipeline report with the headquarters pipeline report on or about January 31, 2008.

For FY 2008 COP planning, we will not require that country teams use a specific format for their portfolio reviews. OGAC will send out a generic portfolio review tool for teams that have not developed their own portfolio review processes. Any portfolio review exercise should be fully transparent, with findings shared across interagency teams.

## Support for COP Development and Submission

Your Core Team Leader and core team members, including the Strategic Information (SI) Advisor, and technical working groups (TWGs) are important participants and can help in supporting the COP process. Your Core Team Leader is your main point of contact at OGAC and should be substantially involved. A key first step in the COP process should be a review of current priorities, activities, results, gaps and issues to ensure that programming is driven by the local country epidemic and with consideration of overall budget allocation realities. The Core Team, and in particular the Core Team Leader and SI advisor, plays a critical role in this effort. In addition, the Core Team Leader can support the PEPFAR Coordinator in developing and overseeing the overall process of COP development, including facilitating essential assistance from the core team and technical working groups. Engaging the SI Advisor early in the process, to assist with target-setting and with planning of Strategic Information activities, is also essential. Your core team members can help with strategic planning of activities, drafting early versions of COP narratives, and reviewing and finalizing the COP. If you would like assistance from one of the technical working groups, please contact your Core Team Leader. The Technical Considerations Compendium, assembled by the TWGs, is a companion document to be used in conjunction with the COP Guidance. Please note that the technical considerations were developed for the focus countries and may not apply to PEPFAR Other Bilateral Countries.

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## KEY ISSUES AND POLICIES FOR FY 2008

### Efforts to Reduce COP Burden

To reduce the burden of data entry in the field in FY 2008, when focus country teams receive their FY 2008 budgets, they will also receive notice if they are in the top tier of performance and/or coverage for a selected set of services in treatment, PMTCT, and counseling and testing. Country teams that have exceeded performance goals and/or expected coverage in any of these areas can assume that all activities in this area are approved. There will be no requirement to write activity narratives for ongoing activities. However, the budget, partners and targets should be completed to ensure the database is accurate for reporting to Congress and others. Program area narratives are required for all countries in all program areas. There are, however, a few exceptions to this exemption. For new activities, a narrative should be provided for information purposes only, to help us identify programs for success stories or for technical working groups to identify lessons learned on expansion. These activities will not be reviewed and can be considered pre-approved. One exception to pre-approval status is should a partner exceed the 8% limit. In this case a justification should still be submitted and will be considered following normal procedures. Please also provide an activity narrative for any ongoing activity that received a yellow or red light in the FY 2007 COP. These will be reviewed according to normal procedures. Lastly, please provide full activity narratives for all PHEs, both new and ongoing, including ongoing targeted evaluations.

For all countries, in all program areas, minimal time and effort should be spent updating ongoing activities, unless there have been major changes. A bullet or two with the update is sufficient. Rather than updating narratives, attention should be given to updating targets, emphasis areas, and budgets. The FY 2008 COP Review will be primarily focused on new activities and ongoing activities that had yellow or red lights in FY 2007. Ongoing PHEs and TEs, however, will receive a full review to ensure the right balance of PHE activities, appropriateness of the question, etc.

### PEPFAR in 2008

With FY 2008 funding, Congress will be looking to PEPFAR's reaching its 2-7-10 goals. Please keep the 2 million on treatment, the 7 million infections averted and the 10 million individuals in care in mind as you plan FY 2008 funding allocations. Please note that the treatment and care goals must be reached by the end of FY 2009, and the prevention goal by the end of 2010. Scaling up to reach your country targets is critical; this should guide your development of the priority program areas listed in the following pages.

Focus Countries should do everything possible to meet their PEPFAR End of Plan Goals. However, targets should not be set to show that End of Plan goals will be met, if the goals are unrealistic.

Targets should be based on the knowledge gained over the last 4 years, which will include an understanding of the environment and epidemic within which programs are taking place.

Things to consider when setting targets:

- Epidemic need and existing coverage - How many individuals are eligible for the service, but not receiving that service?
- Capacity - How many new patients can be brought into the system?
- Funding - Do you have the funding needed to meet the target?
- Program Results - Do targets make sense given past semi-annual and annual progress report trends and future projections?
- Other - Are there any upcoming events/changes to the environment, perhaps non-HIV related, that might have some impact on your programs?

## PEPFAR Beyond 2008

A key concern of all partners is the outlook for funding in FY 2009 and its implications for FY 2008 planning. While the President has announced his intent to seek reauthorization of PEPFAR, no final decisions have been made. For planning purposes, country teams in focus countries should plan based on the assumption that their FY 2009 HIV/AIDS budgets are not anticipated to be lower than the budget they receive in FY 2008. However, as in previous years, the actual amount of funding provided to countries (for FY 2008 and FY 2009) will be contingent on the overall level of appropriations made available for HIV/AIDS.

## Sustainability

There are three major areas where sustainability is a critical concern: sustainability of services, organizational sustainability and financial sustainability. Achieving increased levels of sustainability through the greater assumption of responsibility over programming and management by host country nationals, as well as support for developing the capacity of local indigenous organizations, should be key considerations in developing your FY 2008 COP.

The increase in PEPFAR funding coupled with changes in host nation policies has led, in many cases, to large increases in patient load and demand for treatment, counseling and testing, care and prevention services. Host nation human resource capacity is being stretched to its limit. The government is one of the most sustainable organizations implementing HIV/AIDS programs in many countries. It is important that PEPFAR programs do not inadvertently compromise this sustainability. Technical assistance can be provided to Human Resource units of ministries of health to help facilities conduct workforce analyses to provide HIV/AIDS services without compromising the budget or manpower for other health services. USG implementing partners working with NGOs providing HIV/AIDS services are encouraged to harmonize local compensation practices

with the ministries of health compensation for health workers with the understanding that they do not have to match government salaries but, in general, should not exceed them.

The organizing structure, management, coordination and leadership provided by host governments and local NGOs are essential to an effective, efficient and sustainable HIV/AIDS response. Strengthening the institutional capacity of host governments and national systems is a fundamental strategy of the Emergency Plan. Activities should be designed to increase the number of indigenous partners to help expand and diversify the country's base of partners and support a sustainable response.

In addition to efforts to support government and non-governmental capacity-building, other important activities for sustainability include: enhancing the capacity of health systems and health care workers; strengthening quality assurance; improving financial management and accounting systems; building health infrastructure; and improving commodity distribution and control. Where feasible, national information systems and supply chain management systems that serve an array of government and non-governmental partners should be supported as opposed to separate costly systems for each partner.

Country estimates of the number of health workers and other health managers that PEPFAR supports has become important as we move to sustainable programs and scaling up country activities. In the FY 2008 COP we are requesting that countries provide **estimates** of the numbers of staff who have received full or partial salary support in the following three categories:

- clinical services staff
- community services staff
- managerial and support staff

Ideally these will be broken out by government and non-government support. While PEPFAR guidance does not in general support salaries for government employees, there are many areas where PEPFAR is supporting staff in ministries and government facilities through technical advisors, recruiting agencies, and others. These questions will be included in Table 1, and more information will be sent out in a subsequent News to the Field.

Many local indigenous organizations have limited technical expertise in accounting, managerial and administrative skills, auditing practices and other activities required to receive funding directly from the USG. "Umbrella organizations" have been used to provide this expertise. Wherever possible efforts should be made to support and provide technical assistance to assist these indigenous organizations to 'graduate' to full partner status and enable them to be direct recipients of PEPFAR funds. The fiduciary accountability of local organizations is essential to building sustainable capacity and technical assistance in this area should be made available to partner organizations.

If you have special initiatives or projects that support long-term sustainability, particularly in the areas of salary support and other staff retention strategies, please make sure to highlight these in the Executive Summary, program area narratives, or activity narratives, as appropriate. For additional details on measures to support sustainable programs, including capacity building of local organizations and promotion of Public Private Partnerships, please see Appendix 13. Information on the single-partner funding limit follows in this section.

Please also note that in FY 2008, the pre-service training funding limit has been increased to \$3 million or 1.5%, whichever is smaller.

## Management and Staffing

Management and Staffing, including Staffing for Results (SFR), continues to be a key priority for PEPFAR. Given the very large resource levels, it is imperative that USG country teams seek innovative approaches to assure appropriate fiscal oversight and technical leadership relative to PEPFAR funds, building on the strengths of the inter-agency team. Every country program is expected to undertake some internal staffing analysis prior to finalizing the FY 2008 COP and demonstrate progress toward achieving SFR, which includes identifying priority actions needed to more fully incorporate efficiencies in the inter-agency approach. The Management and Staffing section has been updated to provide additional information on SFR. The Staffing Matrix for USG staff has been replaced by the Functional Staffing Analysis tools, which consist of functional programmatic and agency charts and a staffing database. Additional instructions for completing the staffing analysis tools will be provided to country teams separately. The Staffing Matrix is still required for Peace Corps Volunteers, who are not captured in the staffing database. Please see the Management and Staffing program area for more information.

Additional guidance on using PEPFAR program dollars to support USAID and DOS direct-hire expenses, including salaries and other costs, is under discussion and will be forthcoming shortly.

In FY 2008, the current intent is to have technical assistance-related travel costs by HHS/CDC HQ staff included in the PEPFAR headquarters COP and funded centrally. Under this model, costs for technical assistance travel by HHS/CDC staff should not be included in the countries' COPs. In addition, HQ will continue to cover the costs associated with technical assistance-related travel from HQ to assist the other bilateral countries. However, this is also still under negotiation; we will send the final guidance on this issue shortly.

## Mandatory Budgetary Requirements

For FY 2008, as in prior years, there are three mandatory budgetary requirements for all focus countries: (Abstinence and Be Faithful (AB), Orphans and Vulnerable Children (OVC) and Treatment). For other bilateral countries, only the AB requirement applies. There have been some minor modifications in both the OVC and AB guidance for the FY 2008 COP.

- Track 1.0 central budgets (from headquarters) will be attributed to these mandatory requirements (see further explanation below).
- If meeting any of the mandatory requirements is not reasonable from a programmatic perspective, please submit a justification with the COP (see the COP Planning section on the Extranet for the format of the justifications). You should engage your Core Team Leader in discussions of any necessary justifications.
- Integrated programs should be distributed, as appropriate, across program areas. For more information, please see the guide to allocating activities across program areas on page 59.

### **PREVENTION: ABSTINENCE AND BE FAITHFUL**

Note: Special instructions for Other Bilateral Countries at the end of this section.

ABC – Abstinence, Being faithful, and the correct and consistent use of Condoms for people engaged in high-risk behaviors – is the most effective, evidence-based approach to the prevention of sexual transmission of HIV (as described in PEPFAR's ABC Guidance). In each of the focus countries except Vietnam, the primary mode of HIV transmission is sexual contact; therefore, a significant proportion of prevention funding should be dedicated to ABC activities to prevent sexual transmission of HIV.

In FY 2008, each country should strive to dedicate 50% of total prevention funds to sexual transmission<sup>2</sup>, and within sexual transmission funds, to dedicate 66% to AB. If a country does not meet these expectations, a written justification is required.

However, failure to meet the 50% requirement for sexual transmission within all prevention programs would not justify failure to reach the 66% requirement within sexual transmission prevention funds for AB activities. In some countries, based on epidemiology, it may not make programmatic sense to devote 66% of sexual prevention funds to AB, and in such cases, a written justification would be appropriate.

An example of when a justification would be appropriate is if the country is experiencing a concentrated epidemic, in which case a higher proportion of sexual transmission funds would likely be directed to correct and consistent condom use among people engaged in high-risk behaviors, within the context of the ABC approach.

$$\frac{\text{AB Funding + Condoms and Other Prevention Funding}}{\text{Prevention Funding}} = \% \text{ Sexual Prevention}$$

Note: Prevention Funding = PMTCT Funding + AB Funding + Injection Safety + Blood Safety + Condoms and Other Prevention Funding

$$\frac{\text{AB Funding}}{\text{Sexual Prevention Funding}} = \% \text{ AB}$$

Please note: in a generalized epidemic, a very strong justification will be required if a country does not meet the 66% AB or 50% sexual prevention requirement. Again, please inform your

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

Core Team Leader as soon as possible if you think these budgetary requirements will present a problem, and consider requesting technical assistance from the Prevention TWG.

Generally speaking, the percentage of sexual prevention funds dedicated to AB programming in the country should not decrease between FY 2007 and FY 2008. However, if new evidence or priorities warrant decreasing the percentage of sexual transmission funds dedicated to AB programming, then please provide an explanation for the proposed decrease in the justification narrative.

#### **SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:**

For other bilateral country programs, however, only those with generalized epidemics (i.e. national prevalence rates exceeding 1% in the general population) are expected to meet AB budgetary requirements. New for FY 2008 is that no AB justification is required for countries that have concentrated epidemics, with national prevalence below 1%.

#### **ORPHANS AND VULNERABLE CHILDREN (OVC)**

All focus countries must allocate 10% of total prevention, care, and treatment resources towards OVC programs. Given the maturity of the PEPFAR program and the magnitude of the problem, there is an expectation that countries are bringing OVC programs to scale. New for FY 2008, pediatric treatment will not be counted towards the 10%. This is in no way intended to lessen the focus on Pediatric treatment, which is also highly important; however, pediatric treatment funds should be attributed only to the treatment budgetary requirement, not to OVC.

Please submit a justification if your FY 2008 COP does not meet the 10% OVC requirement.

#### **TREATMENT**

To reach the goal of 2 million, and to meet the Congressional directives that the Emergency Plan allocate 55% of its program resources to antiretroviral treatment (ART), in FY 2008 the 55% budgetary requirement for treatment will continue to apply to all focus countries. Please submit a justification if your FY 2008 COP does not meet the 55% treatment requirement.

$$\frac{\text{ARV Drugs Funding} + \text{ARV Services Funding} + \text{Lab Funding}}{\text{Prevention Funding} + \text{Treatment Funding} + \text{Care Funding}} = \% \text{ Treatment}$$

#### **ADDITIONAL BUDGET ALLOCATION GUIDELINES**

NOTE: The following are illustrative budgetary guidelines, not mandatory requirements. No justification is required if your COP does not meet the guidelines.

***Prevention and Care:*** Individual countries are not required to meet the 20% prevention and 25% care guidelines in the FY 2008 COP. However, countries should continue to move toward meeting these guidelines.

**Strategic Information:** By the end of FY 2008 strategic information activities should support routine data gathering and data quality improvement efforts, including: partner monitoring and data collection programs, implementation of national reporting and surveillance systems, program evaluations, and at least a second population survey since 2000. Partner-specific information systems will not be sustainable in the long run (e.g. in areas such as OVC and treatment where there has been much duplication), and should only be supported when it is not feasible to merge them with national systems. An international guideline for strategic information funding which PEPFAR has adopted is approximately 7% of program expenditures.

**Management and Staffing:** A reasonable estimate of your total country budget (all program areas) that should be allocated to management and staffing is 7%.

**Note: When calculating the Strategic Information, PHE, and Management and Staffing budgets, do not include Track 1.0 dollars in the denominator (total country budget). However, Track 1.0 dollars are included in the denominator of the mandatory budgetary requirements (AB, OVC and Treatment) and for the single-partner funding limit.**

#### SINGLE-PARTNER FUNDING LIMIT

The single-partner funding limit aims to promote the most efficient use of funding, diversify the organizations with which PEPFAR partners, and increase partnerships with indigenous organizations, all with the goal of promoting long-term sustainability of HIV/AIDS programs in our partner countries.

There is no change in this requirement for FY 2008. For focus countries, in FY 2008 the percentage limit on funding to a single partner remains 8%. For Other Bilateral countries, the limit is \$2 million or 8%, whichever is greater.

In computing the percentage, the denominator consists of the country COP budget (central and field dollars), excluding management and staffing costs.

$$\frac{\text{Partner Funding (Prime + Sub - partner funds)}}{\text{Country Budget (Central and Field Dollars) - Management and Staffing Costs}} = \% \text{ Partner Funding}$$

The single-partner funding limit only applies to funding provided through grants and cooperative agreements. **The limit does NOT apply to funding provided or to be provided under competitively awarded contracts**, due to legal requirements for "full and open competition" under the Competition in Contracting Act (1984) and the Federal Acquisition Regulations.

There are three additional exceptions to the cap on single partner funding levels:

- Umbrella awards;
- Commodity/drug costs; and
- Government ministries and parastatals.



## Definition of Umbrella for Purpose of Single-Partner Funding Limit

For FY 2008, the determination of whether an organization is serving as an umbrella for purposes of exception from the cap will be made on an award-by-award basis.

- Grant agreements where the primary objective is for the organization to make sub-awards with the bulk of the resources (i.e., apart from certain administrative and technical expenses) will be considered umbrellas and exempted from the cap.
- Grant agreements that merely include sub-awards as one of many activities will not be exempt, and the full agreement will count against the cap.

Please see additional guidance on umbrellas and the TBD review process in Appendix 14.

Grantees may have multiple PEPFAR awards in a country, some of which qualify as umbrellas and are thus exempt from the cap, while others are not umbrellas and thus count against the cap.

## DRUG AND COMMODITY PURCHASES

All commodity/drug costs will be excluded from partners' funding for the purpose of the cap. The remaining portion of awards, including all overhead/management costs, will be counted against the cap.

## GOVERNMENT MINISTRIES AND PARASTATALS

For FY 2008, all parastatals will also be included under the government ministries exception. See Partner Type on page 52 for more information about parastatal organizations.

## JUSTIFICATIONS

Please submit a justification for any partner that exceeds the 8% limit, after excluding organizations (host country government organizations, parastatals, USG agencies) and funding (umbrella grants, drug and commodity purchases) exempted under the exceptions noted above. No justification is required for partners that would exceed the 8% limit if procured commodities were included; however, in the activity narrative please provide the dollar amount of funding the partner will use for commodity procurement.

## Target Time Period

Targets are required in Tables 2 and 3. The time period for national level targets in Table 2 remains the fiscal year. In Table 3 this year countries may either continue to set targets for the twelve months from when a partner receives funds or set targets using the FY 2009 fiscal year – October 2008 – September 2009. This modification allows countries that receive funds late in the fiscal year to standardize targets across partners and move targets in line with results reporting. Again, this change is optional. In future years, it will be mandated.

Because fiscal year funding takes time to filter down to the implementing partners and the sites where work is being done, funding requested in the FY 2008 COP cannot be expected to be fully expended in the fiscal year; therefore the date for achieving your country-level total care



and treatment goals is September 30, 2009. The date for achieving your country-level prevention (infections averted) goal remains unchanged; this goal is to be achieved by September 30, 2010.

## Priority Program Areas

Certain program areas were identified as having broad gaps generally across all countries and thus require special attention in the FY 2008 COP. These include PMTCT, OVC, Pediatric Treatment, TB/HIV, Unified Monitoring and Evaluation Systems, and Gender. In addition, given that new information is now available concerning the introduction of male circumcision, this is also a new area to be addressed. Staffing for Results is also a critical area that requires careful team planning and discussion in the COP.

### PREVENTION

#### PMTCT

The original goals of the President's MTCT Initiative were to reach 80% of HIV+ pregnant women with prophylaxis and reduce new infant infections by 40% by the end of 5 years in the 15 focus countries. UNGASS has also set goals of reaching 50% of women globally with PMTCT services by 2005 and 80% by 2010. Although much progress has been made, FY 2006 year-end data indicate that only slightly more than 20% of HIV-positive women attending antenatal care in the 15 focus countries received prophylaxis, meaning that programs would need to scale up approximately four-fold over the next two to three years to achieve the goals set by the MTCT Initiative and UNGASS. Many countries should revise PMTCT targets in the FY 2008 COP to be consistent with these goals and strategically plan and program resources to meet them. Please see the PMTCT technical considerations for more guidance on approaches for accelerating scale-up and maximizing impact of PMTCT programs.

PMTCT programs may provide an important "gateway" to HIV/AIDS prevention, care and treatment services. In the FY 2008 COP, countries should increase focus on supporting ART provision for treatment-eligible HIV-positive pregnant women. Almost one-third of USG-supported HIV testing in the focus countries is conducted in PMTCT settings, yet a disproportionately small number of HIV-positive pregnant women are receiving ART. There are also key unmet needs for collecting and reporting data on the numbers of HIV-positive pregnant women initiating ART while pregnant, which is a required PEPFAR indicator. Ensuring this sub-group of HIV-infected women are appropriately screened and treated will dramatically reduce the risk of HIV transmission to their infants and improve overall maternal health and child survival.

#### MALE CIRCUMCISION

The Emergency Plan guidance is consistent with the March 2007, WHO/ UNAIDS recommendations on male circumcision for HIV prevention. Under the leadership of host country governments, and consistent with local policies and norms, Emergency Plan funds can now be utilized to support the implementation of safe male circumcision services. Also new for

FY 2008, the funding limit per country has been lifted for safe male circumcision services or other male circumcision preparatory types of activities.

It is critical to ensure appropriate follow-up and treatment of any complications of male circumcision procedures, while continuing to emphasize the importance of comprehensive prevention messages focusing on an ABC approach. Recognizing that male circumcision is not 100 percent protective, it is essential for countries that are considering incorporating male circumcision delivery to place it within a comprehensive HIV prevention package. Please see the "Guide to Allocating Activities across Program Areas" on page 59 for additional information on the placement of male circumcision activities. The Male Circumcision task force is available to provide additional support and information as you consider the introduction of this important but challenging prevention intervention.

## **CARE**

### **ORPHANS AND VULNERABLE CHILDREN**

Caring for orphans and vulnerable children is a crucial part of our efforts to mitigate the impact of HIV/AIDS. In FY 2006, PEPFAR funds supported over 2 million children directly or indirectly. While this is a substantial increase over the half million children served through PEPFAR funds in 2004, it still represents just a small portion of the millions more in need. Countries should work on a comprehensive approach, collaborating with key government ministries and at the community level to bring OVC programs to scale nationally. In scaling up services, it will be important to address linkages with wraparound services, quality and programming gaps, and to identify best practices. Adequate PEPFAR country team staffing for strategizing and supervising OVC programs is essential for this scale-up. An emerging best practice is hiring child development (or related field) specialists to guide quality and appropriate OVC program scale-up.

Please see the OVC Program Area narrative instructions and OVC technical considerations for more guidance on approaches for accelerating scale-up and maximizing impact of OVC programs.

### **TUBERCULOSIS (TB) / HIV**

Tuberculosis (TB) is the leading cause of death among people living with HIV/AIDS, and addressing TB/HIV is an important part of meeting the Emergency Plan 2-7-10 goals. The prevalence of HIV infection among patients in TB clinical settings is high, and thus patients in TB clinical settings are "high yield" for identification and referral for HIV prevention, care and treatment. Scale-up of the key components of core TB/HIV activities have been slow and there is a need to significantly increase Emergency Plan resources and attention dedicated to this priority area. Recent reports of the emergence of MDR and XDR-TB outbreaks among PLWHA in HIV care settings re-enforces the need to significantly scale-up collaborative TB/HIV activities.

For FY 2008, increased planning and resources are required in order for country teams to develop and implement comprehensive HIV care and treatment programs that address the intertwined dual TB/HIV epidemics. In your FY 2008 COP, please describe TB/HIV activities so that the reviewers can understand how you are addressing the TB/HIV technical priorities (see program narrative guidelines and technical considerations for priorities).

Please also describe how other USG or other donor TB resources contribute to accelerating TB/HIV collaborative activities, particularly in relation to National TB and HIV/AIDS program strategic plans. Specifically, country teams should describe how Emergency Plan resources will leverage ongoing or planned non-PEPFAR USAID funding for TB and/or HIV/TB activities. To maximize USG resources and avoid duplication, we encourage USG teams to develop a USG-wide strategic plan in the area of HIV/TB and TB funding. There are a number of approaches to accomplishing this joint planning objective (e.g., joint visits by USAID bilateral TB TA and PEPFAR TB/HIV TA, interagency technical working groups, annual one-day planning retreats, interagency portfolio reviews, etc.) and TA is available to facilitate the process. We are hoping that these efforts to link all USG support to TB in a cohesive country strategy will also be reflected in the F/OP. While in future years, we would like to better integrate these processes, please note that for this year, we will be working with F to participate in the F/OP review for TB and hope to ensure that during the review, both PEPFAR and USAID resources and assistance will be considered. Please note that this year we will ask USG teams to upload the non-PEPFAR USAID TB and HIV/TB work plans to allow for a better understanding of comprehensive USG support for TB and HIV/TB programmatic activities.

Please see the TB/HIV program area description and the Technical Considerations Compendium for additional information on TB/HIV programming.

## **TREATMENT**

### **PEDIATRIC HIV/AIDS**

The rapid scale-up of pediatric HIV care and treatment programs supported by PEPFAR has occurred principally over the last 2 years. Roughly 45,000 children under the age of 15 were enrolled in treatment programs supported by the Emergency Plan in the focus countries (9% of all persons receiving ART- USG Downstream) in FY 2006; thus pediatric treatment and care services are an important component of PEPFAR programs. In addition, UNICEF and UNAIDS estimate that between 10 and 15% of PLWHA are children.

In order to provide optimal medical care to HIV-infected children, most COP program areas (e.g., PMTCT, palliative care, TB/HIV, OVC, Counseling and Testing, ARV Drugs, ARV Services, Laboratory infrastructure, Strategic Information and Policy and Systems Strengthening) should include activities/plans aimed at providing services for the pediatric population. Many countries have made tremendous strides in this area but providing services to children outside select centers of excellence, remains a considerable challenge. Countries should seek to increase programming in this area in FY 2008.

In the FY 2007 COP, USG teams estimated the total funding planned for pediatric ARV Drugs in Table 3.3.10 and pediatric ARV Services in Table 3.3.11. For FY 2008, pediatric AIDS funding will be collected at the activity level. The activity entries will automatically sum to provide the

planned funding for pediatrics at the Program Area level. Please see the treatment program area descriptions and technical considerations for additional information on pediatric AIDS programming.

### **TRACK 1.0 CENTRAL FUNDING FOR ANTI-RETROVIRAL THERAPY**

In FY 2008, central funding for Track 1.0 ART grantees will be straight-lined at FY 2007 central funding levels, not including any field funding transferred to Track 1.0 grantees in FY 2007.

FY 2008 country budgets must cover:

- The continuing treatment costs of anyone already on treatment using Track 1.0 resources that exceed those costs that can be covered by central Track 1.0 funding.
- The full cost of any expansion of treatment using Track 1.0 grantees.

### **GENDER**

The Emergency Plan places a high priority on confronting the changing demographics of the HIV/AIDS epidemic; working to reduce gender inequalities and gender-based abuse and violence; expanding priority gender activities; and integrating gender considerations throughout all programming areas. The societal issues around gender and HIV/AIDS are complex, and can vary from one country to another; however, addressing these challenges successfully is critical to the achievement of the Emergency Plan's prevention, treatment, and care goals. Indigenous partners are particularly important in the area of gender.

COP program area narratives and activity descriptions should include explicit language describing how the country program will integrate gender into the various different program areas. Furthermore, as per the authorizing legislation for PEPFAR, countries are strongly encouraged to support the five priority gender strategies by ensuring that activities selected contain one or more of these strategies as a primary focus:

1. Increasing gender equity in HIV/AIDS activities and services
2. Reducing violence and coercion
3. Addressing male norms and behaviors
4. Increasing women's legal protection, and
5. Increasing women's access to income and productive resources.

### **STRATEGIC INFORMATION AND PHE**

### **USING DATA TO INFORM PEPFAR PROGRAMMING**

To meet the PEPFAR objectives, it is imperative that our programs are evidence-based and cost effective. As services and data systems scale up, there should be increasing amounts of data available for consideration in updating programs, strategic decision-making, and meeting shifting needs of the dynamic HIV epidemic. There are two sources of information and data that are critical for the scale up of programs and to expand the body of knowledge across countries and programs.

**Routine information systems:**

There is now a wealth of data available to program managers to assess the impact and reach of activities, identify gaps that require additional resources and needs to adjust programs. These data sources may include: routine sentinel surveys; population-based surveys such as DHS+ and national behavioral surveys; routine HIV monitoring and reporting systems (including unified health management information systems); periodic quality assessment/quality improvement activities; formative/feasibility studies; targeted evaluations and public health evaluations; modeling based on local data; local epidemiologic and clinical research studies. A key component of strategic program review and future planning should be active use of existing data for decision making.

**Public Health Evaluation (PHE):**

PHE is a broadened approach to studies within PEPFAR. PHEs should be undertaken strategically to answer questions critical to improving the quality, scope, effectiveness, and impact of program services. PHE places a strong focus on sound methods including comparison groups and sampling, increasing aggregability of data across countries when appropriate through use of consistent data variables, and multi-country studies for priority questions. New multi-country PHE proposals may be generated by evaluation teams or by country teams. See [Appendix 12](#) as well as the FY 2008 Technical Considerations for more details. Local partner involvement in PHEs is critical to successful application of PHE results.

Country teams should think strategically about their overall PHE portfolio. In FY 2007, country PHE budgets ranged from 1-4% of a total country budget (all program areas). This may serve as a reasonable estimate to consider when planning for PHEs. Please note that countries are neither required to perform PHEs, nor are they expected or encouraged to have PHEs in every program area. These decisions are based on in-country assessment of key questions, opportunities and management capacity. Critical areas for PHE may include both successful programs/best practices/innovative models, and also underperforming programs where PHEs are undertaken to identify critical elements & methods for improvement. Note that the most effective PHEs are those that build on existing programs, infrastructure and data collection methods. Sound scientific oversight is required during PHE development and implementation to ensure that data collected are reliable and meaningful, as getting false or inaccurate results to drive programmatic decisions can be harmful. As such, human resources required to implement or oversee PHEs in-country may be out of proportion to expenditures on PHE, and should be taken into account in final decision-making of which and how many PHEs a country team will support.

In FY 2008, PHE activities will be separate activities within the relevant technical area. The activity narrative will replace the background sheets requested in the FY 2007 COP. For this reason, **full PHE activity narratives are required for all PHE activities**, regardless of whether they are new, ongoing, or in a program area where activity narratives are not required. Please see Appendix 12 for more information on PHE and the format for PHE narratives.

**UNIFIED MONITORING AND EVALUATION SYSTEMS**

At this time in the PEPFAR program, every USG team should have transitioned or be transitioning from uncoordinated individual partner program data collection systems to coordinated systems that are part of a national plan for monitoring and evaluation. The national context is especially important when making decisions regarding the funding,

introduction and/or expansion of any partner and national information systems. For example, how does a specific system fit into a national HMIS strategy? Does this system build on the work already done in country or does it represent a competing IT solution? Is information from this system easily integrated into a central, national system and accessible in understandable formats? What is the justification for continuing to fund duplicative and separate partner systems?

Before partners invest additional funding in systems for client tracking and reporting, country teams need to ensure that such a new system contains the monitoring information defined by PEPFAR and other international work groups. These systems also should contain information relevant to tracking program performance and quality improvement.

Country teams also need to ensure that partners do not invest in new data systems when existing applications are available. Most of these examples are used in facility-based service delivery programs, and while community-based Health Monitoring Information System lag behind in development, several countries now have pilot systems that may be useful to other countries. Every partner data system should provide information that is useful for program management and future planning.

Similarly, USG teams should have routine systems for collecting reporting data from partners, for monitoring data quality, and for use in program planning and evaluation. While systems may vary from country to country, they should be integrated into national monitoring and evaluation system strategies and provide country governments with useful information. In this fifth year of HMIS development, USG support for national reporting systems should be producing functional reporting systems that contribute to national results reporting. Technological innovations such as Phones for Health provide opportunities for countries that may be moving to more functional monitoring and reporting systems. Finally, USG country teams should be sufficiently staffed to carry out SI functions, including support for partner monitoring and reporting and data analysis for program use.

## Wraparounds

A wraparound activity wraps or links together PEPFAR programs with those from other sectors to provide comprehensive program support and improve the quality of life to HIV/AIDS-affected and -infected communities. Wraparounds leverage resources, both human and financial, from entities with different funding sources in order to complement Emergency Plan 2-7-10 goals and maximize the effectiveness of programs. Wraparound activities may include other programs funded by the USG (e.g., USAID Development Assistance), the Global Fund, the UN (World Food Program, UNICEF, etc.), the private sector, or other partners. In general, wraparound activities are supported with a mix of funds, primarily from sources other than PEPFAR. However, wraparound activities that directly serve PEPFAR priority populations by supporting the prevention, treatment, or care of HIV/AIDS, and are in keeping with other PEPFAR guidance, may be supported with Emergency Plan funds. In many cases the other sources of funding are used to provide the platform and PEPFAR funds are used to support those activities with our priority populations. In other cases, PEPFAR provides the platform (e.g. home based care infrastructure) for wraparounds, such as delivery of bednets through PMI, immunizations, or medications for neglected tropical diseases.



Some of the key opportunities for wraparound activities under the Emergency Plan include:

- Health sector linkages: family planning, safe motherhood, child survival, PMI, TB
- Other development linkages: education, food and nutrition, economic strengthening

EXAMPLE: In a country, USAID is working with the education sector to strengthen primary education, both at the national level and with provincial authorities. Addressing HIV in education is a key objective of the MOE, including addressing issues of orphans in education. The ministry requests support for technical assistance to improve support for orphans in the schools, incorporating community outreach, funding for books and other needs, training of teachers in social support and HIV prevention using a life-skills approach. They are also concerned about their workforce and would like to adopt an HIV counseling and testing program with linkages to treatment for teachers. PEPFAR and the USAID education program agree to partner on this initiative. PEPFAR agrees to fund a technical advisor to work with the MOE to address HIV and to provide assistance in developing a comprehensive HIV/AIDS and Education strategy. PEPFAR and USAID education programs share funding for scholarship programs for orphans to ensure needs of both those orphaned as a result of AIDS and those orphaned by other causes are met. PEPFAR also funds development of a curriculum to address the needs of orphans in schools and life-skills, but USAID/Education funds the teacher training element. PEPFAR funds the counseling and testing, care and treatment programs for the teachers. Finally, the World Food Program has a school feeding program in-country. The education and health team work with WFP to target community and primary schools where USG is providing support. The PEPFAR team issues a small grant to WFP to provide funding, based on an estimate of the percentage of children that are HIV-related OVCs to provide some additional support to this feeding program.

EXAMPLE: You are working on a PMTCT program that has a strong community follow-up component and is working to decentralize services to community health centers. USAID has an active Family Planning program<sup>3</sup> a small Safe Motherhood program, and your country is a PMI focus country. There is a desire to strengthen the comprehensive approach to pregnant women. The PEPFAR PMTCT team reaches out to other maternal child health managers and together the teams learn that there are existing training materials on PMTCT, family planning, emergency obstetric care and prevention and treatment of malaria in pregnancy. PEPFAR agrees to integrate these modules into the PMTCT training. The PEPFAR team also agrees to work with the family planning program on introducing counseling and testing to primary health centers in high prevalence areas. An agreement is reached with the family planning program to ensure the availability of contraceptives at PMTCT sites. In addition, the PEPFAR team agrees to fund malaria nets and treatment for all clients of PMTCT programs and their infants. They work closely with the PMI team to ensure that commodity needs for PMTCT clients are incorporated into procurement and logistic planning for malaria.

EXAMPLE: In a country, PEPFAR has a strong community-based care program. USAID is also supporting a micro-credit program through its economic growth portfolio. PEPFAR works with

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<sup>3</sup> Please be aware that there are a number of legislative and policy requirements that may be applicable depending on the exact nature and source of funding for "wrap around" activities in the area of family planning. If you have any questions, please consult your core team leader or Bev Johnston Mary McLaughlin at USAID.

the economic growth team and provides funding to its grant to support micro-credit activities to OVCs and/or their caregivers.

Additional information about specific wraparound programming, in particular concerning education and food and nutrition, is in [Appendix 11](#).

For the FY 2008 COP, we request that you estimate funding for food from Emergency Plan or leveraged resources. Please see page 103 for additional information.

## Partnerships

### **COLLABORATION WITH THE GLOBAL FUND TO FIGHT AIDS, TB, AND MALARIA (GLOBAL FUND/GFATM)**

Both in-country bilateral program support and USG central investments in the Global Fund are essential to the Emergency Plan Global Strategy. Implementation of the Emergency Plan has demonstrated the interdependence of these two approaches on the ground. USG Teams are strongly encouraged to have a representative on the Global Fund Country Coordinating Mechanism (CCM). Where possible, country teams should identify areas where Global Fund and bilateral assistance can complement each other, possibly assigning a division of labor between the two resources. For example, the Global Fund can sometimes purchase anti-retroviral drugs that national governments wish to use but that have not received tentative approval or approval from the HHS FDA. In these cases, the Global Fund might consider purchasing first-line drugs with the Emergency Plan dedicating its resources to the procurement of second-line regimens.

Given the commitment of the USG to the principles of the Three Ones, Emergency Plan resources and/or activities should be invested and programmed as needed to directly support HIV/AIDS GFATM grants. Examples include: strengthening the capacity of Country Coordinating Committees or placing time-limited technical advisors in Ministries of Health to strengthen capacity (e.g., strengthen logistics systems and create unified procurement approaches, strategic planning, monitoring and evaluation, etc.). Such investments should be time-limited, not focused on long-term recurring costs, and oriented to specific outcomes that will allow GFATM money to flow more quickly and efficiently. In addition, PEPFAR central funds (not programmed through COPs) provide technical assistance for GFATM HIV/AIDS, malaria and tuberculosis grants to address systemic issues (see Extranet for more details).

In FY 2008, reviewers will assess how countries are coordinating with the Global Fund. Please note that there are three new questions on Global Fund Collaboration in Table 1, and that the Global Fund Supplemental has been expanded and updated (see the Extranet for a sample). Please also describe USG Team interagency and external coordination with and technical assistance to Global Fund grants in program area narratives and activity narratives, where appropriate.

### **PRESIDENTIAL MALARIA INITIATIVE (PMI)**

The Presidential Malaria Initiative (PMI) is a five-year initiative that aims to achieve a 50% reduction in malaria-related mortality in supported countries. PMI targets groups that suffer the



major burden of malaria in sub-Saharan Africa, primarily children under five and pregnant women, and to a lesser extent adults living with HIV/AIDS. Though each program has different priority target constituencies and is accountable for different results, there is considerable overlap between PMI and PEPFAR in both target groups and potential activities, creating a need for both technical and fiscal coordination.

Where both PEPFAR and PMI are active, in-country PMI and PEPFAR teams should coordinate to optimize programming, use of available resources (including Global Fund and World Bank resources), and monitoring and evaluation. Please describe the process of coordination and coordinated activities in the relevant program area narratives (e.g., PMTCT, palliative care, OVC, laboratory, supply chain management, SI). Please include additional detail in activity narratives where applicable.

Focus countries that are also PMI countries for FY 2007 are Ethiopia, Kenya, Mozambique, Rwanda, Tanzania, Uganda and Zambia. Malawi is also a PMI country for FY 2007.

### **MILLENNIUM CHALLENGE CORPORATION (MCC)**

The Millennium Challenge Corporation (MCC) is a USG corporation whose mission is to reduce global poverty through the promotion of sustainable economic growth. Established in January 2004, MCC operates on the principle that aid is most effective when it reinforces good governance, economic freedom and investments in people. MCC provides monetary assistance to eligible countries through two types of programs: compact agreements and threshold agreements. A Compact is a multi-year agreement between the MCC and an eligible country to fund specific programs aimed at reducing poverty and stimulating economic growth. The Threshold program assists countries that are on the "threshold," meaning they have not yet qualified for MCC Compact funding, but have demonstrated a significant commitment to improve their performance on the eligibility criteria. MCC staff oversee Compact development and implementation whereas USAID runs the Threshold program.

Country teams are encouraged to coordinate with USAID on Threshold programs and with MCC staff on Compact programs, and to describe in the FY 2008 COP opportunities for leveraging MCC activities as wraparounds.

Among the focus countries, Mozambique and Namibia are Compact eligible; Guyana, Kenya, Rwanda, Uganda and Zambia are Threshold eligible; and Tanzania is both Compact and Threshold eligible. Other eligible countries include Lesotho (Compact) and Malawi (Threshold).

### **PARTNERSHIP FOR SUPPLY CHAIN MANAGEMENT (SCMS)**

The contract with the Partnership for Supply Chain Management (SCMS) is unique, because SCMS services and expertise are available to USG agencies, foreign governments, USG-financed contractors, grantees, and other organizations doing HIV/AIDS work. Country teams are encouraged to use SCMS because of the efficiency of centralized procurement and its expertise in supply chain management.

SCMS purchases antiretroviral drugs (ARVs), other essential drugs, laboratory supplies and equipment (including rapid test kits), other medical supplies, vehicles, and other equipment.

(e.g., audio-visual). Use of the SCMS contract increases efficiency and reduces costs by volume purchasing and being a single point of contact for manufacturers and consumers. By leveraging the economies of scale created by USG pooled procurement, SCMS is currently at or below the lowest reported price for all ARVs, generic or innovator. All USG agencies should consider using the procurement services of SCMS and phasing out other agreements for ARVs, other essential drugs, test kits and other laboratory supplies and equipment, and other commodities that lend themselves to centralized purchasing.

SCMS provides a full range of supply chain management services, including drug forecasting, quantification, overall management, warehouse and inventory control, procurement, freight and freight forwarding, quality assurance, information systems management, and in-country technical assistance and support. Technical assistance is available regardless of who is purchasing the commodities. Other donors, such as the Global Fund, also use SCMS.

The SCMS initially received core funding for many field activities in years 1 and 2. In FY 2008, field activities will transition to being fully field-funded. As with other central projects, the fully loaded costs to the USG will be made available and transparent for COP planning purposes.

**Allocating funds to SCMS in the COP:** A post can identify in its COP the amount of funds for SCMS that will come "off-the-top"; meaning they will go directly from OGAC to USAID and then SCMS, without being allotted to post. To do this, please identify USAID as the USG agency and Partnership for Supply Chain Management as the Prime Partner when entering the activity into the COP. It is imperative that you do not allocate funds that are allotted to you at post to fund SCMS COP activities, as the "off the top" funds will not be part of your post's allocation. Similarly, if you determine at some point after your COP has been approved that you would like to reprogram funds from another activity to SCMS, you should use the reprogramming process to accomplish this. If your needs are urgent and cannot wait for the next reprogramming, you should contact your core team leader who will work with OGAC/Budget and USAID/OHA/SCMS to determine the most expeditious means of addressing your situation.

In addition, Track I recipients and other USAID and HHS partners can subcontract non-competitively with SCMS, thereby relying on SCMS to satisfy the contract and agreement clauses that require subcontracts be competed to the maximum extent practicable, (often referred to as "the rule of three"). (When doing so, it is recommended that the grantee seek documentation from PFSCM regarding its compliance with this competitive standard.) Foreign governments and other organizations can also contract directly with SCMS or they can buy into the SCMS contract with USAID.

The SCMS contract is managed by USAID. If you have questions, please contact the USAID Supply Chain Management team - Carl Hawkins ([chawkins@usaid.gov](mailto:chawkins@usaid.gov)) Michael Hope ([mhope@usaid.gov](mailto:mhope@usaid.gov)), Kelly Manabe ([kmanabe@usaid.gov](mailto:kmanabe@usaid.gov)), Heidi Mihm ([hmihm@usaid.gov](mailto:hmihm@usaid.gov)), Chana Rabiner ([crabiner@usaid.gov](mailto:crabiner@usaid.gov)) or Jan Miller ([jmiller@usaid.gov](mailto:jmiller@usaid.gov)). More information about SCMS is available at [www.scms.SCMS.org](http://www.scms.SCMS.org).

**HIV/AIDS Working Capital Fund:** Please do not select the Working Capital Fund as a mechanism in the FY 2008 COP. If you used the Working Capital Fund in prior years, please use SCMS or other procurement mechanisms in FY 2008.

**PUBLIC PRIVATE PARTNERSHIPS**

The authorizing legislation for PEPFAR mandates that public-private partnerships (PPPs) be integrated into PEPFAR's strategy to combat HIV/AIDS. PEPFAR defines public-private partnerships as collaborative endeavors that combine resources from the public sector with resources from the private sector to accomplish the goal of HIV/AIDS prevention, care, and treatment. PPPs enable the U.S. Government and private sector entities to maximize their efforts through jointly-defined objectives, program design, and implementation, and through the sharing of resources, risks, and results. Three hallmarks of PPPs are that they help ensure sustainability of programs, facilitate scale-up of interventions, and leverage significant private-sector resources.

In FY 2008, we are asking for additional information on the amount of PPP funding in the COP and the amount of funding leveraged by those dollars. Please see page 103 for more information.

Should you have questions, please contact: British Robinson at (202) 663-2577 or [RobinsonBA1@state.gov](mailto:RobinsonBA1@state.gov) or Susan Williams at (202) 663-1977 or [WilliamsSM2@state.gov](mailto:WilliamsSM2@state.gov)

**NEW PARTNER INITIATIVE**

In FY 2008, NPI activities will be entered into the country COPs. NPI is funded from prior fiscal year budgets, and therefore all planned funding amounts will be entered as \$0. The remainder of the activity level entry should be completed, including narrative, targets and other information. Country teams should set activity level targets for the NPI activities based on what the partner will achieve by September 30, 2009. These targets should be incorporated into the summary targets for the program area, as well as in Table 2.

**Budget Adjustment Strategy**

For FY 2008, a strategy for a plus-up or reduction is not required. However, as you develop your COP, please think about what your funding priorities would be in the event a budget adjustment is required.

## COP Overview

### Changes from FY 2007

1. The “Emphasis Areas” now contain a streamlined list of former emphasis areas and key legislative issues. The definitions have been clarified and expanded, and we are no longer asking for a percentage of effort.

- |   |  |
|---|--|
| <input type="checkbox"/> Construction / Renovation                                    | <input type="checkbox"/> Local Organization Capacity Building                              |
| <input type="checkbox"/> Gender   | <input type="checkbox"/> New Partner Initiative (NPI)                                      |
| <input type="checkbox"/> Addressing male norms and behaviors                          | <input type="checkbox"/> PHE / Targeted Evaluation   |
| <input type="checkbox"/> Increasing gender equity in HIV/AIDS programs                | <input type="checkbox"/> Strategic Information (M&E, HMIS, Survey/Surveillance, Reporting) |
| <input type="checkbox"/> Increasing women's access to income and productive resources | <input type="checkbox"/> Workplace Programs  |
| <input type="checkbox"/> Increasing women's legal rights                              | <input type="checkbox"/> Wraparound Programs (Health-related)                              |
| <input type="checkbox"/> Reducing violence and coercion                               | <input type="checkbox"/> Child Survival Activities   |
| <input type="checkbox"/> Human Capacity Development                                   | <input type="checkbox"/> Family Planning   |
| <input type="checkbox"/> Training   | <input type="checkbox"/> Malaria (PMI)   |
| <input type="checkbox"/> Pre-Service Training   | <input type="checkbox"/> Safe Motherhood   |
| <input type="checkbox"/> In-Service Training  | <input type="checkbox"/> TB  |
| <input type="checkbox"/> Task-shifting  | <input type="checkbox"/> Wraparound Programs (Other)                                       |
| <input type="checkbox"/> Retention strategy   | <input type="checkbox"/> Economic Strengthening  |
|   | <input type="checkbox"/> Education   |
|   | <input type="checkbox"/> Food Security   |

2. Within the Emphasis Area section, we are asking for the dollar amount spent on food, pediatric AIDS treatment, and public-private partnerships.

#### Food Support

- |  |                      |
|--|----------------------|
| <input type="checkbox"/> Estimated PEPFAR Dollars spent on food                    | <input type="text"/> |
| <input type="checkbox"/> Estimation of Other Dollars leveraged in FY 2008 for Food | <input type="text"/> |

#### Pediatric AIDS

- |  |                      |
|--|----------------------|
| <input type="checkbox"/> Dollars Spent on Pediatric AIDS Treatment | <input type="text"/> |
|--|----------------------|

#### Public Private Partnership

- |  |                      |
|--|----------------------|
| <input type="checkbox"/> Estimated PEPFAR Contribution in Dollars    | <input type="text"/> |
| <input type="checkbox"/> Estimated Local PPP Contribution in Dollars | <input type="text"/> |

3. The list of target populations has been streamlined with expanded and clarified definitions.

General Population

- ☐ Children (under 5)
  - ☐ Boys
  - ☐ Girls
- ☐ Children (5-9)
  - ☐ Boys
  - ☐ Girls
- ☐ Adolescents
  - ☐ Ages 10-14
    - ☐ Boys
    - ☐ Girls
  - ☐ Ages 15-24
    - ☐ Men
    - ☐ Women
- ☐ Adults (25 and over)
  - ☐ Men
  - ☐ Women

Other

- ☐ Business Community
- ☐ Civilian Populations (only if the activity is DOD)
- ☐ Discordant Couples
- ☐ People Living with HIV/AIDS
- ☐ Pregnant Women
- ☐ Orphans and Vulnerable Children
- ☐ Refugees / Internally Displaced Persons
- ☐ Religious Leaders
- ☐ Teachers

☐ Most at Risk Populations

- ☐ Incarcerated Populations
- ☐ Injecting Drug Users
- ☐ Men who have sex with men
- ☐ Military Populations
- ☐ Mobile Populations
- ☐ Non-injecting Drug Users (includes alcohol use)
- ☐ Persons in Prostitution
- ☐ Persons who exchange sex for money and/or other goods with one or more multiple or concurrent sex partners (transactional sex), but who do not identify as persons in prostitution
- ☐ Street Youth

4. Pediatric AIDS treatment dollars can no longer be counted toward the OVC budgetary requirement, and must be counted toward the treatment budgetary requirement
5. Country teams will provide estimates of several categories of health care worker support
6. Staffing information will be collected through a new tool in the FY 2008 COP, and the Staffing Matrices have been eliminated, with the exception of the Peace Corps Volunteer Matrix.
7. There is additional guidance on splitting comprehensive activities across program areas / budget codes
8. Pediatric AIDS funding information will be collected at the activity level
9. NPI activities will be entered in the COP with \$0 dollar amounts
10. Country teams will enter Track 1.0 funding information
11. Other bilaterals will enter central funding activities with \$0 dollar amounts
12. PHE activities will be entered as separate activities within the appropriate technical program area in Table 3.3. Activity narratives are required for all PHE activities; the narratives will replace the PHE background sheet.
13. A new field has been added in Table 3.1 to collect the procurement/assistance instrument
14. There are three new questions on Global Fund Collaboration (these are not activity-specific, and will be collected in Table 1).
15. A "Related Activities" Table has been added
16. Early funding requests and narratives will be collected at the activity level

17. There is a new TB/HIV indicator for the “Number of registered TB patients who received counseling and testing for HIV and received their test results at a USG-supported TB service outlet”
18. HQ short-term technical assistance should no longer be included in the COP.
19. Country teams can spend up to \$3 million or 1.5% of the country budget on pre-service long-term training, whichever is smaller.

## COP Sections

1. Table 1 – This table is essentially an overview of the COP, and contains the following information
  - Ambassador Letter
  - Executive Summary / CN Summary – This should follow the Congressional Notification format available on the Extranet. Core Team Leaders can assist countries in drafting the Executive Summary, in order to ensure correct formatting and reduce the need for extensive editing.
  - Five-Year Strategy Updates – This section provides space to update any of the information provided in the Five-Year Strategy
  - Country Contacts – The contact information for each USG Agency participating in the Emergency Plan in your country.
  - Global Fund Questions
2. Table 2 – There are seven indicators listed here for which downstream (direct) and upstream (indirect) country targets need to be set. Targets are required for both the end of FY 2008 and the end of FY 2009.
3. Table 3.1 – This funding mechanism list provides a summary of the unique funding mechanisms in the plan, defined by mechanism type, funding source, USG Agency and prime partner.
4. Table 3.2 – This table is where sub-partner information is entered.
5. Table 3.3 – Activities by funding mechanism are the core of the COP. Table 3.3 provides the details on the activities planned for the fiscal year.
6. Table 4 – The summary budget report is generated automatically by the data system.
7. Table 5 – This table asks for information on any broad data collection efforts that are planned for the fiscal year.

## Required Support Documents

**Any uploaded tables must be live Excel tables.**

1. Budgetary Requirements Worksheet – a new COPRS report will automatically calculate the budgetary requirements worksheet, but country teams should still upload it as a supporting document.
2. Explanation of Target Calculations – An explanation of how targets listed in Table 2 and Table 3.3 were calculated. Please include both downstream (direct) and upstream (indirect) calculations and downstream (direct) summary targets by program area.
3. FY 2009 Funding Planned Activities – Please provide a few paragraphs detailing the work that will be undertaken with FY 2009 funding.

4. Staffing for Results – Peace Corps Volunteer matrix; functional staff charts and data as requested separately
5. Global Fund Supplemental – This document summarizes the support your country provides to the Global Fund in-country. A template and specific instructions are found on the Extranet.
6. Budgetary requirement justifications (if applicable)
7. Single Partner Funding Justification (if applicable)

## System Modifications for FY 2008

Over the past several months, a team comprised of headquarters and field staff has made many enhancements to the COPRS system. We hope that it will be easier to enter data and extract information from the COP.

Although we detail specific changes later in the guidance, below is an overview:

1. Data screens re-organized to minimize wasted space
2. Almost every table in the COP can be sorted by different columns (e.g. Mechanism ID or Prime Partner Name).
3. All indicators have been numbered for easy reference.
4. A new section of the COP lists control numbers for all funding sources. The quality assurance report will compare these numbers to the funding amounts entered in the COP.
5. Mechanism and activity ID will remain the same from FY 2007 to FY 2008. For example, in FY 2007, if the mechanism ID number is 1234.07, in FY 2008, the ID will be 1234.08. When users import activities from the FY 2007 COP, COPRS will establish the link between activities and mechanisms. Country teams can later re-link activities and mechanisms if necessary.
6. Users can search for partners either by full name or by acronym
7. Many screens can be printed or exported to Microsoft Word, Microsoft Excel, or Adobe PDF.
8. From the Table 3.3 Table of Contents, users can navigate to any program area summary or activity list.
9. The Quality Assurance Report has been improved and expanded.
10. New reports are available to assist with data entry.

This briefly summarizes the changes. Please see the following sections for more details.

## System Overview

The COPRS data system is intended for use after you have largely determined the content of your Country Operational Plan. To assist in COP development, we have posted several partner information forms, developed by USG field teams, on the PEPFAR Extranet, under FY 2008 COP Planning.

**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](mailto: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 in a News to the Field announcement in August. The warmline will not begin operation until September 2007.

**Working in Word:** Text can be copied into the data system by copying the text, and then pasting it into the appropriate box in the COPRS data system. Please be aware that special 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, narratives drafted in Word can be readily edited (including spell-checked & length checked) before being copied into the COPRS data system.

Please note that COPRS character counts include spaces, punctuation, and paragraph breaks. Microsoft Word counts characters and spaces, but does not include punctuation and paragraph breaks.

**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 three 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 do not 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 29), 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.

**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. Depending on the administrative rights that you have, you will see only a subset of all the available roles.

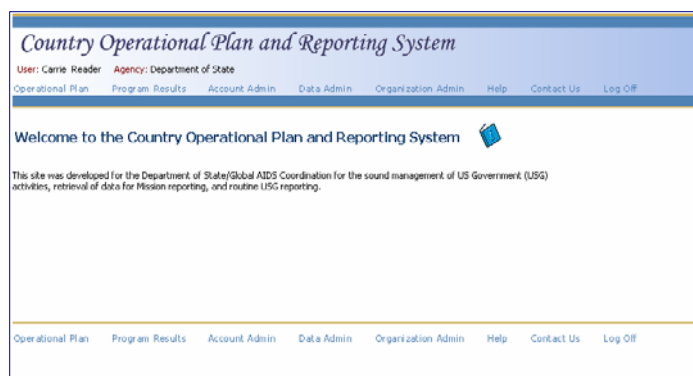
The roles for users in-country are the most extensive and most important. They are relied upon to input all of the data and to ensure the accuracy of the data. The type of access in-country users have will vary at different times of the year depending upon what reporting is being done. The role of users 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.

## Getting Started

**Technology Requirements:** 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.

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

**Welcome:** 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 consist of the following:

**Operational Plan**—Allows users, depending on their access level, to view and/or enter data, print reports, and submit and approve the COP. At any point in time, individuals with any level of access to the COP section will be able to view data in this section.

For all countries, the data entry window for the FY 2008 COPs will begin on August 13, 2007 and will end on September 28, 2007.

**Program Results**—Allows users to enter data, print reports and submit the Program Results. This section is only available for data entry right before the APR is due. Users will still be able to review data, search for information and print reports. However, data entry will not be available.

**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 HQ/ Country USG COPRS administrators to add and update data (agency, country, funding source type, program type, etc.) in the data system.

**Organization Admin**—Allows HQ 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 questions regarding technology, bugs, connection problems


**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 in the system. 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 three minutes remaining before being logged off. If you receive the three 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 alongside 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 review relevant 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 sensitive and 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 two weeks of receiving your user account. If the confidentiality agreement is not returned to Tiffany Peoples at OGAC within two weeks of receiving your user account, your account will be disabled.

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## COP Sections

### Table 1 OVERVIEW

#### MODIFICATIONS IN THIS SECTION:

Table 1 now contains the Executive Summary, Ambassador Letter, Five-Year Strategy updates, and three questions on Global Fund collaboration.

#### AMBASSADOR LETTER

##### CONTENT:

In FY 2008, this letter will be uploaded as part of Table 1. While the document is uploaded in Table 1, it will also appear in / be downloaded from the Supporting Documents section.

#### EXECUTIVE SUMMARY

Note: Special instructions for Other Bilateral Countries at the end of this section.

#### MODIFICATIONS IN THIS SECTION:

We have included more specific instructions for the information that must be included in the Executive Summary. In addition, countries will not need to complete the summary funding or targets table.

##### 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 and specific formatting instructions can be found on the Extranet. Please write the Executive Summary in Word and then upload the file into the data system.

Please note that Core Team Leaders can assist with preparing this document. Please engage them in this process at least a month before your COP is due.

Please do not include additional support documents here. There is a separate section for additional support documents (see page 121 for instructions).

#### SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:

As in FY 2007, Other Bilateral Countries will submit a CN Summary instead of an Executive Summary. The CN Summary should follow the format and instructions described on the Extranet. It should be no more than one paragraph for each USG agency receiving GHAI funding.

#### DATA ENTRY:

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 look at a file that has already been uploaded, select **View**
5. 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 upstream (indirect) target calculation, etc.

## **FIVE-YEAR STRATEGY UPDATES**

### **CONTENT:**

This section is for identifying any modifications to the USG Five Year Strategy that your country will be undertaking, or any changes in country context. If the country context remains largely unchanged, or you have no modifications to the USG Five Year Strategy at the current time, simply answer no to the first question and move on.

### **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 Five-Year Strategy this year?”
2. If the answer is No, continue on.
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).

## **COUNTRY CONTACTS:**

### **CONTENT:**

Please list the contact information for each of the USG agencies working in your country. Typically, this includes individuals for the following USG agencies and the PEPFAR Coordinator:

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

Optional contacts from USG Agencies include: HHS/HRSA, HHS/OGHA, HHS/NIH, HHS/SAMHSA, Department of Labor, and USDA. You may also include additional contact information for any host country ministries 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. 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.

### GLOBAL FUND QUESTIONS

Please answer the following questions concerning your in-country assistance to the Global Fund. You will provide a more detailed explanation in the Global Fund Supplemental.

1. What is the planned funding for Global Fund Technical Assistance in FY 2008?
2. Does the USG assist with Global Fund proposal writing? (Yes/No)
3. Does the USG participate on the CCM? (Yes/No)

## TABLE 2 PREVENTION, CARE AND TREATMENT TARGETS

**For the FY 2008 COP, you will be asked to complete two separate Table 2's.**

- Table 2.1 is an opportunity to provide an update of the targets submitted in your FY 2007 COP for the period that ends September 30, 2008 (FY 2008).
- Table 2.2 covers the period that ends September 30, 2009 (FY 2009).

**The instructions below apply to both tables.**

### MODIFICATIONS IN THIS SECTION:

None

### CONTENT:

#### **NATIONAL (2-7-10) GOALS:**

The prevention, treatment, and care goals set for your country at the initiation of the Emergency Plan reflect national targets. They are the Five-year goals to be achieved by the USG in collaboration with all other donors working in the country and the host country government. These goals will be included in the data system for your country as constant, fixed values. You will not be able to change these national goals. The date for achieving your country-level total care and treatment goals is September 30, 2009. The date for achieving your country-level prevention (infections averted) goal remains unchanged; this goal is to be achieved by September 30, 2010.

#### **USG FY 2008 & FY 2009 TARGETS:**

#### **GENERAL GUIDANCE**

- Table 2 indicators require both Upstream and Downstream Targets (see definitions below). Upstream and downstream targets are equally valued by PEPFAR.
- Assistance with Targets:  
It is critical that you begin working with your Core Team SI Advisor and Core Team Members on this section as early as possible. Your Core Team SI Advisor can assist with setting your targets. OGAC will provide general guidelines, but not specific guidance on how to set these targets for each country, as this is a very country-specific process (See [Appendix 19](#) for information on target setting).

Additional Guidance (These documents can be found in the help section of the COPRS database or on the PEPFAR Extranet):

- *The President's Emergency Plan for AIDS Relief Indicators, Reporting Requirements, and Guidelines: Revised for FY 2007 Reporting, January, 2007*
- *Data Quality Assurance Tool for Program-Level Indicators; January 2007*
- *Target-setting examples*
- Timeframe:

The timeframe for all targets in Table 2 is the fiscal year. However, there are two different fiscal years represented by Table 2.1 and Table 2.2. The timeframe for Table 2.1 is the end of the USG FY 2008, which is October 1, 2007 – September 30, 2008. The timeframe for Table 2.2 is the end of USG FY 2009 which is October 1, 2008 – September 30, 2009. Annual Program Results (APR) will be evaluated against these targets.

Table 2 indicators should reflect what could be accomplished within the given fiscal year, regardless of the year of the funding source. In any given year you may achieve results using funding from previous years as well as the current year. These targets will be used to report to the U.S. Congress what we plan to accomplish over the coming year.

- A target must be expressed as a whole number value (e.g. 400,000), not as a range (e.g. 250,000 – 500,000).
- Track 1.0: The number of individuals receiving care and treatment as a result of central funding to Track 1.0 activities must be included in your USG end of fiscal year country targets.

#### **PREVENTION TARGETS:**

##### Infections Averted:

Due to the difficulty of estimating infections averted, countries are not required to provide a fiscal year target for infections averted. Rather, headquarters will estimate infections averted through modeling, using data from periodic prevalence studies, with the U.S. Census Bureau (BUCEN) taking the lead. Trends in HIV prevalence can be used to estimate trends in HIV incidence and the number of infections averted. The first step of this approach is to establish baseline prevalence trends for each country using data through 2004 to estimate the baseline HIV incidence. Trends will be established again at the end of the Emergency Plan using the most up-to-date information available and the difference between these two HIV incidence trends will represent the net impact of program activities since the start of the Emergency Plan. At present, BUCEN has completed the development of all 15 focus country baseline estimates for HIV incidence. 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.

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

#### **The following indicators are included Table 2:**

##### **PMTCT Indicators:**

- 1.2      Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results**
- 1.3      Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting**



**CARE INDICATORS:**

The Care targets are a sum of the following:

**6.2 Total number of individuals provided with HIV-related palliative care (including TB/HIV)**

**7.2 Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease** (this is a subset of indicator number 6.2)

**8.1 Number of OVCs served by OVC programs**

- The Care sum will be automatically generated by the system as the aggregate of the two care indicators (Palliative Care #6.2 and OVC #8.1).
- The indicator for counseling and testing is not included in the care total due to potential double counting.
- The Palliative Care indicator shown above, inclusive of TB/HIV, is NOT the same indicator that will appear in Table 3. This is because palliative care and TB/HIV are two separate program areas and therefore need to have separate indicators to show targets. Please see [Appendix 5](#) for a complete list of the indicators that appear in Table 3.
- Children on ART may also be counted in either OVC or care depending on the services that they receive. They should not be counted in both OVC and care.

**COUNSELING & TESTING INDICATOR:**

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

The TWG no longer recommends the use of a formula to set CT targets, as this formula has led to confusion and variable interpretations in the field. When setting targets, country teams should ensure that partners have ambitious targets, and for partners with “direct” targets, the targets should be in line with the budget and recommendations on costs per person served.

**TREATMENT INDICATOR:**

**11.4 Number of individuals receiving antiretroviral therapy at the end of the reporting period**

The FY 2008 and FY 2009 COP targets listed here in Table 2 will be evaluated by OGAC based on results reported in the relevant APR.

**USG DOWNSTREAM (DIRECT) SUPPORT:**

An intervention or activity is considered to be a type of “downstream (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 that receives USG support. Sites may receive support from additional partners but should be counted as USG supported sites if they receive USG direct support.

Please estimate the number of individuals receiving prevention, care, and treatment services through service delivery sites/providers directly supported by USG interventions/activities (commodities, drugs, supplies, supervision, continuing on-site training, quality assurance, etc.) at the point of service delivery. If you do not provide downstream support, please use a zero (“0”) for the downstream result.

### **USG UPSTREAM (INDIRECT) SUPPORT:**

Upstream (indirect) support refers to contributions made by the USG to overall system strengthening and capacity building that occur apart from, and at higher levels than, the actual points of service delivery. The level of funding available for USG upstream programs will vary by country, and while USG upstream funded activities may contribute to projected national or regional results, they may not contribute significantly, which is a requirement for setting upstream targets. (See the *Data Quality Assurance Tool for Program-Level indicators* for additional guidance). Upstream and downstream services are valued equally and the distribution of programs and hence results between upstream and downstream is a function of national program development.

For upstream (indirect) targets, project the number of individuals receiving prevention, care and treatment services, beyond those counted above under downstream (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.

For those program areas where only upstream funding is provided, use the national or regional target for that indicator and provide appropriate justification. If national targets do not exist, the USG team needs to estimate a target based on the number of individuals served during the previous fiscal year in the country or region and any other available contextual information.

Examples of upstream (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.

### **TOTAL USG SUPPORT:**

Total USG Support is the simple sum of downstream (direct) and upstream (indirect) support. The data system will automatically calculate the total USG support. However, 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 upstream (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 downstream (direct) counts. Individuals reached through upstream (indirect) support should be in addition to those reached via downstream (direct) support in order to make these categories mutually exclusive. Country teams will need to enter the downstream target and the upstream target already adjusted to take this into account. Total USG support, except in specific and well-documented cases, should not be greater than the national total for any indicator. All results reported against these targets to OGAC should be coordinated with country governments and reviewed by them before submission.

### **SUPPORT DOCUMENTATION:**

It is critical that you work with your SI Advisor and other Core Team Members 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 examples on the Extranet).

	National 2-7-10 ⓘ	USG Direct Target End FY06 ⓘ	USG Indirect Target End FY06 ⓘ	Total USG Target End FY06 ⓘ
<b>Prevention ⓘ</b>	<b>Target 2010: 810,202</b>			
Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<b>Care ⓘ</b>	<b>Target 2008: 1,050,000</b>			
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)		<input type="text"/>	<input type="text"/>	<input type="text"/>
Number of OVC served by an OVC program during the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Number of individuals who received counseling and testing for HIV and received their test results during the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<b>Treatment ⓘ</b>	<b>Target 2008: 210,000</b>			
Number of individuals receiving antiretroviral therapy at the end of the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<input type="button" value="Update Total"/>				

### **DATA ENTRY:**

Enter target numbers into the cells for the two prevention indicators, the three care indicators, the one counseling and testing indicator, and the one treatment indicator. Enter both downstream (direct) and upstream (indirect) targets for each indicator. The data system will automatically sum downstream (direct) and upstream (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 spent in the planning process will be reflected. It is critical that you work as one USG team, engaging all of the USG Agencies with HIV/AIDS activities in-country when coordinating your activities in Table 3.

### PLANNING OBJECTIVES AND TIMEFRAME:

Table 3 provides a valuable opportunity to describe your program, and serves primarily as 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 timeframe for reaching Table 3 targets should be no later than September 30, 2009.

## Table 3.1 FUNDING MECHANISMS & SOURCE TABLE

### FUNDING MECHANISM DEFINITION

#### CONTENT:

The COP is designed to be a document that follows funding, and as such, funding information is organized by what we have termed "funding mechanisms." A funding mechanism is 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.

In Table 3.1, you will list all funding mechanisms needed to provide funds to your partners.

One unique funding mechanism has six key characteristics that together make up a unique entry:

1. funding mechanism type
2. funding mechanism name
3. procurement / assistance instrument (new in FY 2008)
4. USG agency
5. funding source
6. prime partner

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

Example: In the case of a prime partner, such as Family Health International, or a specific project, such as the UTAP 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 other six key characteristics, with its own unique identifier.

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

There is an exception. You might have a prime partner working in your country under two different HQ mechanisms. For example, Academy for Educational Development is the prime partner on both the FANTA Project and the Linkages 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.

**\*Note:** It is possible for a given USG agency to also be considered a prime partner. Please see page 52 for further details about this.

To create a funding mechanism and its row in the master list, you will complete the screen in Table 3.1, which asks for the six characteristics of a unique mechanism. Entering these mechanisms may be the most time-consuming part of working in the COPRS database. FY 2007 funding mechanisms can be imported into your FY 2008 COP, which will save time.

### IMPORTING ITEMS FROM YOUR FY 2007 COP:

#### MODIFICATIONS IN THIS SECTION:

- Early Funding requests will not be imported from your FY 2007 COP
- Partners that were new in FY 2007 will be changed to “not new” when they are imported into the FY 2008 COP
- You no longer need to import activities that do not require additional funding in FY 2008.

#### OVERVIEW:

The COP is designed to be a document that follows funding and as such, many funding mechanisms and activities by funding mechanism are the same from one year to the next. You can select items from your FY 2007 COP to be imported into your FY 2008 COP. You can either import an entire funding mechanism, or select a few activities within a funding mechanism.

You still should review the information that has been imported and you MUST update the imported items based on what will be happening in the current year, particularly with respect to targets and funding. You will receive an error message in the Quality Assurance Report for any imported items that are not updated. In Table 3.1, you will see a red asterisk (\*) next to any mechanism with activities that have not been updated.

#### CONTENT:

You are able to import items from your FY 2007 COP. This import feature will bring in:

- the funding mechanisms listed on Table 3.1

- the sub-partners listed in Table 3.2
- the specific activities linked to that funding mechanism from the different program areas in Table 3.3.

When you select to import funding mechanisms, you will then have the option of selecting specific activities linked to that funding mechanism. When you select an activity, you will be importing all items associated with that activity, including: the Activity Narrative, Targets, and Coverage Areas. For a list of emphasis areas and definitions, please see page 98.

Once you have imported items, you will be able to edit both the funding mechanism information and the activity by funding mechanism information. As procurement/assistance instrument is a new field in Table 3.1, you will need to go back into each mechanism and add the instrument.

The list of emphasis areas has been changed in FY 2008, but if the emphasis area, key legislative issue or target population has not changed, it will still be imported. You must update any new emphasis areas, target populations or emphasis areas with dollar amounts.

**Please note – while you are able to re-import funding mechanisms, the newly imported mechanism will not overwrite the old mechanism, but will create a new record.**

### **Activity Narratives for Ongoing Activities**

As ongoing activities do not need extensive revision in FY 2008, please make sure that all narratives have been updated. If an activity is imported, but you are not going to update the narrative, please delete the narrative or clearly mark that this is from FY 2007 and has not been updated.

If the country team does not have to complete narratives in a specific program area, please delete the activity narrative text before submitting the COP. You should still import the activity from the COP to capture the targets, emphasis areas, target populations, and coverage areas. Unless explicitly stated in the activity narrative text, we will assume all narratives have been updated.

### **DATA ENTRY:**

Below is a list of Mechanisms from previous fiscal year. Select the ones you need to bring forward to current fiscal year by checking the boxes listed below. Then click on the **Next** button.

Mechanism	Planned Funding Agency	Prime Partner
<input type="checkbox"/> Headquarters procured, country funded (HQ)	US Agency for International Development	To Be Determined
<input type="checkbox"/> Headquarters procured, country funded (HQ)	Department of Health & Human Services	To Be Determined
<input type="checkbox"/> Locally procured, country funded (Local)	Department of State	To Be Determined
<input type="checkbox"/> Locally procured, country funded (Local)	Department of Health & Human Services	To Be Determined
<input type="checkbox"/> Headquarters procured, country funded (HQ)	US Agency for International Development	Abt Associates
<input type="checkbox"/> Headquarters procured, country funded (HQ)	US Agency for International Development	Abt Associates
<input type="checkbox"/> Headquarters procured, country funded (HQ)	US Agency for International Development	Academy for Educational Development
<input type="checkbox"/> Headquarters procured, centrally funded (Central)	Department of Health & Human Services	American Association of Blood Banks
<input type="checkbox"/> Headquarters procured, country funded (HQ)	Department of Health & Human Services	Association of Public Health Laboratories
<input type="checkbox"/> Headquarters procured, country funded (HQ)	US Agency for International Development	CARE International
<input type="checkbox"/> Locally procured, country funded (Local)	US Agency for International Development	CARE International
<input type="checkbox"/> Locally procured, country funded (Local)	Department of State	Catholic University of Mozambique
<input type="checkbox"/> Locally procured, country funded (Local)	Department of State	Catholic University of Mozambique
<input type="checkbox"/> Headquarters procured, centrally funded (Central)	Department of Health & Human Services	Columbia University
<input type="checkbox"/> Headquarters procured, country funded (HQ)	Department of Health & Human Services	Columbia University
<input type="checkbox"/> Headquarters procured, country funded (HQ)	Department of Health & Human Services	Columbia University
<input type="checkbox"/> Headquarters procured, country funded (HQ)	Department of Health & Human Services	Crown Agents

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. If an item does not have a check box, then this item has already been imported into your FY 2008 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 sub-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.

NOTE: This screenshot is for illustrative purposes, as the actual data entry screen and data entry instructions may be slightly different.

## ACTIVITIES LIST

### MODIFICATIONS IN THIS SECTION:

This year, users will also be able to add activities from the List Activities screen.

### CONTENT:

You can 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 row.

**3.1 Funding Mechanisms and Source** Print/Export  
View/Add Comments

**Activity List**

**Mechanism Name:** TBD Cooperative Agreement  
**Prime Partner:** To Be Determined  
**Agency:** HHS/CDC  
**Mechanism Type:** Headquarters procured, country funded (HQ)

	Activity ID	Program Area	Activity Narrative	Planned Amount	
<a href="#">Edit</a>	8757	PMTCT	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>
<a href="#">Edit</a>	8778	HVAB	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>
<a href="#">Edit</a>	9898	HVOP	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>
<a href="#">Edit</a>	9898	HVOP	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>

Add activities to:

## FUNDING MECHANISM ID

### MODIFICATIONS IN THIS SECTION:

We have changed the numbering convention of the funding mechanism ID number and made them comparable across fiscal years. For instance, if the FY 2007 mechanism ID was 1234.07, the same mechanism would be 1234.08 in FY 2008.

### CONTENT:

When users import activities from the FY 2007 COP, COPRS will establish the link between activities and mechanisms. Country teams can later re-link activities and mechanisms if necessary. More information on the mechanics of re-mapping will be forthcoming.

## 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 6](#). **Review of this Appendix before entering data in Table 3.1 is crucial!**

There are four options for the funding mechanism type:

1. **CENTRAL:** Headquarters-procured and centrally-funded - Central activities include Track 1.0 grants and the New Partners Initiative.
2. **HQ:** Headquarters-procured and country-funded - HQ mechanisms include field support (USAID), MAARDS (USAID), buy-ins to headquarters managed activities, task orders to headquarters managed activities, PASA activities and country buy-in to Track 1.0 awards. Please see [Appendix 6](#) for a list of HQ mechanisms by Agency.

*For DoD, 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. **LOCAL:** Locally-procured and country-funded - 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 CDC, all funds allotted to post via cable are considered local.*

*For DoD, 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. **UNALLOCATED:** Only the GHAI account may be tagged for unallocated funding. Please see page 50 for more information.

**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.

**New Partners Initiative:** NPI mechanisms should be entered as separate mechanisms in Table 3.1, and the mechanism type should be Central. Please name the mechanism NPI.

#### DATA ENTRY:

"Mechanism Type" is a drop down menu that will have the above four options. You can only select one option.

#### FUNDING MECHANISM NAME:

##### CONTENT:

While this is not a required field, many countries find it much easier to reference and reprogram funds when the mechanism has a unique name.

We have seen the following mechanism naming conventions:

- Partner Acronym: AIHA; CHAZ
- Contract / Cooperative Agreement Number
- Project Name: Support to RDF; Sun Hotel PPP; GHAIN; Track 1.0 buy-in; Track 1.0 OVC
- Funding Source: GHAI, Base (this helps identify different funding streams when users add activities in Table 3.3)

If this is a HQ funding mechanism, you must put the name of the HQ project in the funding mechanism name cell. For example, if you are using the CTRU Project or UTAP, you should use these names in the funding mechanism name field. Please see [Appendix 6](#) for a list 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). Below are several examples of the difference between funding mechanism type, funding mechanism name and prime partner name.

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	UTAP	Columbia University
Local	PSC	U.S. Agency for International Development
Local	Network RFP	To Be Determined

#### DATA ENTRY:

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

#### PROCUREMENT /ASSISTANCE INSTRUMENT:

##### MODIFICATIONS IN THIS SECTION:

This is a new field in FY 2008

##### CONTENT:

In FY 2008, we added a new field for procurement/assistance instrument. The types of procurement/assistance instruments are:

- **Contract:** A mutually binding legal instrument in which the principal purpose is the acquisition, by purchase, lease, or barter, of property or services for the direct benefit or use of the Federal government, or in the case of a host country contract, the host government agency that is a principal, signatory party to the instrument.

Note: IQCs should be listed as contracts

- **Cooperative Agreement:** A legal instrument used where the principal purpose is the transfer of money, property, services or anything of value to the recipient in order to accomplish a public purpose of support or stimulation authorized by Federal statute and where substantial involvement by the USG is anticipated.

Note: PASAs should be listed as cooperative agreements

- **Grant:** A legal instrument where the principal purpose is the transfer of money, property, services or anything of value to the recipient in order to accomplish a public purpose of support or stimulation authorized by Federal statute and where substantial involvement by USG is **not** anticipated.

**DATA ENTRY:**

Select the procurement / assistance instrument from the drop-down menu.

**FY 2008 PLANNED FUNDING (\$):**
**CONTENT:**

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

**DATA ENTRY:**

N/A

**USG AGENCY:**
**CONTENT:**

From the drop-down list, select the USG Agency responsible for managing the funding mechanism.

It is critical that you identify the correct agency, because the USG Agency / Operating Division will be the one that receives the funding from OGAC.

AGENCIES	
DOD (Department of Defense)	HHS (Health and Human Services)
DOL (Department of Labor)	CDC (Centers for Disease Control and Prevention)
Department of State	HRSA (Health Resources and Services Administration)
AF (African Affairs)	NIH (National Institutes of Health)
A (Bureau of Administration)	OS (Office of the Secretary)
EAP (East Asian and Pacific Affairs)	SAMHSA (Substance Abuse and Mental Health Services Administration)
EUR (European and Eurasian Affairs)	Peace Corps
INR (Intelligence and Research)	USAID
NEA (Near Eastern Affairs)	
OGAC (Office of the U.S. Global AIDS Coordinator)	
PM (Political-Military Affairs)	
PRM (Population, Refugees, and Migration)	

SCA (South and Central Asian Affairs)  
WHA (Western Hemisphere Affairs)

**NIH** - 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.

**HRSA** - Please note that although CDC locally manages HRSA partners such as ITECH and the Twinning Center (American International Health Alliance (AIHA)), HRSA should be listed as the associated agency. There may be other instances in which CDC locally manages an activity, but HRSA is the associated agency, such as NY AIDS Institute (HIVQUAL) and Georgetown University (Nursing Capacity Building).

**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.

**State** – To expedite the distribution of funds, please identify the State Department Bureau for all mechanisms where the Department of State is the USG Agency.

#### DATA ENTRY:

Please select the USG Agency from the drop down menu.

**Table 3.1: Funding Mechanisms and Source** ⓘ

**Add Mechanism/Source**

Save Cancel

Mechanism Type: Locally procured, country funded (Local) ⓘ

Funding Mechanism Name: ⓘ

Planned Funding (\$): ⓘ

Agency: DoD ⓘ

Funding Source: DoD ⓘ  
DoL ⓘ

Prime Partner: HHS/CDC ⓘ  
HHS/HRSA ⓘ  
HHS/NIH ⓘ  
HHS/OS ⓘ  
HHS/SAMHSA ⓘ

New Partner: ⓘ

Early Funding Request: Peace Corps ⓘ  
State ⓘ  
State / A ⓘ  
State / AF ⓘ

Select Partner ⓘ

Save Cancel

**FUNDING SOURCE:****CONTENT:**

For each USG agency, there are funding sources associated with that agency. The funding source choices for each agency are:

USG Agency	Funding Source Categories
USAID	GHAI Central (GHAI) Central (CSH)* AEEB * CSH * FSA * ESF *
HHS/CDC	GAP GHAI Central (GHAI)
HHS/HRSA	GHAI Central (GHAI)
HHS/OS	GHAI Central (GHAI)
DoD	GHAI DHAPP *
DoL	GHAI
State	GHAI Central (GHAI)^ FSA*
Peace Corps	GHAI
ALL OTHERS	GHAI

\* Other Bilateral Countries Only

^ If the USG Agency is State Department, RPSO should be the only partner with Central (GHAI) funding source

**GAP** – This category used to be called “Base (GAP Account),” and is still applicable. The list, by country, of “Base” levels will be provided to you in early June 2007. USAID will NOT have “Base” funding for the focus countries.

**Reminder** – Please ensure that you are coordinating as a USG Team in determining funding decisions and that “GAP” funding is not being programmed independently of the USG Team.

**Central/Track 1.0 Mechanisms Funded by HQ Budgets:** When the funding mechanism is Central (Track 1.0 funded out of HQ budgets), the funding source category is “Central”. Central is only to be used for Track 1.0 or NPI partners. Country funding that is going into a Track 1.0 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.

**UNALLOCATED:**

Note: Special instructions for Other Bilateral Countries at the end of this section.

**CONTENT:**

OGAC recognizes that early COP planning reduces program flexibility. Therefore, a flexible funding option will again be available in this year's COP. You may designate up to five percent of your GHAI budget as unallocated. The Quality Assurance Report will verify that no more than 5% of GHAI is set aside as unallocated.

Allocation of unallocated requests must be submitted to OGAC as part of the reprogramming process before funds will be approved and notified. Please submit allocation of unallocated requests as soon as possible. The date of the final submission deadline will be forthcoming.

Country: Ethiopia FY: 2006

**Table 3.1: Country Plan - Funding Mechanisms and Source** ⓘ

Mechanism Type:	Unallocated ⓘ
Planned Funding (\$):	ⓘ

**SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:**

In FY 2008, other bilateral countries cannot have unallocated funds.

**DATA ENTRY:**

Click the **Add Mechanism/Source** button.

1. In the Mechanism Type drop down box, select Unallocated.
2. Type in the planned Unallocated funding into the cell.
3. You do not need to include the \$ sign, commas, decimal places or cents. Enter a number rounded to the nearest dollar.
4. Click on the **Save** button.

**PRIME PARTNER:****CONTENT:**

A prime partner is an entity which receives funding directly from, and has a direct legal 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 or organizations that were entered in the FY 2004, FY 2005, FY 2006, or FY 2007 COPs, which currently includes over 3,000 organizations. Please note that there is a distinction between an organization and a partner. An organization can be any organization listed in the COPRS system. An organization becomes a partner by being selected by a country as either a prime or a sub-partner.

Adding an Organization or Partner to the COPRS Database
<p>If the organization that you are looking for is not in the data system, please send an email to Vanessa Brown (Brown VJ@state.gov). A template is available on the Extranet, which contains all of the required information. You must provide:</p> <ol style="list-style-type: none"> <li>1. the full name of the organization (spelled out, without acronyms or abbreviations)</li> <li>2. the type of organization it is (see below for Prime Partner Type list)</li> <li>3. the status of the organization as a local entity or not (see below for definition of local organization)</li> <li>4. the associated country (If the partner is only working on Botswana, select Botswana. If the partner is working in more than one country, select All).</li> </ol> <p>We strongly encourage you to submit this as early as possible to make sure organizations are entered when you begin data entry. If you provide all of the required information to us in the spreadsheet on the Extranet, we will be able to get it entered into the system fairly quickly (sometimes even overnight).</p> <p>For ALL organizations that need to be added to the COPRS, we MUST receive your request and list of organizations by August 31st. This will allow time for verification and entry in COPRS by September 10<sup>th</sup>. We will try our best, but cannot guarantee that any request submitted after August 31<sup>st</sup> will be entered in COPRS in time for data entry in-country.</p> <p>There are two ways for you to determine if the organizations you are looking for are in the COPRS system.</p> <ol style="list-style-type: none"> <li>1. You could use the <a href="#">Organization Admin</a> to search for organization names.</li> <li>2. Second, there is a full list of the organizations in the data system in the <a href="#">Operational Plan - Reports</a> section entitled "Master Organization List".</li> </ol> <p>Please use one of these two options early on to determine if all of the organizations that you need for your COP data entry are in the data system.</p>

There can be only one prime partner per funding mechanism. When funding mechanisms are awarded to a consortium, the lead partner is the prime, and any 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 that are active in your country.

Do not list partners until they have been formally selected through normal Acquisition & Assistance 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). Please see [Appendix 14](#) for guidance on notifying OGAC once you have identified a 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, 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.

<b>CDC as Prime Partner for a Funding Mechanism:</b>
<p>CDC should only be the prime partner for a funding mechanism in three instances:</p> <ol style="list-style-type: none"> <li>1. management and staffing costs</li> <li>2. technical assistance that CDC in-country provides directly</li> </ol> <p>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.</p> <p>For more assistance with this issue, please contact Heather Pumphrey (hbp7@cdc.gov)</p>

**NOTE: In FY 2008, please do not list the Working Capital Fund as a prime partner. Please see page 21 for more information on SCMS.**

#### **DATA ENTRY:**

1. Click **Select Partner**.
2. Enter the partner name (or any part of the name). We have found that keeping the search very broad works best, such as only entering "Family" if searching for "Family Health International." This year, you will be able to search using the acronym. Remember that not all partners were submitted with associated acronyms.
3. You will receive a selection of possible partner names depending upon what you typed into the search box. If the partner is not on the list or if you think that any of the information is incorrect, please email Vanessa Brown ([BrownVJ@state.gov](mailto:BrownVJ@state.gov)).
4. Click the button next to the partner name and click **Select**.

#### **PARTNER TYPE:**

##### **CONTENT:**

This information will be provided by the data system if the organization already exists in COPRS. If the organization needs to be added to the data system, please send an email to Vanessa Brown ([BrownVJ@state.gov](mailto:BrownVJ@state.gov)) with all of the necessary information (see above under Prime Partner Name). Each organization 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 basing the determination on a 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. This includes ministries, such as a Ministry of Health.
4. Private Contractor. This includes private sector companies such as Deloitte-Touche, John Snow, Inc., and any company involved in a public private partnership.
5. University. (Note: a university affiliate, such as Johns Hopkins JHPIEGO, would be listed under NGO, but Columbia University School of Public Health would be listed under University.)



6. Multi-lateral Agency. This is for organizations such as the World Health Organization or UNAIDS.
7. Other USG Agency. This is any USG entity other than one of the six USG Agencies that are part of the Emergency Plan (DoD, DoL, HHS, Peace Corps, State Dept, USAID)
8. Own Agency. This is for any one of the six USG Agencies that are part of the Emergency Plan (DoD, DoL, HHS, Peace Corps, State Dept, and USAID).
9. Parastatal. This is a state-owned enterprise that operates using a combination of public and private funds. It may be headed by a government appointee.

Determine partner type based on the nature of the entity, not by the funding that it might receive. Please make sure that you identify the type of organization and NOT the source of funding the organization receives.

Example: An entity that receives funding from the host country government is not necessarily a host country government agency. It could be an FBO that receives funding from multiple sources.

#### **DATA ENTRY:**

No data entry necessary. This is done when the partner is added to COPRS.

#### **LOCAL (INDIGENOUS) ORGANIZATION:**

##### **CONTENT:**

Definition: An entity whose primary place of business is in a country or region served under the Emergency Plan. The majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. If you have questions about whether a partner qualifies as a local organization, please contact your core team leader.

#### **DATA ENTRY:**

No data entry necessary. This is done when the partner is added to COPRS.

#### **NEW PARTNER:**

##### **CONTENT:**

As part of our efforts to increase sustainability, country teams should build local capacity by funding new partners.

A new partner is one working for the USG for the first time in health projects in the country or one that has not worked with the USG as a prime partner or sub-partner on a health project in that country in the past five years.<sup>4</sup>

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

<sup>4</sup> Please note that this definition of a new partner is different from the definition used by the New Partners Initiative.

working with CDC for the first time in FY 2008, that partner is NOT new. It is important for the USG Team to ensure that they are appropriately applying the “new” status.

**Examples:**

- A new department within a university that is a current or former partner is only a new partner 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 partner.
- If a contractor has been working on training in child survival activities 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 five years), did not have an agreement in FY 2007, but does have an agreement in FY 2008, 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.

**DATA ENTRY:**

This is a Yes/No radio button. 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”.

The Quality Assurance Report will check that a partner is consistently marked “new” or “not new” throughout the FY 2008 COP. Users can also run a comparison of partners between the FY 2007 and FY 2008 COPs. See the “Useful Reports” section for more information.

**EARLY FUNDING REQUESTS:**

**MODIFICATIONS IN THIS SECTION:**

In FY 2008, countries will enter early funding requests at the activity level (page 94). However, users can view the early funding request for an entire mechanism when they click “edit” in Table 3.1.

Users can also download an early funding report (see [Appendix 8](#)).

## Table 3.2 SUB-PARTNER

### MODIFICATIONS IN THIS SECTION:

Table 3.2 has been re-designed to allow for more flexible viewing / data entry options. When you open Table 3.2, you will see a list of all sub-partners in the COP. This list can be sorted by clicking any of the hyperlinked column headings. This table can also be filtered in the following ways:

- Detail View – Click on **Show Details** to see the associated program areas and new partner status. In detail view, the sub-partner entries can be edited directly on screen.
- Mechanism View – Clicking on any mechanism ID number will display all sub-partners in a specific mechanism. Entries can be edited in this view.
- Custom – You can select a custom list of sub-partners by checking the tickbox in the left-hand column and then clicking **Edit Selected**.

### CONTENT:

A sub partner is defined as an entity to which a prime partner allocates funding. The data system includes all partner/organizations that were entered in the FY 2004, FY 2005, FY 2006, and FY 2007 COPs. The total currently includes over 3,000 organizations. Please search thoroughly before you decide that the entity that you are looking for is not there. If the organization needs to be added to the data system, please email Vanessa Brown (BrownVJ@state.gov) with all necessary information (see above under Partner Name).

As mentioned before, **we MUST receive your list of organizations to be added by August 31<sup>st</sup> to ensure their availability in the system.**

You are asked to enter information for sub-partners only if **EITHER** the name of the sub-partner organization or the 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	<u>Not Included</u>

**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, and 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-PARTNER NAME:**

**DATA ENTRY:**

1. Click on the button that says **Add Sub-partners**
2. Select the mechanism you would like to add sub-partners to
3. Enter the partner name (or any part of the name). We have found that keeping the search very broad works best, such as only entering "Family" if searching for "Family Health International." If you would like to enter multiple sub-partners, do not enter any information in the box and click Search. This year, you will be able to search using the acronym. Remember that not all partners were submitted with associated acronyms.
4. You will receive a selection of possible partner names depending upon what you typed into the search box. If the partner is not on the list or if you think that any of the information is incorrect, please email Vanessa Brown ([BrownVJ@state.gov](mailto:BrownVJ@state.gov)).
5. Click the button next to the partner name and click **Select**. You may add more than one sub-partner at a time.

Note: The screenshot below is for illustrative purposes, as the actual data entry screens may look slightly different.

Country: Botswana FY: 2008

Print/Export

Table 3.2 Sub-Partners Detail

View/Add Comments

Mechanism ID: 8757.08  
Mechanism Name: TBD Cooperative Agreement  
Funding Amount: \$1,000,000  
Prime Partner: Columbia University

Sub-Partner	TBD Funding	Planned Funding	Associated Program Areas																New Partner
			M	T	H	N	H	B	V	B	V	H	H	H	N	H	O	H	
			C	A	B	I	O	H	T	I	T	X	X	A	S	P	M		
			T	B	L	N	P	C	B	D	C	D	S	B	I	S			
Local Health Clinic	<input checked="" type="checkbox"/>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local Health Clinic	<input type="checkbox"/>	\$500,000	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local Hospital	<input type="checkbox"/>	\$500,000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blossom	<input checked="" type="checkbox"/>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Add Sub-Partners

Save Changes

Cancel/Return to Table 3.2

Delete All

View/Add Comments

**NEW PARTNER:**

**CONTENT:**

See the information on page 53

**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".

The Quality Assurance Report will check that a partner is consistently marked “new” or “not new” throughout the FY 2008 COP. Users can also run a comparison of partners between the FY 2007 and FY 2008 COPs. See the “helpful reports” appendix for more information.

**FY 2008 PLANNED FUNDING (\$):**

**CONTENT:**

Enter the amount of FY 2008 planned funding requested for the sub-partner.

The Quality Assurance Report will double-check that the funding for a given sub-partner does not meet or exceed the funding for the prime partner/mechanism.

Please remember that if the partner funding is TBD, you will need to update the funding amount before completing the APR. While this does not have to be submitted as a formal reprogramming, it will need to happen at a time when COPRS is open for data entry.

**DATA ENTRY:**

Enter the planned FY 2008 funding directly into the field. If the amount of FY 2008 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:**

Please check the box next to each program area where that particular sub-partner will be working (see [Appendix 4](#) for a list of program areas). While you do not need to link sub-partners to specific activities in table 3.3, a sub-partner cannot work in any program area if there is not an activity in Table 3.3. For instance, if a prime partner is only working in PMTCT, the sub-partner cannot have any associated program area other than PMTCT. The quality assurance report will double-check this.

When you are in detail view, you can change the associated program area without opening a new screen.

**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 FY 2007 COPs. These program areas correspond to budget codes, which are necessary for tracking program funds in response to legislative requirements and Congressional inquiries. Definitions of what activities should be included in a given program area/budget code will be described later in this section and a comprehensive list can be found in [Appendix 4](#). The following is a list of the program areas:

- 01-MTCT - Prevention of Mother to Child Transmission
- 02-HVAB - Abstinence and Be Faithful
- 03-HBML – Medical Transmission: Blood Safety
- 04-HMIN – Medical Transmission: Injection Safety
- 05-HVOP - Condoms and Other Prevention
- 06-HBHC - Palliative Care: Basic Health Care and Support
- 07-HVTB - Palliative Care: TB/HIV
- 08-HKID - Orphans and Vulnerable Children
- 09-HVCT - Counseling and Testing
- 10-HTXD - HIV Treatment: ARV Drugs
- 11-HTXS - HIV Treatment: ARV Services
- 12-HLAB - Laboratory Infrastructure
- 13-HVSI - Strategic Information
- 14-OHPS - Other/Policy Analysis and System Strengthening
- 15-HVMS - Management and Staffing

### GUIDE TO DETERMINING IN WHAT PROGRAM AREA (BUDGET CODE) AN ACTIVITY FITS

The Emergency Plan encourages integrated programs, and as described in the policy overview, promotes cross-cutting activities in key areas. As the COP tracks funding by program area, it is necessary to distribute components of your integrated program across the 15 areas. Many activities have components that should be described (with funding amounts) in several different program areas. Below is a list of common cross-cutting issues/programs with considerations for how to distribute their constituent elements across the 15 program areas. While the information below can guide you, please use common sense when distributing activities into different program areas. In some cases, you may decide to code activities differently than in previous years. If this is the case, please use your best judgment and be thoughtful about consequences to results reporting. You may not split an activity in such a way that an activity has targets but no planned funding.

#### PMTCT

Provision of ARV prophylaxis and other ANC services for HIV-infected pregnant women should be funded under PMTCT. Procurement and provision of HAART for pregnant women should be attributed under ART drugs and ART services. Funding for counseling and testing in the context of preventing mother-to-child transmission can be coded under MTCT or HVCT; targets should be included in MTCT.

#### ABC

While many sexual prevention activities will either be AB only or C only, integrated ABC prevention programs should be attributed to Abstinence/Be Faithful (HVAB) and Condoms and Other Prevention (HVOP) in proportions appropriate to the scope of the activity. Comprehensive ABC programs can be divided by activity, with certain activities (e.g. programs

focusing on delaying sexual debut, reducing number of sexual partners, and behavior change around male norms and transgenerational sex) funded under AB. Activities related to condom promotion and distribution should be funded under Condoms and Other Prevention. One should use common sense in this process. There are some target populations where the entire program should be funded under Condoms and Other Prevention. For example, activities targeted toward persons in prostitution should be described entirely in Condoms and Other Prevention; likewise, a school-based activity for youth ages 10-14 should be described entirely in AB (consistent with PEPFAR's ABC guidance). Please contact your core team leader should you have any questions.

#### Gender-based Violence, including Post-Exposure Prophylaxis

Activities to address the intersections between gender-based violence and HIV/AIDS are multi-faceted and may include clinical services, behavioral change interventions, and local and systems-level work with law enforcement, legislative, and judicial bodies. Relevant program areas include Abstinence/Be Faithful, Condoms and Other Prevention, ARV Drugs, Counseling and Testing, and Other Policy and Systems Strengthening. The proportion of GBV funding categorized under each program area will reflect the particular package of activities offered. Procurement of post-exposure prophylaxis (PEP) for rape victims should be funded under ARV Drugs. Depending on the target population and other program attributes, behavior change prevention such as promotion of social and community norms against rape, incest and other forced sexual activity might be funded under AB, or under Condoms and Other Prevention. Additional activities such as work with police and judicial systems could be funded under Other/Policy Analysis and System Strengthening.

#### Male Circumcision (MC)

Feasibility studies and needs assessment activities should be funded under Condoms and Other Prevention and/or Other/Policy Analysis and System Strengthening (OHPS).

MC services must be delivered within a comprehensive package of prevention services, which include provider-initiated and -delivered HIV counseling and testing; active exclusion of symptomatic STIs and syndromic treatment where required; provisional promotion of correct and consistent use of condoms; and counseling on behavior change, including a gender component that addresses male norms and behaviors and sexual violence. Thus, MC falls under several program areas, including Abstinence/Be Faithful, Condoms and Other Prevention, and Counseling and Testing.

Currently MC is NOT recommended for men who are HIV-positive. All male circumcision service delivery sites must include HIV counseling and testing for all patients (the USG follows the WHO MC for HIV prevention recommendations and therefore strongly encourages but does not mandate HIV testing). All MC sites should include links or referrals to HIV care and treatment for HIV-positive men. For countries that are planning MC service delivery, a letter from your Minister of Health requesting USG assistance for such work is required (please attach in supporting documents). Given the importance of counseling and testing and comprehensive HIV prevention, all MC services should include funding from Condoms and Other Prevention (up to 50-60%), AB (up to 20-25%) and CT (up to 20-25%). Other areas that could apply include Other/Policy Analysis and System Strengthening (OHPS) and Strategic Information (SI) for any survey-related activities.



Prevention with Positives

Prevention with Positives interventions are generally a component of a palliative care and/or treatment intervention, including both behavioral and biomedical interventions that are routine standard of care in HIV care and treatment settings. Consequently, they should be coded under Palliative Care or Treatment Services depending on where the program service is being delivered. For example, if the activities are being carried out in a clinic setting, then funding would be reflected in Treatment Services. If carried out in home-based settings, the activities would be part of Palliative Care. Activities for a program directed to the promotion and provision of condoms to PLWHA would be funded under the Condoms and Other Prevention. Any work to provide AB messages should be funded under AB.

Family Planning<sup>5</sup>

PEPFAR funds may only be used for prevention, treatment, care and related HIV/AIDS services and thus may not be utilized to support contraceptives other than male and female condoms. Depending on the scope of the activity, family planning-related activities can either be placed under PMTCT or Palliative Care. Please refer to the wrap around section for more information.

TB/HIV

Activities directed at the nexus of TB and HIV potentially encompass several program areas, including Palliative Care: TB/HIV, ARV Drugs and Services and Counseling and Testing. TB/HIV programs that provide basic health care and support services such as clinical or psychosocial services should be categorized under Palliative Care: TB/HIV; those expanding to provide clients with ART should code such services under ARV Drugs and ARV Services.

If TB programs provide HIV testing and counseling services on-site or refer patients to co-located and integrated USG-supported counseling and testing services, these services would be coded under Palliative Care: TB/HIV (3.3.07). Palliative Care TB/HIV program area funding may be used to procure HIV rapid test kits and other commodities necessary for these services.

OVC

ARV treatment of children is **not** included under the Orphans and Vulnerable Children program area, and should be coded under ARV Drugs or ARV Services. All other health care should be coded under the OVC program area, when delivered within programs for orphans and other vulnerable children affected by HIV/AIDS. Children cannot be counted under both OVC and palliative care programs, since they are summed under the Table 2 care target.

Pediatric Treatment

Procurement of pediatric ARVs should be funded under ARV Drugs. All other treatment services should be funded under ARV Services.

PHE


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<sup>5</sup> Please be aware that there are a number of legislative and policy requirements that may be applicable depending on the exact nature and source of funding for "wrap around" activities in the area of family planning. If you have any questions, please consult your core team leader or Bev Johnston or Mary McLaughlin.

Public Health Evaluations should be placed in the relevant technical program area (such as PMTCT) rather than Strategic Information.

### SI

The following types of activities should be included in the SI program area (HVSI 3.3.13):

- Activities that support the collection, analysis and dissemination of HIV/AIDS behavioral and biological surveillance and monitoring information;
- facility surveys;
- support for national, USG-wide, or program monitoring systems or HMIS activities which involve multiple implementing partners;
- assistance to countries in the establishment of standard data collection methods and capacity building; and
- Emergency Plan program efficiency and effectiveness or impact studies.

Conversely, these types of activities might be more appropriate in another program area:

- Activities that are relatively small in scope and cost;
- Activities directly supporting one specific program area; and
- Activities that are integral components of a prevention, care, or treatment funding mechanism.

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 tick box for Strategic Information should be checked. If different HMIS or other software tools are being proposed for use by different implementing partners, the SI program area context and/or supporting documentation should describe how each of the supported tools or software contributes to the development of a single HIV monitoring and evaluation systems (i.e., the "Third One.")

### Other/Policy Analysis and System Strengthening

Activities supporting a specific program area can be included under the appropriate technical program area. However, all activities in OHPS must still have benchmarks, or other deliverables associated with the activity.

Below are a few examples that should be coded under OHPS. The following activities should be placed in the Other Policy program area (OHPS – 3.3.14)

- Policy change
- Advocacy
- Human Capacity Development
- Increasing women's legal rights

On the other hand, an activity establishing structural interventions to address alcohol consumption may be better placed in AB or Condoms and Other Prevention. Another example might be an activity that supports a national infant feeding policy, which might be in PMTCT.

### Management and Staffing

The following categories should be included in the Management and Staffing program area: technical leadership/management positions, technical advisor/program managers, contracting staff, financial/budget staff and administrative/support staff (see the Staffing Analysis guidance for additional information).

Technical advisors/non-management staff, who spend most of their time implementing programs in specific technical areas, as well as their administrative support staff, should be allocated as appropriate to the other 14 program areas. However, if a position is supporting more than three program areas, include that position in the Management and Staffing program area.

## Table 3.3 Program Area Summary

There are three main parts to the overview of each program area: program area context narrative; FY 2008 planned funding for program area; and program area summary targets. Each one of these will be discussed below, followed by specific instructions for each program area.

### PROGRAM AREA CONTEXT:

Note: Special instructions for Other Bilateral Countries at the end of this section.

Program area descriptions should provide a sufficient level of detail to evaluate whether the USG approach, as reflected in the activities, appropriately targets and addresses the needs of the country.

The program area description should:

1. Provide the context for that program area in your country and focus on describing the broader strategic USG vision, instead of merely listing separate activities. Be sure to link the FY 2008 COP with the vision expressed in the five-year Strategy and with accomplishments and program directions established from FY 2004 through FY 2007.
2. Discuss progress made and barriers encountered since the FY 2007 COP; provide program indicator data when applicable.
3. Discuss the work of, as well as linkages with, other implementing partners, in particular the Global Fund, and the host country government in the specific program area.
4. Discuss how you will address sustainability for this program area (e.g., site graduation, government capacity building, etc.).
5. Describe how the USG team will support the monitoring and evaluation of routinely collected program indicators. If there are any PHEs proposed for this program area, please highlight how these specific activities and/or answers will contribute to and enhance programming in this area.

In addition, you will find program-area specific guidance below. We request this additional information to facilitate a better understanding of the context and overall approach and to reduce the need for excessive clarification from the field. **Please note: In some cases, the information requested may not be available. If this is the case, please do not respond.**

The program area narratives should not be more than 8,000 characters (approximately two pages). You are not required to use the entire space.

### SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:

If you are not working in a particular program area, because of limited resources and/or government and/or other international partner efforts, please leave the Program Area Context blank. There is no expectation that PEPFAR Other Bilateral Countries will work across all 15 program areas.

Please note that in PEPFAR Other Bilateral Countries, the central approach of interventions is to leverage other host country and international partner resources, including the Global Fund. Thus, there is no expectation that these program area descriptions will demonstrate support to comprehensive programs; rather, they will describe strategic interventions that could be brought to scale nationally by others or that fill essential program area gaps.

**DATA ENTRY:**

These are narratives that are entered into text boxes. There is an 8,000 character limit (approximately two pages) for each narrative. We recommend that you write the narrative in Word, then paste the text into the text box in COPRS. You may also type directly into the box on the screen, but COPRS does not have a spell-check function.

**FY 2008 PLANNED FUNDING FOR PROGRAM AREA:****CONTENT:**

The data system will automatically generate the Total FY 2008 Planned Funding for the program area, which is the sum of all FY 2008 planned funding for the activities listed in the program areas of Table 3.3. You cannot enter any information into this cell.

**PROGRAM AREA SUMMARY TARGETS****Target Timeframe:**

The targets in this section relate to the time period that ends September 30<sup>th</sup>, 2009. PEPFAR is moving in future years toward setting all activity targets using the fiscal year. However, this year countries may continue to have partners set targets for the 12 months from the date that funding is received up to September 30, 2009 or they may require targets from October 1, 2008 through September 30, 2009.

**CONTENT:**

The program summary targets are intended to show what will be accomplished by all USG funded activities collectively in that program area. The program summary targets should not simply be the sum of the targets for a given indicator across individual activities listed. Many individual activities may be supporting the same sites, 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, adjusting for double counting. Double counting should be avoided at the partner or activity level – the targets should be an accurate reflection of the partners' reach for the given funding level.

Please ensure that the targets you describe here are for your NEW FY 2008 funding. You should only include here targets for ongoing activities for which you are NOT requesting FY 2008 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 the OHPS program area, please include deliverables in the program area narrative. See the program area summary instructions for more information.

**DATA ENTRY:**

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

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## Program Area Specific Narratives

### TABLE 3.3.01 PREVENTION OF MOTHER TO CHILD TRANSMISSION

<b>PROGRAM AREA DESCRIPTION:</b>
PMTCT (COPRS ID = MTCT) – activities aimed at preventing mother-to-child HIV transmission, including ARV prophylaxis for HIV-infected pregnant women and newborns and counseling and support for maternal nutrition and safe infant feeding practices. PMTCT-plus ART activities should be described under HTXD (3.3.10) and HTXS (3.3.11). Funding for counseling and testing in the context of preventing mother-to-child transmission can be coded under MTCT or HVCT; targets should be included in MTCT.
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>
<p>In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.</p> <p>Statistics:</p> <ul style="list-style-type: none"> <li>• The current national geographic coverage of PMTCT services</li> <li>• The number and proportion of ANC and L&amp;D sites providing PMTCT services and the number of sites providing services at different levels (i.e. primary health centers, district hospitals)</li> <li>• The national antenatal prevalence and any relevant urban-rural or regional differences</li> <li>• The current and planned (COP 2008) number of HIV+ pregnant women receiving prophylaxis nationally relative to the estimated total number of HIV+ women delivering annually (note key contributions of USG non-PEPFAR funds and other donors' contributions)</li> <li>• The current and planned (COP 2008) USG-specific contribution to the national program including the number and proportion of women attending antenatal care each year who receive PMTCT services and the number of HIV+ women receiving prophylaxis. Targets should be consistent with the goal of reaching 80% of HIV+ women attending ANC with prophylaxis by the end of FY 2009.</li> <li>• How USG resources are strategically focused to maximize PMTCT impact.</li> <li>• The estimated number and proportion of pediatric infections USG support will help avert in the country with COP 2008 funding, taking into account the efficacy of prophylaxis provided. This estimate should be consistent with the goals of achieving a 40% reduction in new infections by the end of FY 2009.</li> </ul> <p>Services:</p> <ul style="list-style-type: none"> <li>• The type of counseling and testing for PMTCT (i.e. group pre-test counseling, opt-out, rapid tests with same day results)</li> <li>• The current level of uptake of testing and prophylaxis (the "PMTCT cascade"), and explanations for low uptake if applicable. This would include information about the percentage of women who attend at least one antenatal care visit and the percentage that deliver in a facility.</li> <li>• The number and proportion of vulnerable HIV-exposed infants who will receive essential follow-up interventions, including nutritional support, infant diagnosis, cotrimoxazole prophylaxis, and other elements of the basic preventive care package for children.</li> <li>• The approach to supporting infant feeding, including providing nutritional counseling, support for exclusive feeding modality, growth monitoring, nutritional supplementation, and support for complementary feeding and safe early weaning where applicable.</li> <li>• The current prophylaxis regimen(s) being used in the country and proportions of sites implementing the most effective regimens (i.e. AZT + single dose NVP and provision of ART for eligible women) in keeping with most recent WHO guidelines.</li> <li>• Approaches to measuring and improving quality at PMTCT sites</li> <li>• Specific and measurable plans to strengthen the above elements of the program in FY 2008.</li> </ul>

<p>Referrals and Linkages:</p> <ul style="list-style-type: none"> <li>• PMTCT is a “gateway” for other prevention, care and treatment services. Please describe how your program will facilitate linkages to care and treatment for eligible women (e.g. number and proportion of women successfully referred for ART during and after pregnancy)</li> <li>• The current and planned (COP 2008) number and proportion of HIV+ women identified in PMTCT programs initiated on ART during pregnancy. (Recommend this be 20% or more of women identified at PMTCT sites that are linked to ART)</li> <li>• The current and planned (COP 2008) number and proportion of women identified in PMTCT settings enrolled in longitudinal care (Recommend 80% or more of HIV+ women identified)</li> <li>• The number and proportion of HIV-exposed infants receiving a basic package of postnatal care interventions, as described under services above. (Recommend at least 80% of HIV-exposed children). Provision of care to these highly vulnerable children can be counted toward OVC or palliative care targets, depending on the services they receive. Programs should also describe any other linkages to OVC programs.</li> <li>• Specific plans to strengthen linkages to routine maternal and child health services, including family planning.</li> </ul> <p>Policy:</p> <ul style="list-style-type: none"> <li>• Plans to address national level policy barriers, supply chain management, training, monitoring and evaluation, management and supervision, and human resources, as well as other system strengthening. Please include specific plans for integration and coordination of PMTCT with both ART and MCH systems in these areas.</li> <li>• How PEPFAR PMTCT monitoring activities relate to the national PMTCT monitoring system.</li> <li>• Activities to address gender-based violence, reduce stigma, and provide psychosocial support for HIV+ pregnant and lactating women.</li> <li>• Partner testing, strategies to involve men in PMTCT, and primary prevention activities occurring in the context of PMTCT, including prevention with positives.</li> <li>• Please use the program and activity narratives to describe plans for the coordination of PMI and PEPFAR resources in PMTCT programs.</li> </ul> <p>Please highlight any other outstanding challenges or gaps that the program is facing.</p>
<p><b>REQUIRED TARGETS:</b></p> <ol style="list-style-type: none"> <li>1.1 Number of service outlets providing the minimum package of PMTCT services according to national and international standards</li> <li>1.2 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results</li> <li>1.3 Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting</li> <li>1.4 Number of health workers newly trained in the provision of PMTCT services according to national and international standards</li> </ol>

### TABLE 3.3.02 ABSTINENCE / BE FAITHFUL

<p><b>PROGRAM AREA DESCRIPTION:</b></p> <p>Abstinence/be faithful (HVAB) – activities (including training) to promote abstinence, including delay of sexual activity or secondary abstinence, fidelity (including partner reduction), and related social and community norms, as well as the counseling component of male circumcision activities.</p> <p>For more information, please see “ABC Guidance #1: <i>For United States Government In-Country Staff and Implementing Partners, Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections Within The President’s Emergency Plan for AIDS Relief.</i>”</p>
--



**PROGRAM AREA SPECIFIC INSTRUCTIONS:**

To the extent the information is available, please describe the following, highlighting plans for support in the upcoming year.

**Epidemic Context:**

- Please describe the profile of the epidemic within the general population, including overall national HIV prevalence (specifying whether the data come from a population-based survey or ANC surveillance), as well as a brief overview of major variations in prevalence by age, sex, geography or other factors.
- Drawing on data from recent surveys, please describe patterns of behavior that represent the major epidemic drivers in the country context. For example, in generalized epidemics, these may include frequency of: multiple and concurrent sexual partnerships; informal transactional sex; cross-generational sex; early initiation of sexual activity; low risk perception; etc.
- Please mention how USG-funded AB programs support national prevention strategies and priorities, and complement activities supported by other donors.
- Please touch on key USG AB prevention achievements to date, and highlight any major challenges these efforts are facing, e.g. weak political leadership, limited capacity of local implementing partners, etc.

**Services:**

- Please outline overall priorities for AB prevention for the COP 08 period, including the relative emphasis on programming to prevent new infections among young adults and adults vs. among adolescent youth. Please briefly highlight key behaviors, populations and geographic locales that will be targeted by USG prevention partners, depending on the epidemic context.
- Please briefly summarize and characterize the proposed number and mix of AB prime partners (e.g. government ministries, international NGOs, CBOs/FBOs, private business sector, etc.).
- Describe the overall technical approaches to prevention that will be applied to different population segments and in different contexts. Please specifically address the balance and linkages between media and community outreach activities.
- Please comment on any activities that directly address prevention for men in the general population, including efforts to reduce multiple and concurrent sexual partnerships, patronage of persons in prostitution, etc.
- Where relevant, please describe prevention activities that focus specifically on reducing cross-generational sex, informal transactional sex, and sexual coercion and violence.
- In concentrated epidemics, describe prevention activities that target “bridge” populations or subgroups within the general population engaging in risky behavior with risk avoidance messages (e.g., clients of persons in prostitution, young males in urban slum settings).
- If applicable, describe the approaches targeted towards men or youth receiving male circumcision services.
- Please mention any specific activities to harmonize and coordinate the overall USG prevention portfolio, and to improve the quality of prevention efforts.

**Referrals and Linkages:**

- Please describe the linkages and integration with condoms and other prevention activities for all programs dealing with individuals who are sexually active and engage in high-risk behaviors.
- Please mention any linkages between AB prevention and OVC, counseling and testing, and other care, support and treatment services. Please also mention any wrap-arounds to integrate HIV prevention with voluntary family planning programs (both education and services.)

**Policy:**

- Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening relating to AB prevention efforts.

Note: Individual activity narratives should support and reinforce the priorities and themes highlighted in the program area narrative.

For country teams that are interested, the South Africa COP 07 provides a good model of an AB Prevention program area narrative that incorporates much of the above information.

#### **BUDGETARY REQUIREMENTS**

In FY 2008, each country should normally dedicate 50% of total prevention funds to sexual transmission, and within sexual transmission funds, to dedicate 66% to AB. If a country does not meet these expectations, a justification is required. See further discussion on page 9. Please note that in a generalized epidemic a very strong justification will be required if a country does not meet the 66% AB requirement for sexual transmission prevention funding.

#### **REQUIRED TARGETS:**

- 2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful
  - 2.1.A. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of the total reached with AB)
- 2.2 Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful

### **TABLE 3.3.03 MEDICAL TRANSMISSION/BLOOD SAFETY**

#### **PROGRAM AREA DESCRIPTION:**

Medical transmission/blood safety (HMBL) – activities supporting a nationally-coordinated blood program to ensure a safe and adequate blood supply including: infrastructure and policies; donor-recruitment activities; blood collection, testing for transfusion-transmissible infections, component preparation, storage and distribution; appropriate clinical use of blood, transfusion procedures and hemovigilance; training and human resource development; monitoring and evaluation; and development of sustainable systems.

#### **PROGRAM AREA SPECIFIC INSTRUCTIONS:**

The general context should describe the national blood service, the network of national and regional blood banks, and key partners in blood safety. Describe the contribution that the Emergency Plan has made to the national program, as well as other sources of support. Note any problems in policy, infrastructure, or other barriers that limit the provision of an adequate supply of safe blood for the country.

#### Statistics:

- The number of units collected nationally per 1,000 population per year and the proportion collected by the national service
- The percent of voluntary, non-remunerated blood donations (as opposed to paid or family donation), and the proportion who are regular donors (donated in the previous 12 months)
- The prevalence rate of HIV among first-time and regular/repeat blood donors
- The proportion of blood donors who have their results returned to them and the process of confirming and delivering those results
- The production and use of red cell concentrates and other blood component preparations
- The number of health facilities that offer transfusion and the number that receive at least 80% of their supply from the national blood service
- The proportion of hospitals that transfuse blood that have functioning Blood Transfusion Committees
- The number of people trained in blood safety
- The cost of a unit of collecting, screening and processing a unit of blood

#### Services:

<ul style="list-style-type: none"> <li>• Describe the approaches to increasing the pool of regular, voluntary non-remunerated blood donors.</li> <li>• Describe the role of other organizations in recruiting and retaining blood donors.</li> <li>• Describe the screening of blood donors and whether and how they receive results.</li> <li>• Describe training needs and plans, including donor recruiting, blood collection and screening, and appropriate transfusion.</li> <li>• Describe plans for management and supervision of blood banks and hemovigilance activities.</li> <li>• Describe systems for data recording, program monitoring and quality assurance.</li> </ul> <p>Policy:</p> <ul style="list-style-type: none"> <li>• Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.</li> <li>• Describe how the country intends to assure rational use of blood including alternatives to transfusion when possible.</li> </ul> <p>Please highlight any outstanding challenges and gaps that the program is facing.</p>
<b>REQUIRED TARGETS:</b>
3.1 Number of service outlets carrying out blood safety activities 3.2 Number of individuals trained in blood safety

### TABLE 3.3.04 MEDICAL TRANSMISSION/INJECTION SAFETY

<b>PROGRAM AREA DESCRIPTION:</b>
<p>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.</p> <p>***Please note though that only renovation of incinerators can be supported with PEPFAR funds, and new construction of incinerators cannot be. It is expected that for the most part funding to support the improvement of waste management would be described in this section; if though the improvement of waste management is tied to the scale-up of treatment sites, it may be appropriate to include funding for those activities in Table 3.3.11 Treatment: ARV Services.</p>
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>
<p>In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.</p> <p>Statistics:</p> <ul style="list-style-type: none"> <li>• Average number of medical injections per person per year</li> <li>• The number and proportion of USG supported facilities with medical/safe injection programs in place</li> <li>• The percent of facilities in which syringes used for patient care (e.g., injections, preparation and administration of medications, phlebotomy) were single use and sterile (e.g., observed to come from a new, unopened package)</li> </ul> <p>Services:</p> <ul style="list-style-type: none"> <li>• Please describe the basic approaches being applied.</li> <li>• Please describe how activities integrate with other HIV/AIDS services (like ARV Treatment, Counseling &amp; Testing, TB/HIV clinics, PMTCT, etc.).</li> <li>• Please comment on activities of Track 1.0 providers and the degree of collaboration with the country team.</li> </ul>

Policy: <ul style="list-style-type: none"> <li>Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening</li> </ul>
<b>REQUIRED TARGETS:</b>
4.1 Number of individuals trained in injection safety

### TABLE 3.3.05 CONDOMS AND OTHER PREVENTION

<b>PROGRAM AREA DESCRIPTION:</b>
<p>Condoms and 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, messages/programs to reduce other risks of persons engaged in high-risk behaviors, and male circumcision programs. These populations include injecting and non-injecting drug users (IDU and NIDU); at risk youth; men having sex with men (MSM); mobile populations, including migrant workers, truck drivers, and members of military and other uniformed services (e.g. police); and persons who exchange sex for money and/or other goods with multiple or concurrent sex partners, including persons engaged in prostitution and/or transactional sexual partnerships.</p> <p>For more information on injecting drug use, please see <i>“The President’s Emergency Plan for AIDS Relief: HIV Prevalence Among Drug Users Guidance #1 - Injection Heroin Use.”</i></p>
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>
<p>In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.</p> <p>Statistics:</p> <ul style="list-style-type: none"> <li>The demographic and epidemiological make-up of your population of persons engaged in high-risk behaviors, with details about how emerging high-risk groups are identified. Please refer to data sources (e.g. BSS or other) if available.</li> <li>Please describe the availability of condoms in your country and the USG contribution to that supply. If known, please also discuss condoms procured by USAID population funds and other international partners. Additionally, please provide information on whether condom procurements will be targeted towards prevention with positives activities.</li> </ul> <p>Services:</p> <ul style="list-style-type: none"> <li>Please describe the basic approaches being applied and how they are building on previous years’ investments.</li> <li>Please comment on programs that provide access to substance abuse and treatment services.</li> <li>Comment on how your program and other donors’/international partners’ programs provide outreach and HIV services to persons engaged in high-risk behaviors.</li> </ul> <p>Referrals and Linkages:</p> <ul style="list-style-type: none"> <li>Please describe the opportunities and linkages for providing health services to persons engaging in high-risk behaviors, including HIV counseling and testing and STI and HIV/AIDS treatment and care.</li> </ul> <p>Policy:</p> <ul style="list-style-type: none"> <li>Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.</li> </ul>

- Please describe any plans to address changes in guidelines that are likely to facilitate greater access to services for persons engaged in high risk behaviors and the removal of barriers to these services.

Please highlight any other outstanding challenges and gaps that the program is facing

#### *Data Entry*

Table 3.3.5 Condoms and Other Prevention: Amount of Condoms and Other Prevention Funding which is used to work with IDUs: Provide the dollar amount that is planned for work with injecting drug users.

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.

#### **REQUIRED TARGETS:**

- 5.1 Number of targeted condom service outlets
- 5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
- 5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful

### **TABLE 3.3.06 PALLIATIVE CARE: BASIC HEALTH CARE AND SUPPORT**

#### **PROGRAM AREA DESCRIPTION:**

Palliative Care: Basic health care and support (HBHC) – all facility-based and home/community-based activities for HIV-infected adults and children and their families aimed at extending and optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness through provision of clinical, psychological, spiritual, social, and prevention services. Clinical care should include prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide treated nets, safe water interventions and related laboratory services), and related laboratory services), pain and symptom relief, and nutritional assessment and support. Psychological and spiritual support may include group and individual counseling and culturally-appropriate end-of-life care and bereavement services. Social support may include vocational training, income-generating activities, social and legal protection, and training and support of caregivers. Prevention services may include “prevention for positives” behavioral counseling and counseling and testing of family members. Facility-based and home/community-based palliative care for HIV-positive children within programs for orphans and other vulnerable children affected by HIV/AIDS may fall under HBHC or under HKID (3.3.08). ARV treatment should be coded under HTXD (3.3.10) and HTXS (3.3.11).

For more information, please see *“HIV/AIDS Palliative Care Guidance #1 for United States Government In-Country Staff and Implementing Partners”*, *“Guidance for United States Government In-Country Staff and Implementing Partners for a Preventive Care Package for Adults”* as well as *“Guidance for United States Government In-Country Staff and Implementing Partners, for a Preventive Care Package for Children Aged 0-14 Years Old Born to HIV-positive Mothers.”*

#### **PROGRAM AREA SPECIFIC INSTRUCTIONS:**

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

Please note that Prevention with Positives is included under Palliative Care. This is a very important strategic approach and we strongly encourage you to refer to the technical considerations for more information.

**Statistics:**

- Estimated number of people requiring services during planning period
- The number of HIV+ individuals that will receive services relative to the estimated total number of people needing them (note other key international partners' contributions)
- The USG-specific contribution to the national program including the number and proportion of individuals receiving care, relative to the need
- Where possible, information about the numbers of persons accessing key services such as cotrimoxazole prophylaxis, pain relief or nutritional support

**Services:**

- Please define what services are provided through palliative care programs in your country program, including an explanation of who is counted as receiving palliative care.
- Please describe key elements of the USG-funded palliative care program and the basic approaches of scale up, including:
  - the components of the program (clinical, psychological, social support, spiritual, preventive),
  - the sites at which services are being provided (home-based, healthcare facility-based),
- Please describe the status of supply chain management for palliative care-related commodities and how that system will be strengthened to support palliative care activities including procurement and distribution of OI drugs and opioid and non-opioid pain medication (use of the PSCMS is encouraged).
- Please describe the status of improving/increasing pediatric palliative care coverage.
- Please differentiate, where appropriate, services provided to specific groups (e.g. children, pregnant women).
- Please outline any general efforts to involve PLWHA in providing palliative care services and any general efforts to provide support for caregivers.
- Please describe plans for establishing a minimum standard of care and program improvement through on-site supportive supervision and other efforts to improve quality.
- Please include clearly defined prevention services targeted specifically to HIV-infected persons and their partners that are integrated into routine HIV care and treatment.

**Referrals and Wraparound programming:**

- Please describe how the activities relate to the network model for provision of HIV care in your country and plans to strengthen these linkages. In particular, please note approaches to incorporate and/or refer to treatment, prevention, OVC and other needed social services.
- Where applicable, please use the program and activity narratives to describe plans for the coordination with other health programs including PMI, TB, family planning, safe motherhood and child survival programs, as appropriate.
- Please describe wraparound programming with other sectors, for example strengthening livelihoods. See page 18 for more information as well as [Appendix 11](#).

**Policy**

- Describe policy barriers that need to be overcome to ensure success of the palliative care program in the future (e.g., availability, accessibility and prevalence of prescriptions of opioids for pain relief, national cotrimoxazole policy, etc.).
- Please highlight any other outstanding challenges and gaps that the program is facing.

Where applicable, all USG teams are encouraged to use the Partnership for Supply Chain Management (PSCMS) for commodities, including pain medications, OI drugs and rapid test kits. For more information, please see page 21.

**Pediatric HIV/AIDS Care (see Treatment narrative for pediatric ART)**

Description of ongoing and planned activities aimed at providing HIV care services to HIV-infected



children including counseling and testing, nutrition support, ARV drugs, ARV services, Palliative care, TB/HIV, OVC, Strategic information, Laboratory infrastructure and Other policy and systems strengthening. Include a description of the overall strategy for Pediatric HIV care and how PEPFAR is supporting activities to meet these goals and targets. If possible, include a break-down by age of the number of children receiving care services (e.g.: 0-2 years; 2-14 years)

In addition to the general Care program area context information and if the information is available, if available please describe the following, highlighting plans for support in the upcoming year.

- The national estimates of the burden of pediatric HIV infection, including any relevant urban-rural or regional differences
- National care targets for children and current progress toward reaching the above targets
- The current and planned (COP 2008) USG-specific contribution to the national Pediatric HIV Care and OVC programs including the number of children receiving HIV care services Program targets should be consistent with the goal that 10-15% of all HIV+ patients receiving ART are children under 15 years of age
- The current national geographic coverage of Pediatric HIV care services
- The number and proportion of sites providing Pediatric HIV Care services at different levels (i.e. primary health centers, district hospitals) and plans for service decentralization and integration into MCH programs.
- The entry points that will be used to identify HIV-exposed and infected children (e.g.: PMTCT, maternal and child health clinics, other out-patient settings and in-patient settings) and approaches the USG government will put into place to increase access to HIV testing and care and treatment services for this population
- The basic preventive care package of services which should be provided to all HIV-exposed infants in the first years of life, including infant feeding counseling, other nutritional support, cotrimoxazole prophylaxis, access to infant diagnosis, malaria interventions, clean water interventions, and strengthening of linkages to routine child health services.
- How PMTCT programs are linked to Pediatric HIV Care programs to ensure that HIV exposed and infected infants receive needed care, treatment and follow-up.
- Describe pediatric HIV activities related to OVC, Palliative care, TB/HIV, Counseling and Testing, Strategic Information, Other policies and system strengthening, Laboratory infrastructure and efforts to develop, support or expand pediatric related services within these program areas.
- How USG resources are strategically focused within the larger national program context to maximize the impact of Pediatric HIV care efforts.

#### **REQUIRED TARGETS:**

- 6.3 Number of service outlets providing HIV-related palliative care (excluding TB/HIV)
- 6.4 Number of individuals provided with HIV-related palliative care (excluding TB/HIV)
- 6.5 Number of individuals trained to provide HIV palliative care (excluding TB/HIV)

The program level indicators for the Palliative Care: Basic Health Care and Support section of Table 3.3 are not the same indicators that appear in the indicator guidance and in Table 2 of the COP. When setting the targets for Table 3 of the COP, articulate what will be accomplished with your Palliative Care: Basic Health Care funding. The inclusive indicators that appear in Table 2 are necessary to minimize double counting, but they do not allow us to assess what is being accomplished with funding from the Palliative Care: Basic Health Care and Support program area.

**TABLE 3.3.07 TB/HIV**

<b>PROGRAM AREA DESCRIPTION:</b>
<p><b>Palliative Care: TB/HIV (HVTB)</b> – includes exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis (including medications), as well as screening and referral of TB clinic clients for HIV testing, and clinical care. The location of HIV/TB activities can include general medical settings, HIV/AIDS clinics, home-based care and traditional TB clinics and hospitals.</p> <p>If TB programs expand to provide clients with ART, such services would fall under HTXD (3.3.10) and HTXS (3.3.11). Counseling and testing of TB facility clients including the purchase of HIV test kits should be included under TB/HIV program area. Lab support intended to strengthen TB diagnosis and management should also be included under TB/HIV.</p> <p>PEPFAR TB/HIV program activities should address the following: HIV testing and counseling of TB clients and referral and/or management of HIV-positive patients HIV prevention and clinical care (including ARV and cotrimoxazole therapy); TB screening of people living with HIV/AIDS; Referral mechanisms for and/or provision of treatment (using DOTS management strategy) for HIV-infected persons diagnosed with TB; Relevant laboratory and diagnostic service capacity; Infection control activities to prevent TB transmission in HIV care facilities; Isoniazid preventive therapy (for HIV-positive persons in whom active TB has been ruled out) in HIV clinical care settings; Where appropriate, working with host governments and its partners, such as Global Fund, to conduct surveillance for and manage drug resistant TB.</p>
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>
<p>In addition to the general program area context information, please describe the following if available, highlighting plans for support in the upcoming year.</p> <p>Statistics:</p> <ul style="list-style-type: none"> <li>• Key TB control statistics (e.g., cases per 100,000 population, reported national cases per year, new smear positive case detection and treatment success, DOTS coverage).</li> <li>• The prevalence of HIV in TB patients</li> <li>• The number/percentage of TB patients tested for HIV</li> <li>• The number/percentage of TB patients on cotrimoxazole; number/percentage referred and on ART</li> <li>• Estimate of percentage of TB patients with multidrug resistant TB (MDR-TB)</li> </ul> <p>Services:</p> <ul style="list-style-type: none"> <li>• Provide a general description of U.S. government (USG) support to TB/HIV activities, building on previous years' successes, and explain how they contribute to achieving the goals stated above.</li> <li>• Explain how program activities strengthen TB diagnostic capabilities for persons living with HIV/AIDS (e.g., smear microscopy services, external quality assurance, support for national reference laboratories, culture capability, drug resistance testing).</li> <li>• Describe how program activities support HIV testing and counseling in TB clinical settings.</li> <li>• Describe how program activities address the recording/reporting of patients with TB disease and HIV-infection, including referral to HIV care and treatment.</li> <li>• Describe TB/HIV related services provided to pediatric patients.</li> <li>• Discuss how HIV patients in care are screened for TB and referred for diagnosis and treatment.</li> </ul> <p>Referrals and Linkages:</p> <ul style="list-style-type: none"> <li>• Describe integration of TB and HIV programs in the country. Discuss how patients are referred between programs and the systems to ensure that patients receive adequate care and treatment.</li> </ul> <p>Monitoring and Evaluation:</p> <ul style="list-style-type: none"> <li>• Describe the systems for monitoring and evaluating TB/HIV activities including on-site supervision.</li> </ul>



**Policy:**

- Describe the extent to which TB is a part of the national HIV strategic plan and note any national policies or legislation that address TB/HIV.
- Please describe any plans to address national level policy barriers, training, management and supervision as well as other system strengthening.
- Describe policies and plans to address TB infection control issues to prevent TB transmission in HIV care settings.

Please highlight any other outstanding challenges and gaps that the program is facing.

Where applicable, all USG teams are encouraged to use the Partnership for Supply Chain Management (SCMS) for commodities, including rapid test kits. For more information, please see the program narrative instructions for ARV Drugs (Table 3.3.10).

Please also describe how other USG or other donor TB resources contribute to accelerating TB/HIV collaborative activities, particularly in relation to National TB and HIV/AIDS program strategic plans. Specifically, country teams should describe how Emergency Plan resources will leverage ongoing or planned non-PEPFAR USAID funding for TB and/or HIV/TB activities. To maximize USG resources and avoid duplication, we encourage USG teams to develop a USG-wide strategic plan in the area of HIV/TB and TB funding. There are a number of approaches to accomplishing this joint planning objective (e.g., joint visits by USAID bilateral TB TA and PEPFAR TB/HIV TA, interagency technical working groups, annual one-day planning retreats, interagency portfolio reviews, etc.) and TA is available to facilitate the process. We are hoping that these efforts to link all USG support to TB in a cohesive country strategy will also be reflected in the F/OP. While in future years, we would like to better integrate these processes, please note that for this year, we will be working with F to participate in the F/OP review for TB and hope to ensure that during the review, both PEPFAR and USAID resources and assistance will be considered. Please note that this year we will ask USG teams to upload the non-PEPFAR USAID TB and HIV/TB work plans to allow for a better understanding of comprehensive USG support for TB and HIV/TB programmatic activities.

In [Appendix 19.3](#), we have included national estimates of the number of adult HIV-positive TB cases eligible for ART. It is hoped that PEPFAR programs can coordinate activities in such a way as to contribute to these national goals and targets.

**REQUIRED TARGETS:**

- 7.1 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
- 7.2 Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease
- 7.3 Number of individuals trained to provide clinical treatment for TB to HIV-infected individuals (diagnosed or presumed)
- 7.4 Number of registered TB patients who received counseling and testing for HIV and received their test results at a USG-supported TB service outlet

### TABLE 3.3.08 ORPHANS AND VULNERABLE CHILDREN

<p><b>PROGRAM AREA DESCRIPTION:</b></p> <p>Orphans and Vulnerable Children (HKID) – activities are aimed at improving the lives of orphans and other vulnerable children (OVC) affected by HIV/AIDS, and doing so in a measurable way. Services to children (0-17 years) should be based on the actual needs of the child and could include ensuring access to basic education (from early childhood development through secondary level), health care services, targeted food and nutrition support, protection and legal aid, economic strengthening, training of caregivers in HIV prevention and home-based care, etc.. Household-centered approaches that link OVC services with HIV-affected families (linkages with PMTCT, palliative care, treatment, etc.) and strengthen the capacity of the family unit (caregiver) are included along with strengthening community structures which protect and promote healthy child development (schools, churches, clinics, child protection committees, etc.) and investments in local and national government capacity to identify, monitor and track children's well-being. Programs may be included which strengthen the transition from residential OVC care to more family-centered models. (See the OVC Technical Considerations and OVC Guidance for further details.)</p>
<p><b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b></p> <p>As part of the information which provides general program area context, please describe the following, if available. (Suggestions for activity-level descriptions are found in OVC Technical Considerations.)</p> <p>Statistics:</p> <ul style="list-style-type: none"> <li>• Estimates of the number of children orphaned as a result of HIV/AIDS, and number orphaned from other causes, such as armed-conflict, famine, etc.</li> <li>• Estimates of the number of other vulnerable children due to HIV/AIDS in your country.</li> <li>• The estimated total number of OVCs due to HIV/AIDS in your country who need assistance during this planning period.</li> <li>• Number and percentage of those children reached</li> <li>• Through direct services with PEPFAR support             <ul style="list-style-type: none"> <li>▪ During past reporting period</li> <li>▪ Anticipated to receive services in coming year</li> </ul> </li> <li>• Through the support of the national government or other partners (may or may not have indirect PEPFAR support)</li> </ul> <p>Services:</p> <ul style="list-style-type: none"> <li>• Prior year services:             <ul style="list-style-type: none"> <li>▪ Describe the services which are provided through your OVC care programs.</li> <li>▪ Highlight your major program accomplishments from last year.</li> <li>▪ Which program models were your greatest successes?</li> <li>▪ What particularly successful program models do you intend to scale-up this year?</li> <li>▪ Please highlight outstanding challenges and gaps this program area is facing.</li> <li>▪ Describe how your activities further your country's National Plan of Action for OVCs due to HIV/AIDS, fit in your PEPFAR five-year strategy, and align with the PEPFAR OVC Guidance.</li> <li>▪ Please describe the role of the USG, relative to other key international partners in the sector (e.g., UNICEF, GFATM, and other key donors).</li> <li>▪ Review your overall strategy for reaching OVC, and cite any changes needed in that strategy for the coming year.</li> </ul> </li> <li>• Emphasis areas for 2008: The OVC TWG has 6 key foci for the coming year. Describe how your program will address each (See OVC Technical Considerations for more details):             <ul style="list-style-type: none"> <li>▪ <b>Focus on scale-up:</b> Increase the coverage of OVC programs to respond to the enormous need of HIV/AIDS-affected children, their households and communities.</li> </ul> </li> </ul>

<p>Include the leverage of local and national public-private partnerships. Implement strategies or effective models for providing high-quality services to the most OVC.</p> <ul style="list-style-type: none"> <li>▪ <b>Improve quality:</b> Strengthen the consistency and effectiveness of services provided to OVC and caregivers. Establish efficient and effective service delivery methods to reach the most OVC and caregivers.</li> <li>▪ <b>Coordinate Care:</b> Provide comprehensive OVC care that networks with and leverages resources (human, material, financial) across the spectrum of service areas - including education, child survival, water and sanitation, economic growth, agriculture, etc.</li> <li>▪ <b>Reach especially vulnerable children:</b> Ensure that the broader OVC strategy reflects a developmental, life-cycle approach spanning the range from under-5s to older adolescents. Ensure that marginalized OVC subgroups (e.g., vulnerable girls, disabled children, those outside family care, etc.) are well-integrated into the national OVC plan. Consider the country's contextual factors which may cause some children to be even more disadvantaged than other OVC (e.g., orphans forced into early marriage, exploitive labor, etc.)</li> <li>▪ <b>Strengthen Capacity:</b> Strengthen the local and national structures to provide a long term response to reaching the most OVC with quality, comprehensive services.</li> <li>▪ <b>Build knowledge:</b> Enhance strategic decision-making for OVC programming through improved data collection and use, building on lessons learned/emerging best practice, and south-to-south exchanges. Support related training and capacity building at all levels, from volunteers to professional education (e.g., curriculum of teachers, social workers etc.)</li> </ul> <p>Referrals and Linkages:</p> <ul style="list-style-type: none"> <li>▪ All health programs working with HIV infected families (e.g. PMTCT, palliative care, treatment) should establish linkages with OVC programs to ensure that the children's needs in these homes are being addressed comprehensively. OVC programs should initiate these linkages.</li> </ul> <p>Policy:</p> <ul style="list-style-type: none"> <li>• Describe your plans to address national-level policy or legal barriers to caring for OVC.</li> <li>• Describe your plans to work with specific national institutions and ministries in order to address issues related to system strengthening – e.g., training, monitoring and evaluation, management and supervision, etc.</li> </ul> <p>Where applicable, please use program and activity narratives to describe your plans for coordinating PMI and PEPFAR resources in OVC programs. (See page 20 for more information.)</p>
<b>REQUIRED TARGETS:</b>
8.1 Number of OVC served by OVC programs <ul style="list-style-type: none"> <li>8.1.A Primary Direct</li> <li>8.1.B Supplemental Direct</li> </ul> 8.2 Number of providers/caretakers trained in caring for OVC

### TABLE 3.3.09 COUNSELING AND TESTING

<b>PROGRAM AREA DESCRIPTION:</b>
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 where knowledge of their status would enable access to care and support. Funding for counseling and testing in the context of preventing mother-to-child transmission can be coded under MTCT or HVCT; targets should be included in MTCT.
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

**Statistics:**

- Please identify the targets for persons to be reached with CT and how this will contribute to both the national treatment and prevention goals. Please explain direct and indirect (downstream and upstream) targets.
- Please estimate the overall number of people accessing testing (with USG and all other sources) and what percentage of the adult population this represents.
- Please indicate what proportion of them are accessing CT services in health settings versus community settings (such as standalone, outreach and mobile services).
- Please describe geographic coverage of counseling and testing services.

Should we ask about provider initiated c and t?

**Services:**

- Please comment, as appropriate, on how your programs are:
  - Creating a variety of CT approaches to give clients different options to learn their status
  - Increasing access to CT in clinical settings (including male circumcision service delivery programs)
  - Increasing recruitment of, and access for, couples and families to CT services, with an emphasis on reaching discordant couples
  - Ensuring that CT programs have solid linkages to care, treatment, and other services.
- Please describe training programs for counselors and other health care workers providing counseling and testing.
- Please describe promotion programs to increase utilization of counseling and testing.
- Please describe CT services for children and adolescents.
- Please describe how HIV test kits will be procured and the supply chain management.

**Referrals and Linkages:**

- Discuss specific plans for linking HIV-infected persons to treatment, care, and other support services as well as providing methods for prevention for all CT clients with a specific focus on discordant couples.

**Policy:**

- Please describe any key policy barriers to scaling up or implementing CT and efforts to strengthen the policy environment.
- Discuss methods for maintaining a standard registry or recording system and for routinely reporting HIV testing information from clinical and community sites.
- Please describe any plans to address national-level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.

Please highlight any other outstanding challenges and gaps that the program is facing

**REQUIRED TARGETS:**

- 9.1 Number of service outlets providing counseling and testing according to national and international standards
- 9.2 Number of individuals who received counseling and testing for HIV and received their test results
- 9.3 Number of individuals trained in counseling and testing according to national and international standards

**TABLE 3.3.10 TREATMENT: ARV DRUGS**

<b>PROGRAM AREA DESCRIPTION:</b>
HIV/AIDS treatment/ARV drugs (HTXD) – including distribution/supply chain/logistics, pharmaceutical management and cost of ARV drugs. All Post exposure Prophylaxis procurement for rape victims should be included within this program area.
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>
<p>In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.</p> <p>All USG teams are strongly encouraged to use the Partnership for Supply Chain Management (SCMS) for ARV and other commodity procurement when local systems are not functional. By leveraging the economies of scale created by USG pooled procurement, SCMS is currently at or below the lowest reported price for all ARVs, generic or innovator. A large part of the SCMS mandate is assisting and strengthening national systems, which includes working to help them access lower prices. SCMS can provide the full scope of supply chain management services, including overall management, procurement (including drug forecasting), freight and freight forwarding, quality assurance, information systems management, and in-country technical assistance and support. The SCMS can assist countries with COP FY 2008 planning and assist with the development of a detailed national and/or USG procurement plan.</p> <p>In the program narrative, USG teams should discuss the specific ARV regimes and drugs they expect to procure in the coming year and how the supply chain and procurement plan will be managed by the USG country team and its partners. Additionally, specific information regarding progress in the registration and importation of FDA-approved/tentatively-approved generics should also be included. Please note what percentage of USG-purchased ARVs were generic vs. innovator for FY 2006. The narrative should also briefly include the overall country context regarding ARV procurement and the roles of other stakeholders such as the Global Fund. When applicable, the narrative should discuss USG support and/or engagement in the national ARV planning and procurement process.</p> <p>Regardless of the partners involved (e.g. SCMS, Crown Agents, Track 1.0, etc.), the narrative should include a description of USG's management and/or support for the steps of the procurement cycle. These steps include:</p> <ul style="list-style-type: none"> <li>• Product Selection: quality assurance and national treatment guidelines considerations, appropriate packaging and cold chain requirements, coordination with other donor agencies;</li> <li>• Forecasting/Quantification: educated estimates on future ARV needs, national forecasts with USG and any other donor funding ARV procurement, scale-up and pediatric considerations;</li> <li>• Procurement: include estimated amount of funding for ARV procurement and number of current USG supported patients on treatment and expected scale-up needs;</li> <li>• Freight/forwarding and Importation: freight forwarding, importation challenges if any, average amount of time shipments spend in port, etc.;</li> <li>• In-country warehousing and distribution: describe warehousing and distribution systems including cold chain and security needs and how they are addressed, and explain USG supported distribution; i.e. to central warehouse or to sites, use of public sector warehousing and distribution systems;</li> <li>• Logistics Management Information System: tracking, inventory management at warehouses and treatment sites, monitoring and evaluation.</li> <li>• Capacity Building: strengthening local supply chain capacity, including training in logistics, warehouse/inventory management, forecasting</li> </ul>
<p><i>Data Entry:</i></p> <p>Percent of Total Funding Planned for Drug Procurement: Provide the percent that is planned for ARV</p>

drug procurement only (including ARVs for PMTCT+), exclusive of overhead and other logistics costs. 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.
<b>BUDGETARY REQUIREMENTS:</b>
To meet the Congressional directive that the Emergency Plan allocate 55% of its resources to antiretroviral (ARV) treatment and related care in FY 2008, all focus countries will need to incorporate the 55% goal as a budgetary requirement. If it does not make programmatic sense, please provide a justification.

### TABLE 3.3.11 TREATMENT: ARV SERVICES

<b>PROGRAM AREA DESCRIPTION:</b>
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-3.3.06 or HVTB-3.3.07).
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>
<p><b>General Instructions:</b></p> <p>Please give a comprehensive picture of the context for this program area for adults and children in your country. Include a description of the activities and accomplishments of the host country government and other donors, linkages between USG-funded programs and the national program, and activities that leverage Global Fund support. Link proposed COP activities with the vision expressed in your country Five-Year Strategy and the accomplishments and program directions established in FY 2004-FY 2007 COPs. Address the following issues: (a) explain how the USG will reach the Emergency Plan treatment target for the country, (b) provide data showing that ART is high quality, and (c) describe what is being done to integrate the USG-funded programs into the national program and to assure sustainability.</p> <p>Statistics</p> <ul style="list-style-type: none"> <li>• Number of service outlets providing antiretroviral therapy for adults and for children at the beginning of the reporting period and projected for the end of the reporting period.</li> <li>• Number of adults and children receiving HIV care, including those on antiretroviral therapy, at the beginning of the reporting period and projected for the end of the reporting period.</li> <li>• Number of adults and children on antiretroviral therapy, at the beginning of the reporting period and projected for the end of the reporting period.</li> <li>• Of persons who enrolled in ART, what proportion are alive and on ART at 12 months of therapy? Calculate the proportions separately for both adults and children. Explain how you have calculated these proportions.</li> <li>• Of those who enrolled in ART but are not currently on ART, what proportions (a) died, (b) stopped therapy, (c) transferred, or (d) were lost to follow up at 6, 12, and 24 months?</li> <li>• If available, of persons on ART, what is the median differential between the CD4+ cell count or percentage (for children &lt;5 years of age) at baseline and the CD4+ count/percentage at 12 months of therapy? Calculate the proportions for both adults and children. Explain how you have calculated these proportions.</li> <li>• Number of health workers trained to deliver adult ART services, according to national and/or international standards.</li> <li>• Number of health workers trained to deliver ART services to children, according to national and/or international standards.</li> </ul> <p>The following are 12 key components of an HIV care and treatment program for adults and children (&lt;15 years of age). Please discuss how these elements have been incorporated into your program, and how</p>

they will be further developed in the coming year.

(1) Leadership and Management – Demonstrate that USG and partners are helping the host country develop plans, leadership, and management structure for a national high-quality ART program that is sustainable over the long term.

(2) Standard Operating Procedures – Demonstrate that standard operating procedures (SOPs) for clinical care and treatment of HIV-infected adults and children have been established. These SOPs should include procedures for identifying HIV-exposed and at-risk children, providing cotrimoxazole for all eligible HIV-infected persons, ensuring linkages across programmatic areas, promoting adherence and rapidly identifying those lost to follow-up, providing laboratory and community services, monitoring and evaluation, including on-site supervision, and managing drug and health commodities.

(3) Human Resources – Demonstrate that the human resources, especially the staff for HIV counseling and testing, care and treatment, laboratory and community services, monitoring and evaluation, and drug and health commodities management are adequate to initiate and maintain high-quality ART for the projected treatment targets for adults and children.

(4) Physical Infrastructure – Demonstrate that the physical infrastructure, especially the space for HIV counseling and testing, care and treatment, laboratory, and pharmacy is adequate to initiate and maintain high-quality ART for the projected ART targets for adults and children.

(5) Training – Demonstrate that systems are in place to train care providers, laboratory staff, pharmacists, and community workers required to provide the necessary treatment for adults and children.

(6) Drug and Health Commodities Management – Demonstrate that systems to select, procure, store, track, distribute, and provide drugs, especially antiretroviral drugs, and health commodities are adequate to ensure a continuous and timely supply to initiate and maintain adults and children on care and treatment to achieve each facility's ART targets.

(7) Laboratory Services – Demonstrate that the laboratory equipment, supplies, reagents, and quality assurance are adequate for diagnosing and treating HIV and opportunistic infections and evaluating drug toxicities in HIV-infected adults and children.

(8) Monitoring and Evaluation – Demonstrate that monitoring and evaluation of the HIV care and treatment programs for adults and children includes systems for collecting information for ongoing review, measuring clinical outcomes, reporting indicators, and disseminating lessons learned.

(9) Community Services – Demonstrate that systems are in place to assure community-based involvement including the promotion of HIV prevention, counseling and testing, and adherence to ART for adults and children.

(10) Linkages of HIV Programs – Demonstrate that the HIV care and treatment programs for adults and children are linked with counseling and testing, PMTCT, TB/ HIV, wraparound and other HIV-related facility- and community-based services.

(11) Promotion of HIV Prevention – Demonstrate that the HIV care and treatment programs for adults and children promote HIV prevention in the clinic and surrounding community.

(12) Sustainability – Demonstrate that the HIV care and treatment programs are designed and operate in a manner that promotes indigenous capability-building which will enhance sustainability for years to come.



All USG teams are strongly encouraged to use the Partnership for Supply Chain Management (SCMS) for ARV and other commodity procurement. Please see the program area description in ARV Drugs (Table 3.3.10) and [Appendix 20](#) for details.

**Pediatric HIV/AIDS Treatment (see Care section for pediatric care)**

Include a description of the overall strategy for Pediatric HIV treatment and how PEPFAR is supporting activities to meet these goals and targets. Include a break-down by age of the number of children receiving treatment services (e.g.: 0-2 years; 5-14 years)

In addition to the general adult and pediatric ART program area context information and if the information is available, please describe the following, highlighting plans for support in the upcoming year.

- The national estimates of the burden of pediatric HIV infection, including any relevant urban-rural or regional differences
- National treatment targets for children and current progress toward reaching the above targets
- The current and planned (COP 2008) USG-specific contribution to the national Pediatric HIV treatment programs including the number of children receiving HIV treatment services Targets should be consistent with the goal that 10-15% of all HIV+ patients receiving ART are children under 15 years of age
- The current national geographic coverage of Pediatric HIV treatment services
- The number and proportion of sites providing Pediatric HIV ART services at different levels (i.e. primary health centers, district hospitals) and plans for service decentralization and integration into MCH programs.
- The entry points that will be used to identify HIV-exposed and infected children (e.g.: PMTCT, maternal and child health clinics, other out-patient settings and in-patient settings) and approaches the USG government will put into place to increase access to HIV testing and care and treatment services for this population
- The basic preventive care package of services which should be provided to all HIV-exposed infants in the first years of life, including infant feeding counseling, other nutritional support, cotrimoxazole prophylaxis, access to infant diagnosis, malaria interventions, clean water interventions, and strengthening of linkages to routine child health services.
- How PMTCT programs are linked to Pediatric HIV ART programs to ensure that HIV exposed and infected infants receive needed treatment and follow-up.
- How USG resources are strategically focused within the larger national ART program context to maximize the impact of Pediatric HIV treatment efforts.
- Which pediatric formulations are widely used in the country and if there are critical shortages of essential formulations what steps are being taken to address these.

Please highlight any other outstanding challenges and gaps that the program is facing

**BUDGETARY REQUIREMENTS**

To meet the Congressional directive that the Emergency Plan allocate 55 percent of its resources to antiretroviral (ARV) treatment and related care in FY 2008, all focus countries will need to incorporate the 55 percent goal as a budgetary requirement. If it does not make programmatic sense, please provide a justification.

**REQUIRED TARGETS:**

- 11.1 Number of service outlets providing antiretroviral therapy
- 11.2 Number of individuals newly initiating antiretroviral therapy during the reporting period
- 11.3 Number of individuals who ever received antiretroviral therapy by the end of the reporting period
- 11.4 Number of individuals receiving antiretroviral therapy at the end of the reporting period
- 11.5 Total number of health workers trained to deliver ART services, according to national and/or international standards



**TABLE 3.3.12 LABORATORY INFRASTRUCTURE**

<b>PROGRAM AREA DESCRIPTION:</b>	
<p>Laboratory infrastructure (HLAB) – development and strengthening of laboratory facilities to support HIV/AIDS-related activities including purchase of equipment and commodities and provision of quality assurance, staff training and other technical assistance. Specific laboratory services supporting TB testing goes under HYTB. Laboratory services supporting counseling should go under HVCT or MTCT. Laboratory services supporting palliative care should go under HBHC. Laboratory services supporting treatment should be included under HTXS.</p>	
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS</b>	
<p>In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.</p> <p>Statistics:</p> <ul style="list-style-type: none"> <li>• Number of USG-supported labs at the levels of the network model <ul style="list-style-type: none"> <li>◦ Reference level</li> <li>◦ Referral level</li> <li>◦ Health center level</li> </ul> </li> </ul> <p>Services:</p> <ul style="list-style-type: none"> <li>• Please describe the tiered public health laboratory services structure(s) available in your country.</li> <li>• Identify laboratory-specific unmet needs and policy or administrative issues that impede full implementation of laboratory programs.</li> </ul> <p>Referrals and Linkages:</p> <ul style="list-style-type: none"> <li>• Identify links to USG implementing partners and other major international donors/partnerships.</li> </ul> <p>Policy:</p> <ul style="list-style-type: none"> <li>• Discuss whether there is a national public-health laboratory strategic plan</li> <li>• Indicate how these services link to your strategic planning for USG-supported laboratory activities.</li> <li>• Also define the priorities of USG-supported laboratory services and their relevance to your country's 5-year plan. All programs are encouraged to use the Partnership For Supply Chain Management (SCMS) as the prime partner for purchase of laboratory commodities.</li> <li>• Please describe any plans to address national-level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.</li> <li>• Where applicable, please use the program and activity narratives to describe plans for the coordination of PMI and PEPFAR resources in laboratory infrastructure programs. See page 20 for more information.</li> </ul>	
<b>REQUIRED TARGETS:</b>	
12.1	Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests
12.2	Number of individuals trained in the provision of laboratory-related activities
12.3	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

**TABLE 3.3.13 STRATEGIC INFORMATION**

<p><b>PROGRAM AREA DESCRIPTION:</b></p> <p>Strategic information (HVSII) – Strategic Information is the cornerstone of evidence based planning and decision making for PEPFAR. The USG and its partners are committed to demonstrating progress towards the PEPFAR 2-7-10 goals through continued support of the development and implementation of program area-specific monitoring systems and routine evaluation activities. HIV/AIDS behavioral and biological surveillance, facility surveys, monitoring partner results, reporting results, supporting health information systems, assisting countries to establish and/or strengthen such systems, and related analyses and data dissemination activities fall under strategic information.</p> <p>For more information please consult Strategic Information Technical Considerations and your country team's strategic information advisor.</p>
<p><b>PROGRAM AREA SPECIFIC INSTRUCTIONS</b></p> <p>Ensuring adequate technical staffing and one inter-agency strategic information team coordinated by a strategic information liaison remains a priority. The staff who perform strategic information technical functions are responsible for supporting the entire USG program, which includes building capacity of local partners and national governments.</p> <p>Please describe the three major strategic information challenges that you see in FY 2008 and briefly summarize information on your strategic information team, target setting and results reporting, surveillance and surveys, HMIS, and local capacity building. The points below are listed under each of these categories as guides for your description.</p> <p>Strategic Information Team</p> <ul style="list-style-type: none"> <li>• Please provide a description of your strategic information team including the SI Liaison and coverage of HMIS, M&amp;E and surveillance functions.</li> <li>• Has the team developed one inter-agency strategic information strategy for funding surveys and surveillance, results reporting, and HMIS? How is the strategy updated?</li> <li>• How does the team support capacity building at the national and partner level for surveillance, surveys, and reporting?</li> </ul> <p>Target Setting</p> <ul style="list-style-type: none"> <li>• Please describe the process by which your USG sets country targets.</li> <li>• How does your USG team evaluate partner targets when they are submitted for the COP?</li> <li>• How do you evaluate partner results against targets?</li> </ul> <p>Results Reporting</p> <ul style="list-style-type: none"> <li>• What are your priorities for strengthening results reporting in FY 2008?</li> <li>• What support is planned for the national monitoring and reporting system?</li> <li>• Is a national system for HIV results reporting currently in use or under development and how are USG results reported into the national system?</li> <li>• How will the Global Fund results country reporting and USG reporting be coordinated in 2008?</li> <li>• How do you support partner monitoring and reporting systems? How often do partners report results to you?</li> <li>• What is your approach to the development of partner and country monitoring and evaluation capacity development?</li> <li>• What is your data quality improvement strategy for partner data?</li> <li>• How will you analyze and use partner data, commodities information, or other information for PEPFAR team program planning in the coming year?</li> </ul>

<p><b>Surveillance and Surveys:</b></p> <ul style="list-style-type: none"> <li>• Please describe the status of any DHS, AIS or other population surveys being planned or in the field.</li> <li>• Are any treatment or care cohorts being supported?</li> <li>• Are ANC surveillance or other HIV surveillance activities planned or in the field?</li> <li>• Are you supporting facility surveys (like a SPA or SAM) and/or any mapping efforts?</li> <li>• How is mapping of the epidemic and/or services used in planning?</li> <li>• How are you supporting capacity development of country surveillance and survey staff?</li> </ul> <p><b>Information Systems:</b></p> <ul style="list-style-type: none"> <li>• What information system(s) is being used for national reporting?</li> <li>• What is its current operational status – coverage of both community and clinical services, regions of country?</li> <li>• How often is information from the system available for use in monitoring national results and reporting to international agencies, such as UNAIDS and WHO?</li> <li>• In 2008 will you fund individual partner information systems? If yes, how are you assuring their integration with national reporting systems?</li> <li>• What systems, including data warehouses, will you support for partner reporting and national collection and storage of information?</li> <li>• How are you moving to build country capacity for operating HMIS systems?</li> </ul>
<b>BUDGETARY REQUIREMENTS</b>
As a general guideline approximately 7% of your total country budget (all program areas) should be attributed to Strategic Information.
<b>REQUIRED TARGETS:</b>
13.1 Number of local organizations provided with technical assistance for strategic information activities 13.2 Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)

### TABLE 3.3.14 OTHER POLICY AND SYSTEMS STRENGTHENING

<b>PROGRAM AREA DESCRIPTION:</b>
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 capacity development (HCD), stigma and discrimination, and gender issues; and other cross-cutting activities to combat HIV/AIDS.
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS</b>
<p>Please provide a description of the general approach you are undertaking to strengthen health care systems to benefit HIV/AIDS programs and your approach to sustainability. Some of the activities and funding to support systems strengthening may be described and accounted for under specific program areas. This section, however, is intended to provide information about the overarching approach, including efforts to build on previous years' successes. Please describe how you are:</p> <ul style="list-style-type: none"> <li>• Strengthening the capacity of host country government institutions to plan, manage, and implement HIV programs</li> <li>• Strengthening local or indigenous organizations, particularly in management and leadership and policy development</li> <li>• Strengthening leadership and the policy environment to reduce stigma and discrimination including addressing key gender issues</li> <li>• Strengthening leadership and policy environment to expand access to HIV care and treatment services for children. Document any positive outcomes from previous years investments in this area</li> </ul>

<p>(e.g., new policy or guidelines, new legislation, etc.)</p> <ul style="list-style-type: none"> <li>• Trying to strengthen the GFATM management structure and to improve donor coordination</li> <li>• Document any positive outcomes from previous years investments in this area (e.g., new policy or guidelines, new legislation, etc.)</li> </ul> <p>Human Capacity Development affects all program areas. Some of the specific activities that support HCD are cross-cutting and can be described in this section. These include:</p> <ul style="list-style-type: none"> <li>○ HR assessment and implementation of HR plans</li> <li>○ Strengthening the HR management function within USG, the ministry of health and NGOs</li> <li>○ Implementation of incentive and retention schemes</li> <li>○ Development of supportive HR policies, including policy reform to support task-shifting</li> <li>○ Strengthening indigenous training institutions, particularly in management and leadership</li> <li>○ Development and/or strengthening of an HR information system to track the number of health care workers, where they are deployed, where and when they were trained, what credentials they hold, etc</li> <li>○ Any activities beyond specific trainings that reinforce the training provided under PEPFAR, such as standardization of guidelines or curricula across partner institutions.</li> </ul> <p>Please highlight any other outstanding challenges and gaps that the program is facing.</p>
<p><b>REQUIRED TARGETS:</b></p> <p>14.1 Number of local organization provided with technical assistance for HIV-related policy development</p> <p>14.2 Number of local organization provided with technical assistance for HIV-related institutional capacity building</p> <p>14.3 Number of individuals trained in HIV-related policy development</p> <p>14.4 Number of individuals trained in HIV-related institutional capacity building</p> <p>14.5 Number of individuals trained in HIV-related stigma and discrimination reduction</p> <p>14.6 Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment</p> <p>Please note that, in addition to the specific targets, it is critical that each activity describe a specific benchmark or outcome that will be achieved with the resources during the funding period, for example "law drafted"; "HCD assessment completed with recommendations included in MOH budget request to Ministry of Finance"; etc. This information should be included at the end of the program area summary.</p>

## Table 3.3 Activities

Each COP activity contains the following details:

<ul style="list-style-type: none"> <li>• Funding Mechanism name</li> <li>• Planned Funds</li> <li>• New / Continuing Activity</li> <li>• Activity Narrative</li> <li>• Activity Targets <ul style="list-style-type: none"> <li>○ Downstream (Direct)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Emphasis Areas</li> <li>• Target Populations</li> <li>• Coverage Area</li> <li>• Continuing Activities</li> <li>• Related Activities</li> <li>• Early funding requests</li> </ul>
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Please complete one table for each Funding Mechanism/Prime Partner that will undertake activities in FY 2008 for the given program area.

In general, each unique funding mechanism outlined in Table 3.1 should have only one entry in each program area. However, if a specific funding mechanism/prime partner will undertake several activities in a given program area and you feel very strongly that these activities are sufficiently distinct that a single narrative would not provide an adequate description, you may put them into separate entries. Comprehensive programs may need to be broken up across several program areas. For more information, please see page 59.

Ongoing activities for which no additional FY 2008 funds are requested: Please describe activities that will continue from FY 2007 to FY 2008 in the Activity Narrative, and designate the planned funding amount as \$0. **Do not update targets**, as there is no new funding to link to the targets. These activities will not be reviewed for approval during the COP review process. In most cases minimal time should be spent on ongoing activities, even those receiving FY 2008 funding, and their review will be equally brief.

### INSTRUCTIONS FOR ADDING TRACK 1.0 ACTIVITIES (FOCUS COUNTRIES ONLY)

#### MODIFICATIONS IN THIS SECTION:

In FY 2008, country teams will enter all Track 1.0 information in the COP.

#### CONTENT:

OGAC will send a table to the field in June, 2007 providing each country's planned central funding for the five Track 1.0 program areas (e.g., AB, ART, Blood Safety, Injection Safety, and OVC). This table will also identify the relevant implementing partner, mechanism, and USG agency and bureau/operating division for each Track 1.0 activity. It will be used as the basis for entering centrally-funded Track 1.0 activity and funding data into the FY 2008 COPs, as described below.

#### DATA ENTRY:

1. Enter Track 1.0 information as you would enter any other activity, using the table sent by HQ.

**FUNDING MECHANISM:****CONTENT:**

This is a drop down list of all the funding mechanisms that you 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. You will not provide information by sub-partner in this table.

**DATA ENTRY:**

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

**PLANNED FUNDS:**

Note: Special instructions for Other Bilateral Countries at the end of this section.

**MODIFICATIONS IN THIS SECTION:**

In FY 2008, focus countries will enter NPI activities in the COP, with \$0 in the planned funding field.

**CONTENT:**

Enter the amount of FY 2008 funding planned for this activity, rounded to the nearest dollar. The summary budget table (Table 4) generates automatically 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 FY 2008 funding, please enter \$0 for the planned funding.

**SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:**

For activities with central as the mechanism type (headquarters procured, centrally funded), please enter \$0.

**DATA ENTRY:**

Please enter the FY 2008 planned funding (in whole U.S. dollars) directly into the cell. You do not need to enter dollars signs or commas.

**NEW/CONTINUING ACTIVITY:****CONTENT:**

For the purposes of the COP, a continuing activity is any activity continued from the previous year. If the program is expanding to reach more people, adding a new province, etc., the activity is continuing. If, however, the partner is taking on a totally new role in a new program area, for example in the past, a partner worked with orphans and vulnerable children, but is going to start providing care services to adult PLWHA, the activity in the Palliative Care program area should be marked new. In addition, if an umbrella is changing to conduct technical assistance in addition to its role as an umbrella, it would be new.

If you have any questions about whether an activity is new or continuing, please contact your core team leader.

All activities need to be selected as either a new activity or a continuing activity. If an activity is imported from the FY 2007 COP, it will select automatically as a continuing activity. If an activity is entered using the “Add Activity” button, it will select automatically as a new activity. You can change the default setting.

**Continuing Activities with FY 2008 Funds:** Please include the new funding requested in the Planned Funds box and new targets to be achieved with FY 2008 funds. The targets included in the FY 2008 COP, should NOT be the sum of FY 2007 and FY 2008 targets. As stated earlier, we anticipate minimal time and effort should be spent describing on-going activities, with attention mostly dedicated to changes in targets and a brief description of what is new under these programs.

**New Activities:** Please ensure that the Continuing Activity button is unchecked and that you have included a funding amount in the Planned Funds box, and provided targets to be achieved by September 30, 2009. If an FY 2007 funding mechanism is imported for use in describing a new FY 2008 activity, please uncheck the Continuing Activity button.

#### **DATA ENTRY:**

None, except to change the default setting.

#### **ACTIVITY NARRATIVE:**

##### **CONTENT:**

The activity narrative is of particular importance, because COP reviewers depend heavily on the description in this narrative. Please give enough detail for reviewers to understand what the activity entails, and what this activity will accomplish in the program area.

Please include appropriate descriptive narratives for your Central/Track 1.0 activities. These activities are as important for reviewers as field activities. If you need assistance in getting sufficient information from your Track 1.0 partners to complete the COP data entry, please contact your Core Team Leader.

Each narrative should specifically mention:

1. Emphasis areas of the activity (please describe how you will address the emphasis area, rather than just listing);
2. Populations the activity is targeting (please describe how you will reach these populations, rather than just listing);
3. How you will reach the specific planned targets; and
4. 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.
5. Any linkages of the specific activity to other USG resources and/or other donor support.

Please see the Extranet for an example of an activity narrative.

**HELPFUL HINT:** For one activity that is divided into multiple activity narratives (for example, if the activity is a joint one done by multiple partners or if one activity is funded by multiple funding sources) you do not need to provide a different narrative for each entry. We encourage you to copy and paste one write-up into multiple activity narratives.

### **Activity Narratives for PHE**

Activity narratives are required for all PHE activities, regardless of whether they are new or ongoing activities. In FY 2008, the activity narrative will replace the PHE background sheet collected in previous years. Please see the template in Appendix 12, and note that it is very important this template be adhered to.

### **Activity Narratives for Ongoing Activities:**

Although ongoing activities do not need extensive revision in FY 2008, feel free to include a sentence or two describing any changes. It is very important that you clearly identify narratives that have not been updated from FY 2007.

If the country team does not have to complete narratives in a specific program area, please delete the activity narrative text before submitting the COP. Please note that country teams may still include some information in the activity narrative, and it is worthwhile to import the activity to capture the targets, emphasis areas, target populations, and coverage areas.

**Unless explicitly stated in the activity narrative text, we will assume all narratives have been updated.**

### **SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:**

As this is the first year Other Bilateral Countries will enter activity narratives, please include a brief narrative for all activities, both new and ongoing.

#### **DATA ENTRY:**

These are narratives that are entered into text boxes. There is an 8,000 character limit (approximately two pages) for each narrative. We recommend that you write the narrative in Word, then paste the text into the text box in COPRS. You may also type directly into the box on the screen, but COPRS does not have a spell-check function.

### **CONTINUING ACTIVITIES TABLE:**

#### **MODIFICATIONS IN THIS SECTION:**

This table replaces the "Associated Activity" table in the FY 2007 COP, and has been expanded to include activities for multiple years.

#### **CONTENT:**



This table is intended to track continuing activities from previous years. When an activity is imported from the FY 2007 COP, the FY 2007 activity will automatically be included in this table. You will be able to edit the table and select activities from FY 2006 and FY 2005.

Users can change the default setting, but one FY 2007 activity can only be associated with one FY 2008 activity (within the same program area). There may be instances where an FY 2007 activity splits into two FY 2008 activities, but COPRS will not allow you to display that here. Please use your best judgment when completing the table, and remember that you can add a comment or use the activity narrative to explain a discrepancy if you wish.

Continuing Activities				
ID	Fiscal Year	Mech. ID	Prime Partner	Planned Funding
<a href="#">1234.07</a>	FY 2007	1342.07	Columbia University	\$100,000
<a href="#">1234.06</a>	FY 2006	1342.06	Columbia University	\$75,000

[Change/Add Activities](#)

Note: The activity IDs are hyperlinked to the COP activity page.

Continuing PHE Activities: Note that in most cases, FY 2007 COP activities did not break out PHE as a separate activity; thus, the FY 2007 activity linked to the FY 2008 activity will be the main programmatic activity that does not include PHE. Therefore, in FY 2008, you may have a continuing activity, but no entry in the continuing activity table.

#### DATA ENTRY:

This table is automatically populated with FY 2007 data when you import. Data entry is only required to change the default setting or to add FY 2006 or FY 2005 listings.

1. Click Change / Add Activities. You will see a list of all activities (within the program area) from the FY 2007, FY 2006, and FY 2005 COP.
2. Click the radio button you would like to select
3. Click Save

Note: If you make changes, COPRS will update the continuing activity tables in the respective COP for you.

#### RELATED ACTIVITIES TABLE:

##### MODIFICATIONS IN THIS SECTION:

This table replaces the line in the activity narrative listing other related activities.

##### CONTENT:

This table lists all of the related activities within your FY 2008 COP. While you can list as many activities as you like, we would like to suggest you limit the scope and definition of related activities. Please include any comprehensive programs that are split across program areas, such as a comprehensive ABC program or any of the other information from page 59. You do not need to reference every referral hospital you are working with.

While we ask you to limit what you include, use your best judgment.

**Related Activities:**

Program Area	Activity ID	Mech. ID	Mechanism Name	Prime partner	Planned funding
01-MTCT	<a href="#">1234.08</a>	2234.08	ICAP	Columbia University	\$50,000
02-HVAB	<a href="#">1455.08</a>	3089.08	Education	Ministry of Health	\$500,000

Note: Clicking the activity ID will take you to the activity screen of that entry.

**DATA ENTRY:**

1. Click change / add activities.
2. You will see a list of all activities in your COP. This list can be sorted by clicking any of the hyperlinked column headings. (CTRL+F is also an easy way to search for something).
3. Select the activities you want to mark as related
4. Click Save
5. The table will be updated with your selections and reflected throughout the COP. Using the sample screenshot above, if you clicked on activity 1234.08 (MTCT), you would see activity 1455.08 (HVAB) in the related activities table.

**EARLY FUNDING:**

Note: Special instructions for Other Bilateral Countries at the end of this section.

**MODIFICATIONS IN THIS SECTION:**

In FY 2008, early funding requests will be made at the activity level.

**CONTENT:**

Early funding requests are only for activities that will require funding in advance of normal COP approval and Congressional Notification timelines. Please take into account two items as you decide on early funding requests:

1. Early funding can be requested under a Continuing Resolution but it 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.

If you have a funding mechanism which will require funding to continue operations prior to April 30, 2008, please check the box for early funding. Only request the amount of funding to cover your activity until the full funding arrives in-country. (There should be very few instances where you would request an entire activity as early funding.)

In the early funding narrative, please describe what the early funds will be used for and why early funds are necessary. The character limit is 1000 characters (approximately 1 paragraph).

CDC Management and Staffing Early Funding Requests: FY 2008 COPs should include an early funding request to cover ongoing HHS/CDC operations costs to support Management and Staffing (M&S) requirements prior to release of the first Congressional Notification for FY 2008.

The COPs should request sufficient early funding to cover all urgent M&S costs through the first seven months of FY 2008 (through April 30, 2008), including such activities as salaries, travel, training, housing and other personnel-related expenses. The early funding request should cover all ongoing mandatory costs to be incurred during the period, but may not include funding for new activities; only ongoing activities can be funded under a continuing resolution. Non-urgent discretionary M&S costs should not be requested as early funding and will not be approved by OGAC. The early funding request should be reduced by any carryover funding available for M&S costs. Please note that if the COP does not contain an early funding request for HHS/CDC M&S costs, the funds will not be available until after the COPs have been approved and notified to Congress.

### SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:

Other Bilateral Countries can only request early funding for GAP or GHAI funds.

### DATA ENTRY:

For activities that require early funding:

1. Select the check box next to Early Funding Request. This will regenerate the page with additional information needed.
2. 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, commas, decimal points, or cents. Please round to the nearest dollar.
3. Enter a brief narrative in the Early Funding Request Narrative box. This narrative should not be more than 1000 characters.

Mechanism 1234.08  
Total Early Funding Request: \$520,000

Early Funding Activities				
Program Area	Activity ID	Early Funding Narrative	Early Funding Request	Planned Funds
01-MTCT	1234.08	The request is for salaries of staff to ensure that the staff continues to get their salaries without failure.	\$100,000	\$720,000
05-HVOP	2342.08	The Ipoletse Hotline is expanding its services with FY06 funding, to include cell and land line phone access to the information line and a counseling line. With other donor funding, the service will also include a treatment line for physicians and nurses, but some of the administrative costs for that project are covered by USG support. An interruption in services would damage the credibility of the service severely, so early FY07 funding is requested to ensure that an interruption does not happen.	\$50,000	\$150,000
07-HVTB	1093.08	Early funding is requested to maintain the salary support for a BP funded position. COP06 funds have only been allocated up to March 2007 and any delay in the awarding of COP07 funds will have a detrimental impact on the implementation of the MOH TB&HIV program.	\$270,000	\$710,000
13-HVSI	2094.08	ANC sentinel HIV surveillance preparatory activities start early in March of each year. \$ 100,000 are being requested as early funding to allow purchasing the service a courier to transport blood specimens from different ANC sentinel sites to the national HIV laboratory in Gaborone, to print of the 2007 ANC sentinel surveillance reports, flyers and posters, and to support the dissemination of the 2007 ANC sentinel surveillance report. All these processes and agreement must be in place before the survey commences in May.	\$100,000	\$150,000

### ACTIVITY TARGETS:

#### Targets' Timeframe:

The targets in this section relate to the time period that ends September 30<sup>th</sup>, 2009. PEPFAR is moving in future years toward setting all activity targets using the fiscal year. However, this year countries may continue to have partners set targets for the 12 months from the date that

funding is received up to September 30, 2009 or they may require targets from October 1, 2008 through September 30, 2009. As stated previously, ongoing activities requiring No new FY 2008 funding, should maintain the FY 2007 targets.

Country teams can use one set of targets to describe a Track 1.0 partner's activities with all funding sources. The one set of targets is the sum of targets associated with central funding as well as targets associated with any additional country funding; there is no need to disaggregate by funding stream as it is all one activity. Please remember to reference the activity ID number of the Track 1.0 entry in the country-funded narrative and vice versa. As always, these targets will also need to be unduplicated when calculating the program area summary targets.

### **DOWNSTREAM (DIRECT) TARGETS:**

#### **CONTENT:**

The only required indicators and associated targets for Activities by Funding Mechanism are those for USG **downstream (direct)** support. Upstream (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 5](#) shows the full list of all required indicators by program area. Please also reference the *President's Emergency Plan for AIDS Relief Indicators Reference Guide: January 2007*.

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 the 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 must be collected and reported in the Program results. Please review *The President's Emergency Plan for AIDS Relief Indicators Reference Guide: January 2007* 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 downstream (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 commas. 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.

### **UPSTREAM (INDIRECT) TARGETS:**

#### **CONTENT:**

Indirect targets should be national level targets, and therefore should not be set at the activity or partner level. However, there will be a text box in each activity entry for you to provide information on how the partner may be supporting or contributing to any upstream (indirect) targets. 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 downstream (direct) targets) use the box labeled with **Please Enter Upstream (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.

### **CUSTOM TARGETS:**

#### **MODIFICATIONS IN THIS SECTION:**

In FY 2008, countries will be able to set targets at the program area summary level. We have also made it easier to add, delete, and manage custom indicators.

#### **CONTENT:**

In addition to the indicators provided in the COPRS, while neither required, nor particularly encouraged, 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, you will be able to select whether the targets appear at the activity level, program area level, or both. 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, but only those for which you want the indicator to apply. Finally, please be conservative in adding indicators. It is widely recognized that countries will need additional indicators to manage their program; however, not all are appropriate to add into COPRS, which is specifically intended for the highest level reporting and aggregation across countries. Indicators should only be added if a majority of activities in the program area will be contributing to their achievement.

Several TWGs have developed a list of indicators for program management, which may be useful as you are thinking about custom indicators. For more information, please see the technical considerations.

#### DATA ENTRY:

1. At the bottom of the targets page (see screen shot above under downstream (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 for which you would like to have the target available. You can select only one, or all years.
5. Click the **Save Custom Target** button to return to the targets page.

#### EMPHASIS AREA TICKBOXES:

##### MODIFICATIONS IN THIS SECTION

The “Emphasis Areas” now contain a streamlined list of former emphasis areas and key legislative issues. The definitions have been clarified and expanded, and we are no longer asking for a percentage of effort.

##### OVERVIEW:

OGAC uses these Emphasis Areas in responding to both Congressional and media inquiries and therefore it is critically important that they reflect the field reality as closely as possible. For the FY 2008 COP, we have revised the list.

You should ensure that each of these selections are justifiable, according to the definition. That is to say that you would be able to support each selection in the event of an audit.

Many TWGs have written additional guidance on the issues related to these emphasis areas. For more information, please see the technical considerations.

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Construction / Renovation</li> <li><input type="checkbox"/> Gender               <ul style="list-style-type: none"> <li><input type="checkbox"/> Addressing male norms and behaviors</li> <li><input type="checkbox"/> Increasing gender equity in HIV/AIDS programs</li> <li><input type="checkbox"/> Increasing women's access to income and productive resources</li> <li><input type="checkbox"/> Increasing women's legal rights</li> <li><input type="checkbox"/> Reducing violence and coercion</li> </ul> </li> <li><input type="checkbox"/> Human Capacity Development               <ul style="list-style-type: none"> <li><input type="checkbox"/> Training                   <ul style="list-style-type: none"> <li><input type="checkbox"/> Pre-Service Training</li> <li><input type="checkbox"/> In-Service Training</li> </ul> </li> <li><input type="checkbox"/> Task-shifting</li> <li><input type="checkbox"/> Retention strategy</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Local Organization Capacity Building</li> <li><input type="checkbox"/> New Partner Initiative (NPI)</li> <li><input type="checkbox"/> PHE / Targeted Evaluation</li> <li><input type="checkbox"/> Strategic Information (M&amp;E, HMIS, Survey/Surveillance, Reporting)</li> <li><input type="checkbox"/> Workplace Programs</li> <li><input type="checkbox"/> Wraparound Programs (Health-related)               <ul style="list-style-type: none"> <li><input type="checkbox"/> Child Survival Activities</li> <li><input type="checkbox"/> Family Planning</li> <li><input type="checkbox"/> Malaria (PMI)</li> <li><input type="checkbox"/> Safe Motherhood</li> <li><input type="checkbox"/> TB</li> </ul> </li> <li><input type="checkbox"/> Wraparound Programs (Other)               <ul style="list-style-type: none"> <li><input type="checkbox"/> Economic Strengthening</li> <li><input type="checkbox"/> Education</li> <li><input type="checkbox"/> Food Security</li> </ul> </li> </ul> |
|---|--|

**DEFINITIONS:**

Please use the following definitions to determine whether an activity includes one of the emphasis areas.

**Construction and Renovation:** Construction of any new facility, or the change in use, square footage, technical capacity, or other infrastructure improvements to any facility. Please note that the definition of renovation is intentionally broader than the CDC definition used for funding renovations.

**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 rights
- Reducing violence and coercion

For more information on gender, please see [Appendix 10](#).

**Human Capacity Development:**

- **Training:** A series of coordinated, strategic interventions addressing gaps and imbalances in skills, knowledge and practice. Training may address both short-term and long-term needs within the overall HCD strategy.
  - Pre-service Training – pre-service training includes medical and nursing degrees as well as masters' degrees in public health, public administration, epidemiology, pharmacology and other health professions. Pre-service training should take place in a local university or other appropriate, accredited educational institution.
  - In-Service Training – In-Service training is short-term training of health care workers such as doctors, nurses, pharmacists, laboratory technicians, community health workers, peer educators, and administrative and support staff. In-service training could include training in a specific task or skill, refresher training or on-the-job training.
- **Task Shifting:** Activities that seek to shift tasks or skills from a specialized to a less specialized health worker, such as from physicians to nurses or from nurses to community health workers.
- **Retention Strategy:** Activities and incentives that seek to motivate and retain existing health workers, such as provision of free ART to health workers and their families, training support or other incentives such as supplies and equipment.

**Local Organization Capacity Building:** Strengthening the ability of key local institutions to implement programs efficiently with diminishing reliance, over time, on external technical assistance. This includes activities to improve the financial management, human resource management, management information systems (MIS), quality assurance, strategic planning, and leadership and coordination of partner organizations.

**New Partner Initiative (NPI):** Activities that are part of a New Partner Initiative award. The Initiative provided \$200 million (over the course of the initiative) for grants to new partners providing HIV/AIDS prevention and care services in an effort to identify potential new



Emergency Plan partner organizations, increase their capacity to provide care and prevention services, and to increase the total number of Emergency Plan partners.

*Note:* The NPI tickbox will only appear in activities in the MTCT, HVAB, HVOP, HBHC, HVTB, HKID, HVCT, and OHPS program areas. Please contact your core team leader if you have an NPI activity in another program area.

**Public Health Evaluations (PHE)/Targeted Evaluations (TE):** PHE includes TE, but recognizes that a broader range of studies and methodologies are needed to answer critical questions over time. Targeted Evaluations are studies to rapidly identify promising models or best practices, to inform mid-course corrections and improvements for a project, or to indicate whether a specific program model accomplished its goals. PHE expands on the base of TE, shifting the focus from individuals to communities and populations. All PHE/TE studies should reflect appropriate methodologies to ensure reliable and meaningful results. Overall, PHE includes studies of program activities, characteristics, outcomes and impact, to determine effectiveness of a program, compare program models, answer operational questions for implementation; emphasizes use of sound scientific practices, including systematic sampling, comparison groups, and randomization when appropriate; supports the PEPFAR strategy for implementing scientifically sound, cost-effective strategies; prioritizes local investigator participation and capacity-building. PHE does **NOT** extend to basic or investigational clinical research activities

For more information on PHE, please see [Appendix 12](#).

**Strategic Information (M&E, HMIS, Survey/Surveillance, Reporting):** 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

**Workplace Programs:** Activities that encourage 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.

**Wraparounds** - A wraparound activity wraps or links together PEPFAR programs with those from other sectors to provide comprehensive program support and improve the quality of life to HIV/AIDS-affected and -infected communities. Wraparounds leverage resources, both human and financial, from entities with different funding sources in order to complement Emergency Plan 2-7-10 goals and maximize the effectiveness of programs. Wraparound activities may include other programs funded by the USG (e.g., USAID Development Assistance), the Global Fund, the UN (World Food Program, UNICEF, etc.), the private sector, or other partners. In general, wraparound activities are supported with a



mix of funds, primarily from sources other than PEPFAR. However, wraparound activities that directly serve PEPFAR priority populations by supporting the prevention, treatment, or care of HIV/AIDS, and are in keeping with other PEPFAR guidance, may be supported with Emergency Plan funds. In many cases the other sources of funding are used to provide the platform and PEPFAR funds are used to support those activities with our priority populations. In other cases, PEPFAR provides the platform (e.g. home based care infrastructure) for wraparounds, such as delivery of bednets through PMI, immunizations, or medications for neglected tropical diseases.

#### Health-related Wraparounds

- **Child Survival Activities:** The goal of child survival activities is to support the availability and use of proven life-saving interventions that address the major killers of children and improve their health status. Examples of wrap-around services include care, routine immunization, polio eradication, safe water and hygiene, micronutrients, growth monitoring, improved infant and young child feeding, and treatment of life-threatening childhood illnesses
- **Family Planning:** The goal of family planning programs is to enable couples to determine whether, when, and how often to have children, resulting in improved maternal and child health. Voluntary family planning has profound health, economic, and social benefits for families and communities and by averting unintended pregnancies among HIV-infected women can reduce mother-to-child transmission. PEPFAR funds cannot be used to pay for contraceptives other than male and female condoms. However, expanding access to high-quality voluntary family planning (FP) services and information, and reproductive health (RH) care can be achieved through wraparound programming in such activities as ensuring that the minimum package of PMTCT services includes access to voluntary family planning and that, where feasible, ART providers include family planning information and services as part of routine treatment care. Wraparound programming can also be utilized to link family planning with prevention for people living with HIV/AIDS, voluntary counseling and testing, and other programs that may reach people who are at high risk for both HIV infection and unintended pregnancy.<sup>6</sup>
- **Malaria:** The goal of these programs is to support the implementation of the President's Malaria Initiative (PMI), related malaria control programs, and malaria research activities to reduce malaria-related mortality. Development of effective malaria vaccines, new malaria treatment drugs, and targeted operations research are key interventions that would also fall under this emphasis area. Relative to HIV this would include wraparound activities that target people living with HIV/AIDS and OVC.
- **Safe Motherhood:** The goal of safe motherhood programs is to reduce maternal mortality and disability by following a continuum of care from pre-pregnancy through

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<sup>6</sup> Please be aware that there are a number of legislative and policy requirements that may be applicable depending on the exact nature and source of funding for "wrap around" activities in the area of family planning. We anticipate further guidance will be forthcoming, however in the interim, if you have any questions, please consult your core team leader or Bev Johnston or Mary McLaughlin.

the post partum period. Wraparound activities would support efforts such as improving pre and postnatal care services with PMTCT programs to help improve maternal health outcomes. Wraparounds could also support facility-based and outreach services to improve the quality and equitable coverage of antenatal care, especially as PMTCT services are taken to scale. Delivery and postpartum care services, including periodic evaluation of the progress of pregnancy, labor support and active management of the third stage of labor, should be addressed in all PMTCT programming through such wraparound approaches.

- **TB:** The goal is to reduce the number of deaths caused by TB by increasing detection of cases of TB, and by successfully treating detected cases, as well as addressing issues of multi-drug resistant TB, TB/HIV, and investing in new tools for TB.

#### Other Wraparounds

- **Economic Strengthening:** A broad term that incorporates Microfinance, Enterprise Development and Job Creation. **Microfinance** is defined as finance for poor households and/or their microbusinesses. The "core unit" here is the household; the business is generally understood as one of the income generators for the household. **Enterprise Development** is defined as business development for poor enterprises. This could include getting poor people into productive value chains. The "core unit" is the activity/business rather than the household, although the household is certainly understood to be supported by the business. Finally, it includes activities that are intended to increase availability of jobs to those who are poor. Relative to HIV, this would include wraparound activities that target people living with HIV/AIDS and OVC.
- **Education:** The goal of education programs is to promote effective, accountable, and sustainable formal and non-formal education systems. Relative to HIV this includes using these systems as a means to address HIV/AIDS prevention, care and treatment targets and through support to children, the education workforce and associated institutions such as relevant Ministries, Parent Teacher Associations etc.
- **Food Security:** The goal of these activities is to work towards both national- and/or household-level food security. National food security exists when all people, at all times, have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. Household food security means access by all members at all times to enough food for an active, healthy life. Food security includes at a minimum (1) the ready availability of nutritionally adequate and safe foods, and (2) an assured ability to acquire acceptable foods in socially acceptable ways (that is, without resorting to emergency food supplies, scavenging, stealing, or other coping strategies). Relative to HIV/AIDS, wraparound programs include support of food security for people living with HIV/AIDS and OVC as well as food-for-prescription programs.

#### **DATA ENTRY:**

Check the tickbox of the applicable emphasis area.

Several emphasis areas have subsets; if you check one of the subsets, COPRS will check the parent emphasis area for you.

- ☒ 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 rights
  - ☐ Reducing violence and coercion

### EMPHASIS AREA DOLLAR AMOUNTS:

#### MODIFICATIONS IN THIS SECTION

This year, we are asking for the dollar amount spent on food, public private partnerships, pediatric AIDS treatment, and early funding requests at the activity level.

#### CONTENT:

The following are identified as high priority areas and there is a need for more in-depth information. This gives us better information on the overall topic for congressional queries and gives the TWGs a better sense of the type of activities being implemented.

#### Food Support

- ☐ Estimated PEPFAR Dollars spent on food
- ☐ Estimation of Other Dollars leveraged in FY 2008 for Food

#### Pediatric AIDS

- ☐ Dollars Spent on Pediatric AIDS Treatment

#### Public Private Partnership

- ☐ Estimated PEPFAR Contribution in Dollars
- ☐ Estimated Local PPP Contribution in Dollars

#### DEFINITIONS:

**Pediatric Treatment Planned Funding:** The amount of planned funding for pediatric ARV services or ARV Drugs. Pediatric is defined as ages 14 and under.

**Public Private Partnerships:** PEPFAR defines public-private partnerships (PPPs) as collaborative endeavors that combine resources from the public sector with resources from the private sector to accomplish the goal of HIV/AIDS prevention, care, and treatment. PPPs enable the U.S. Government and private-sector entities to maximize their efforts through jointly defined objectives, program design, and implementation, and through the sharing of resources, risks, and results. Three hallmarks of PPPs are that they help ensure sustainability of programs, facilitate scale-up of interventions, and leverage significant private-sector resources.

Leveraging significant resources may include financial resources, in-kind contributions and intellectual property. Significant resources are considered **greater than or equal to** a dollar for dollar or 1:1 match of partner(s) to PEPFAR resources. To meet the definition of a Public-Private Partnership, of the matching resources from partners external to PEPFAR, a minimum of 25% must come from the private sector. The other 75% may be composed of other USG contributions (e.g., from the President's Malaria Initiative), multilateral donors (e.g., UNICEF), or other public resources (e.g., bilateral contributions from foreign governments). Only partnerships that meet the requirement of a 1:1 leverage and 25% private resource threshold are counted as PPPs. (See Technical Considerations for further explanation.)

Private-sector partners could include a wide range of organizations such as: foundations, U.S. and non-U.S. private businesses, business and trade associations, unions, and philanthropic leaders, including venture capitalists. Non-governmental organizations and private voluntary organizations may play a role in implementing partnerships established between the Emergency Plan and private sector entities; however, they are *not* intended to be prime contributors under a PPP arrangement.

PPPs are *not* workplace programs; they are *not* interventions that engage or involve the private sector (e.g., private providers) without a specific, quantifiable contribution from that sector; they are *not* traditional social marketing programs; and they are *not* partnerships without a 1:1 leveraging of resources.

☐ Estimated PEPFAR Contribution in Dollars

The amount of funding planned for the PPP in this activity (funding from the country's own PEPFAR allocation, not including central funding).

☐ Estimated Local/Non-USG Partner Contribution to the PPP in Dollars

Any non-U.S. Government funding from local private and public sources (can include other donor governments and organizations). Local is considered any PPP that is not coordinated centrally by OGAC, but by the in-country USG team. This dollar amount must match the total U.S. PEPFAR contribution by a ratio of at least one to one. Private-sector contributions must account for at least 25% of the reported dollar amount.

### Support for food:

There is a very strong imperative that we be able to report on PEPFAR funds that are used for the provision of food and other nutritional supplements to people living with HIV/AIDS and OVC. Examples of nutritional supplementation include support for the purchase of food, fortified products, replacement feeding for infants, and micronutrient supplementation within keeping with PEPFAR guidance.

Please note that while the estimated dollar amounts below focus on nutritional supplementation primarily through the provision of food, as opposed to nutritional assessment and counseling,

this is not intended to deemphasize the importance of nutritional assessment and counseling as a precursor to any supplementation. Nutritional assessment and counseling is central to quality services, and should be supported and monitored. It is not necessary, however, to report dollars spent on assessment and counseling to headquarters. Also, please note that there is no change to the Food and Nutrition guidance and all nutritional supplementation should be in keeping with the guidance.

Activities that are NOT included in this definition of nutritional supplementation are nutritional assessment, nutritional counseling and education, livelihood support, food security support, support to agriculture and local food industries, and policy development.

☐ Estimated PEPFAR Dollars spent on food

The amount for nutritional supplementation in this activity (funding from the country's own PEPFAR allocation, not including central funding). By definition, the dollar amount reported cannot exceed the full amount allocated to this activity, but may represent a portion of the activity allocation.

☐ Estimation of Other Dollars leveraged in FY 2008 for Food

Leveraged food aid is food aid from non-PEPFAR resources used to benefit PEPFAR-supported HIV-infected or affected persons and/or their families (PL 480 is a non-PEPFAR resource). This can include support through downstream approaches (i.e. when supplementation is provided directly to PEPFAR beneficiaries) or through upstream approaches, (i.e. when nutritional supplementation is provided through other donor support to affected family members).

*Note:* The food questions will only appear in the MTCT, HBHC, HVTB, HKID, and HTXS program areas. If you need this textbox in another program area, please contact your core team leader.

#### DATA ENTRY:

Enter the \$ amount in the space provided. COPRS will automatically check the textbox for you.

☒ Dollars Spent on Pediatric AIDS Treatment

\$500,000

If you enter \$ amounts for any of these tickboxes, COPRS will automatically display the total funding in the program area summary. Therefore, it is essential that these dollar amounts are not duplicated in another activity. To double-check your entries, there is a show/hide details feature that will display all entries in the program area.

#### TARGET POPULATIONS:

#### MODIFICATIONS IN THIS SECTION

The list of target populations has been streamlined. Country teams will no longer be able to add custom 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. The following target populations will need to be identified by the partner for each of their activity entries. These tick boxes will primarily assist in identifying activities for follow-up or during the review process.

<p><b>General Population</b></p> <p><input type="checkbox"/> Children (under 5)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Boys</p> <p style="padding-left: 20px;"><input type="checkbox"/> Girls</p> <p><input type="checkbox"/> Children (5-9)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Boys</p> <p style="padding-left: 20px;"><input type="checkbox"/> Girls</p> <p><input type="checkbox"/> Adolescents</p> <p style="padding-left: 20px;"><input type="checkbox"/> Ages 10-14</p> <p style="padding-left: 40px;"><input type="checkbox"/> Boys</p> <p style="padding-left: 40px;"><input type="checkbox"/> Girls</p> <p style="padding-left: 20px;"><input type="checkbox"/> Ages 15-24</p> <p style="padding-left: 40px;"><input type="checkbox"/> Men</p> <p style="padding-left: 40px;"><input type="checkbox"/> Women</p> <p><input type="checkbox"/> Adults (25 and over)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Men</p> <p style="padding-left: 20px;"><input type="checkbox"/> Women</p> <p><b>Other</b></p> <p><input type="checkbox"/> Business Community</p> <p><input type="checkbox"/> Civilian Populations (only if the activity is DOD)</p> <p><input type="checkbox"/> Discordant Couples</p> <p><input type="checkbox"/> People Living with HIV/AIDS</p> <p><input type="checkbox"/> Pregnant Women</p> <p><input type="checkbox"/> Orphans and Vulnerable Children</p> <p><input type="checkbox"/> Refugees / Internally Displaced Persons</p> <p><input type="checkbox"/> Religious Leaders</p> <p><input type="checkbox"/> Teachers</p>	<p><input type="checkbox"/> <b>Most at Risk Populations</b></p> <p><input type="checkbox"/> Incarcerated Populations</p> <p><input type="checkbox"/> Injecting Drug Users</p> <p><input type="checkbox"/> Men who have sex with men</p> <p><input type="checkbox"/> Military Populations</p> <p><input type="checkbox"/> Mobile Populations</p> <p><input type="checkbox"/> Non-injecting Drug Users (includes alcohol use)</p> <p><input type="checkbox"/> Persons in Prostitution</p> <p><input type="checkbox"/> Persons who exchange sex for money and/or other goods with one or more multiple or concurrent sex partners (transactional sex), but who do not identify as persons in prostitution</p> <p><input type="checkbox"/> Street Youth</p>
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### DEFINITIONS:

**Civilian Populations:** This tickbox should only be used if the activity is a DOD activity and targets civilian populations. Note: You will be asked to confirm your response during data cleaning.

### MARPS (Most at Risk Persons):

- **Incarcerated Populations:** Persons being held in penal institutions either as pre-trial detainees (remand prisoners) or convicted and sentenced prisoners
- **Injecting drug users:** Persons who use needles and syringes to subcutaneously or intravenously inject illicit narcotics, or other substances into their bodies

- **Men who have sex with men:** Men (including self-identified gay, bisexual, transgendered, and/or heterosexual) who engage in sexual activity, including but not limited to anal and oral sex, with other men
- **Military Populations:** Include Army, Navy, Air Force, Coast Guard, Peacekeepers, their families, employees and surrounding community using the military services.
- **Mobile populations:** Individuals who move from one place to another temporarily, seasonally or permanently for a variety of reasons. This movement may be voluntary or involuntary.
- **Non-injecting Drug users (including alcohol use):** Persons who use illicit narcotics and inhalants by a non-injection mode, and persons who misuse or abuse alcohol. (\*\*Also includes non-medical use of prescription-type drugs)
- **Persons in Prostitution:** Persons (including male, female or transgendered) who exchange sex for money or other goods with clients
- **Persons who exchange sex for money and/or other goods with one or multiple or concurrent sex partners (transactional sex) but who do not identify as persons in prostitution.**
- **Street youth:** Children who might not necessarily be homeless or without families, but who live in situations where there is no protection, supervision, or direction from responsible adults, and as a consequence may be vulnerable to maltreatment, physical and/or sexual abuse, disease, malnutrition and substance abuse.

#### Refugees / Internally Displaced Persons:

- **Refugees:** Persons who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, are outside the country of their nationality, and are unable to, or, owing to such fear, are unwilling to, avail themselves of the protection of that country. (UNHCR)
- **Internally displaced persons (IDPs):** People who have similarly been forced from their homes, but have not crossed an internationally recognized state border. (UNHCR)

#### DATA ENTRY:

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

Several target populations have subsets; if you check one of the subsets, COPRS will check the parent target population for you.

- ☒ Adolescents
- ☒ Ages 10-14
- ☐ Ages 15-24

#### COVERAGE AREA:

Note: Special instructions for Other Bilateral Countries at the end of this section.

#### MODIFICATIONS IN THIS SECTION

None

**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.

If you need to make changes to the list of coverage areas, please contact Vanessa Brown ([BrownVJ@state.gov](mailto:BrownVJ@state.gov)). For consistency across COP years, we try to limit the number of changes to coverage areas, but we do understand that changes are sometimes necessary.

**SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES**

Other Bilateral Countries do not need to enter coverage areas.

**DATA ENTRY:**

Please check the tickbox(es) next to all relevant coverage areas. Multiple coverage areas are allowed.

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<b>PROGRAM AREA DESCRIPTION:</b>
<b>Management and Staffing (HVMS)</b> - 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.
<b>SECTION OBJECTIVES</b>
<p>This section of the COP has two objectives:</p> <ol style="list-style-type: none"> <li>1. To provide an overview of all staff working on PEPFAR; and</li> <li>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.</li> </ol>
<b>STAFFING FOR RESULTS</b>
<p><b>BACKGROUND</b></p> <p>Management and Staffing and interagency coordination continue to be important priorities for PEPFAR. In the fourth year of Emergency Plan implementation, country teams have been asked to fully implement “Staffing for Results” (SFR). SFR means having in place a fully functioning, interagency team that jointly plans, implements, and evaluates its programs with appropriate technical leadership and management oversight in light of program size, number and capacity of local partners and technical experts, country working conditions, and other relevant factors. The <b>goal</b> of SFR is to institutionalize a structure, with defined roles, responsibilities, and processes that support interagency planning, implementation, and evaluation to reach Emergency Plan goals. The process of achieving SFR requires that country teams analyze and determine the optimal composition of a well-integrated and efficient interagency team in light of Emergency Plan goals and strategies for the country. The outcome is the creation of an individual “footprint” for each country that outlines the best possible mix of staff across agencies building on core competencies needed to ensure program performance, reasonable costs, and long-term sustainability.</p> <p>While significant inter-agency changes have been ongoing since the onset of PEPFAR, SFR formalizes the change in interagency structure and culture needed to fully integrate one USG team. SFR institutionalizes management and staffing decisions based on meeting the overall PEPFAR prevention, care, and treatment goals in the most efficient and effective way possible – instead of agency needs driving organization and staffing decisions. Under SFR, headquarters and field staffing decisions are based on having the optimal mix of staff across agencies to program, manage, and evaluate PEPFAR and its support of broader development goals given legislative and budget constraints.</p> <p>Ideally, the country team should be working in a complementary, non-redundant fashion (e.g. all technical staff are working as a team, shared team responsibility for the entire USG program rather than just one agency's portfolio, and new technical staffing needs are considered by the team rather than just one agency). Knowledge gained from four years of implementation experience should guide your team in creating the best mix of skills to create a footprint unique to each country's fight against HIV/AIDS. Implementing SFR will require considerable analysis and discussion by the country team and should be an ongoing process.</p>

Core team leaders and Deputy Principals are assisting many countries in this effort, along with a Field Staffing for Results Working Group. Specific support for countries will be forthcoming. Please note that it is widely recognized that countries have very different circumstances; thus this process must be largely driven by the country team, and the footprint may be different from country to country.

As part of the staffing analysis, country teams should consider their staffing needs to continue meeting the program management demands into FY 2009 and beyond. Focus countries should proceed on the assumption that their country's FY 2009 HIV/AIDS budget will not be lower than their FY 2008 budget with the understanding that, as in all years, the actual amount of funding is contingent on the overall appropriation. (See the "talking points" on PEPFAR phase II, News to the Field, March 16, 2007.)

### **Staffing for Results Benchmarks and Deliverables for FY 2008**

#### **1) An implementation plan established for Staffing for Results; key tasks in developing the implementation plan include:**

- a) Engaging the Chief of Mission or designee and agency heads to support and lead this process
- b) Identifying an interagency work group, process, or point of contact dedicated to Staffing for Results
- c) Completing a functional mapping of the existing PEPFAR management and programmatic country team structure, which includes identifying the
  - (1) core strengths of each agency working in the PEPFAR program
  - (2) existing agency management and organization
  - (3) existing PEPFAR team structure
- d) Identifying staffing gaps and developing strategies to address duplication and recruitment for both short and long term
- e) Identifying a list of concerns and barriers (such as rightsizing and recruiting) and developing a plan to address those issues
- f) Developing a plan for a team building approach to define roles/responsibilities of functional cross-agency leadership/coordination
- g) Documenting the USG approach to communication and coordination for program management and implementation (both within the USG team and with partners and other stakeholders)
- h) Continuing and expanding existing joint planning and program oversight processes, including
  - (1) Developing a plan for joint portfolio reviews and interagency partner monitoring
  - (2) Defining the structure for setting annual priorities and budget for management
- i) Developing a plan to engage HQ and other identified SFR support, including Core Team Leads regional platforms, etc.

#### **2) Staffing Analysis Tools**

As a part of the COP, country teams are asked to complete a Functional Staffing Analysis to reflect staffing patterns under SFR. **Deliverables** for the FY08 COP include the following completed tools: a functional staffing chart, agency management charts, and a staffing database. These charts and database will be submitted as supporting documents to inform the

information in Table 3.3.15. They should serve as tools to manage the staffing data and help inform the SFR process in each country. The tools will capture all staff working at least 10% of their time on PEPFAR to gain a truer picture of the USG PEPFAR footprint. Although the charts and database replace the Staffing Matrix required in previous COPs (except for Peace Corps volunteers – see below), country teams are still asked to complete Table 3.3.15 with supporting narrative and budget information. Additional instructions for completing the staffing analysis tools will be provided to country teams separately.

Please note that the FY08 SFR benchmarks defined in number 1 above are to assist you in your SFR planning. The actual SFR implementation plan identified in number 1 is not a required deliverable; however, its key elements should be *summarized* in the Management and Staffing narrative (see below).

#### **PROGRAM AREA SPECIFIC INSTRUCTIONS:**

In the Management and Staffing overall narrative, please briefly discuss the state of the USG Team in your country and progress made under SFR. Please include in your narrative summary information on “a-i” in benchmark 1 above. Please make sure you cover:

1. The vision for SFR by the country team
2. How the team has implemented its SFR plan to date, including its:
  - a. Current Staffing Pattern: Based on the analysis undertaken through SFR, each country is asked to describe the current staffing pattern and the ideal mix of staffing skill sets needed for your particular country to maximize success. Include information on whether the team is fully staffed, working on recruitment, planning changes to key personnel, experiencing difficulties in recruitment and retention, experiencing difficulties in staying within the 7% budget target, and how it is employing FSN staff- in management of the program including as leads of technical working groups, etc. If you are using any innovative approaches to staffing, such as sharing positions across agencies, please describe them here. Please include how the interagency team collaborates and manages the overall program, including how each agency fits into the overall program planning, management, and evaluation process (for example, contribution of expertise). Also include information about individual and agency primary functions and responsibilities. This should include information on non-presence agencies that have programs in-country.
  - b. List of concerns and issues impeding SFR implementation and how the team plans to address or where HQ or other support may be requested.
3. How the team plans to continue implementing SFR post-COP submission
4. New positions: For new positions, please describe in detail the specific skill sets (e.g. administrative, technical, program-area-specific care/prevention/treatment, etc.) needed for both the short- and long-term to achieve success and sustainability, and how you will fill those positions building on agency core competencies. For any new staff positions and Peace Corps volunteers that are requested, there is an assumption that these have emerged from the SFR exercise and that there is consensus with the entire in-country PEPFAR team on the need, roles, and hiring agency. The information should explain the new staff information included in the staffing database. Descriptions of new positions should correspond to the position title and category of position requested in the database. For each agency, please identify the number of staff funded in other program

areas and the number funded in the M&S section.

If extra space is required to fully describe your country team's SFR process, you may upload further text as a supporting document. In addition, while not required, countries may upload any other documents (such as terms of reference, vision, goals) that explain the team's SFR process to share with reviewers.

Please note that the requirement that management and staffing costs not exceed 7% of a country's budget applies to the overall PEPFAR budget for each country; it is not applied by agency. The approval of management staffing activities will take into account the in-country management of the funds going through the Partnership for Supply Chain Management. For example, the review of the CDC/Ethiopia management and staffing budget will take into account their in-country responsibility for managing the procurement of lab reagents and related technical assistance even though those funds are not reported as CDC in the COP.

### **Peace Corps Volunteers**

Please note that a Peace Corps Volunteer Matrix (instructions at end of this section) is still required this year because Peace Corps volunteers are not captured in the staffing database. The Matrix should include information on existing as well as new positions requested for *volunteers* working more than 50% of their time on PEPFAR. Volunteers are an important part of the Emergency Plan effort and need to be captured through the COP process.

Funding of Peace Corps Volunteers in FY 2008 - Three-year funding for Peace Corps Volunteers funded by PEPFAR must be included in the FY08 COP because Volunteers arriving in June 2008 will have expenses in FY2008, FY2009 and FY2010. The FY08 COP must request funds to cover all of the expenses incurred in this timeframe. Peace Corps Volunteer services are not contracted or outsourced and costs are incurred before and throughout the Volunteer's 27-month period of service. For example, obligations incurred include those associated with recruitment, placement and training of the Peace Corps Volunteer prior to the beginning of his or her service and living allowance through the close of service.

Additionally, the continuing costs of Peace Corps Volunteers funded by PEPFAR in FY 2007 (who still have a year or more of service remaining) must be included in the FY 2008 COP, if not included in the FY 2007 COP.

### **Additional Guidance**

Additional guidance on using PEPFAR dollars to support direct-hire expenses, including salaries and other costs, will be sent separately to country teams.

In FY 2008, the current intent is to have technical assistance-related travel costs by HHS/CDC HQ staff be included in the PEPFAR headquarters COP and funded centrally. Under this model, costs for technical assistance travel by HHS/CDC staff should not be included in the countries' COPs. In addition, HQ will continue to cover the costs associated with technical assistance-related travel from HQ to assist the other bilateral countries. However, this is still under negotiation; we will send the final decision as soon as possible.

### Hiring PEPFAR Coordinators

There are a number of options for hiring in-country Emergency Plan coordinators. These include USDH slots (FTE), local hire contractors, and international hire contractors.

USDH: It is becoming more and more difficult to obtain a USDH FTE position for use as an in-country PEPFAR coordinator. State positions are few and far between, as are those from other agencies such as HHS and USAID. We expect this option will only be available in exceptional circumstances. OGAC does not have USDH positions to offer for this purpose.

Local Hire Contractors: The preferred mechanism is using State's PSA authority for hiring coordinators who are residents of the host-nation.

International Hire Contractors: OGAC is working to obtain a delegation of PSA authority to the Africa Bureau of the Department of State for the purpose of hiring PEPFAR coordinators. This would become the preferred option, as opposed to using CDC or USAID PSC authorities, to hire a person that reports to the Chief of Mission. Current practice however is to recruit through USAID or CDC, with the understanding that the agency association is only for mechanistic purposes and the position will report to the Ambassador or DCM and be fully accountable to the inter-agency PEPFAR team on the ground.

### PROGRAM AREA BUDGETARY REQUIREMENTS

You should not allocate more than 7% of the total country budget (all program areas) for management and staffing. Exclude Track 1.0 funds in the denominator.

### REQUIRED TARGETS

There are no indicators for the management and staffing program area and therefore no required targets.

### Functional Staffing Analysis

Country teams will record the staffing analysis information in a functional staff chart, agency management charts, and the staffing database tool. The tools will capture all staff working at least 10% of their time on PEPFAR to gain a truer picture of the USG PEPFAR footprint. Additional instructions for completing the staffing analysis tools will be provided to country teams separately.

If country teams wish to start the data collection process before the tools are available, the following is a list of the data fields requested for each staff position in the staffing database:

- Last Name
- First Name
- Funding Agency (if position is co-funded, list secondary funding agency as well)
- Agency Title Name (position's title within agency structure)
- PEPFAR Title Name (position's title within PEPFAR)
- Type of Position (technical leadership/management positions, technical advisor/program managers, contracting staff, financial/budget staff, or administrative/support staff)
- Time Devoted to PEPFAR (10-100%)
- Employment Mechanism (US Direct Hire, US Personnel Services Contractor (PSC), Locally Employed Staff (LES), or institutional contractor, i.e. IAPWS)

- Type of Funding (Operating Funds or Program Funds)
- Program Area Funding (identifies which program area(s) funds the position)
- Staffing Status (Filled, Vacant (approved in the COP), Planned)
- Urgent (check box whether position needs immediate clearance)
- Schedule (full-time, part-time, seasonal)
- Technical Areas (list which technical areas or technical working groups the position participates in)
- Technical Sub-Areas (list any technical sub-areas or technical working groups the position participates in)
- Technical Area Chair (checkbox)
- Technical Area POC (checkbox)

**FUNDING MECHANISM:**

The funding mechanisms that should appear in the Management and Staffing program area are those that have either one of the six USG Agencies involved in the Emergency Plan as the Prime Partner or an M&S implementing partner, such as IAP Worldwide Services, as the Prime Partner. The funding mechanisms can also include central or locally procured activities. Please see additional information about separate mechanisms for each cost of business (i.e. ICASS, CSCS, IRM tax) below.

**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 or other M&S partner performing M&S functions, in keeping with the principles outlined in the program area description above.

If not included in the overall M&S narrative, please include information about agency primary functions and responsibilities. In activity narratives, explain what is being funded in that activity (i.e. X number of positions, administrative support, rent). It is helpful to break out the associated administrative activities and their costs to understand the total going to each type of administrative activity. You do not need to list specific positions if explained in the program area narrative, but provide context as to what positions are funded by the relevant activity.

In some HHS/CDC COGH country offices (e.g., in Kenya), there will be management and staffing costs associated with the overall HHS/CDC mission. These should be listed as a separate item in the COP.

As you draft your agency activity narratives, please consider the following best practices from the FY 2007 M&S narratives:

- The portion of each agency's staffing charges going to each program area were identified.
- In general, there should be a correlation between the size of an agency's in-country staff and its percentage of the M&S budget, and between its percentage of the M&S budget and its percentage of the total country budget. However, please be sure to take into account important factors that can skew these comparisons, such as USAID PFSCM funds for activities that will be overseen or managed by HHS on the ground. Because

PFSCM funds are allocated to USAID, they will make the ratio of the HHS M&S budget to total budget seem higher than it actually is and you will need to adjust your calculations accordingly.

- All ICASS, Capital Security Cost Sharing (CSCS), and IRM tax costs were identified for each agency.

### **Costs of Doing Business (ICASS, CSCS, IRM tax)**

For each agency, please identify the ICASS, Capital Security Cost Sharing, and the IRM tax costs, as appropriate, and briefly describe what these costs are associated with, i.e. how many employees are associated with the ICASS charge to your agency, OR, what are the services paid for with the IRM tax. Please budget for your entire FY 2008 estimated ICASS, CSCS, and IRM tax costs in your COP.

**ICASS:** Each implementing agency, including State Dept., 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 2008 anticipated ICASS costs by preparing a “what-if” ICASS budget using each PEPFAR agency’s anticipated ICASS workload. This FY 2008 ICASS cost estimate, by agency, should then be included in the M&S program area.

For ICASS charges incurred for State Department employees, please select “OGAC” as the bureau in your COP. There will be NO opportunity to increase these funds from OGAC or your agency’s headquarters later in the year.

**Capital Security Cost Sharing:** Non-State Dept. agencies should include the Capital Security Cost Sharing tax in the M&S program area, except where this is paid by the headquarters agency.

**IRM:** USAID should include the IRM tax on HIV-program-funded positions.

The entire “cost of doing business” for both M&S staff and program staff should be reflected in the M&S section and NOT in program areas. **Each USG agency as prime partner should have at least two entries:**

- ONE entry for all M&S budget details (salaries, travel, hiring PSCs, etc.) and
- ONE entry for each type of “cost of doing business” taxes such as ICASS, the IRM tax, and Capital Security Cost Sharing. **There should be a separate mechanism for each type; therefore, each type should be entered as a separate activity.** For consistency, please specify mechanism name as “ICASS Charges” or “CSCS Charges” and list the “Prime Partner” as State. All entries should have a brief activity description.

Each activity may also have a different funding mechanism if the agency needs to differentiate between central and local procurement activities. This is similar to adding funding mechanisms in the other 14 program areas. For example, CDC might have up to five entries if they are using both GAP/BASE and GHAI funding as well as differentiating between central and local procurement activities.

The Peace Corps subscribes to minimal ICASS services at post. Most GSO and all financial management work (except FSC disbursing) are carried out by Peace Corps field and HQ staff. In order to capture the associated expenses, Peace Corps posts must include a 15% cost element in their budgets to cover this support in lieu of ICASS. These costs can be included in either the program area in which it supports, or in the M&S section as one entry.

Otherwise, all USG agencies should reflect ICASS. These should be absorbed by the country budget, not headquarters.

### Implementing Partners

Any M&S implementing partners (non-USG agencies) should have their own separate entries. For example, if USAID (the USG agency) uses IAP World Wide Services as a prime partner for M&S services, you would have a new entry for IAP in addition to the USAID as the prime entry. All M&S budget details (salaries, travel, hiring PSCs, etc.) should be combined and included as ONE entry for each USG agency and each M&S implementing partner.

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

The following are not applicable to the management and staffing program area. They will not appear as options: **Emphasis Areas, Key Legislative Issues, Targets, and Target Populations.**

### PEACE CORPS VOLUNTEER MATRIX

The Peace Corps Volunteer Matrix is still required this year because Peace Corps volunteers (PCVs) are not captured in the staffing database. The Matrix should include information on existing as well as new positions requested for *volunteers* working more than 50% of their time on PEPFAR. OGAC will send out prepopulated matrices to each country that includes the data submitted with the FY 2007 COP.

#### Instructions for Peace Corps Matrix:

**Number of HIV/AIDS Volunteers Funded with PEPFAR Resources:** This column should reflect the total number of PCVs that devote more than 50% of their time to GHAI-specific HIV/AIDS activities and are funded *only* by GHAI.

**Number of HIV/AIDS Volunteers Funded with Non-PEPFAR Resources:** This column should reflect the total number of PCVs that devote more than 50% of their time to HIV/AIDS activities and are funded by sources other than GHAI (e.g. Peace Corps' annual appropriation).

**Of Total—Percentage Working 100% on the Emergency Plan:** Of the Total Number of Volunteers, please indicate the number of volunteers who work full-time on the Emergency Plan. Enter data as number of staff and not as a percentage.



<b>"Country" Peace Corps Volunteer Matrix</b>			
	<b>Peace Corp Volunteers Working 50% or more on HIV/AIDS (As of Sept. 30, 2007)</b>		
	<b>Funded with PEPFAR Resources</b>	<b>Funded with Non- PEPFAR Resources</b>	<b>Of Total--Number Working 100% on EP</b>
<b>Number of Volunteers</b>			0
			0
			0
			0
			0
			0
	0	0	0
	<b>NEW PEACE CORPS VOLUNTEERS (Estimated for FY 2008)</b>		
	<b>Funded with PEPFAR Resources</b>	<b>Funded with Non- PEPFAR Resources</b>	<b>Of Total--Number Working 100% on EP</b>
<b>Number of Volunteers</b>			0
			0
			0
			0
			0
			0
	0	0	0
	<b>NEW PEACE CORPS VOLUNTEERS (Estimated for FY 2009)</b>		
	<b>Funded with PEPFAR Resources</b>	<b>Funded with Non- PEPFAR Resources</b>	<b>Of Total--Number Working 100% on EP</b>
<b>Number of Volunteers</b>			0
			0
			0
			0
			0
			0
	0	0	0
	0	0	0

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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.

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## Table 5 PLANNED DATA COLLECTION IN FY 2008

### CONTENT:

Please answer each of the questions in this table in relation to data collection activities planned in your country during fiscal year 2008. 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 2008 (October 1, 2007 through September 30, 2008). 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, national ART outcomes, or impact evaluation. 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 Emergency Plan goals for your country.

### DATA ENTRY:

**Table 5: Planned Data Collection**

Please answer each of the questions in this table in relation to data collection activities planned in your country in fiscal year 2006. Include all data collection being undertaken, not just that being funded by USG money.

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1. Is an AIDS Indicator Survey (AIS) planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, Will HIV testing be included?</i>	<input type="radio"/> Yes <input type="radio"/> No
<i>When will preliminary data be available?</i>	<input type="text"/>
2. Is a Demographic and Health Survey (DHS) planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, Will HIV testing be included?</i>	<input type="radio"/> Yes <input type="radio"/> No
<i>When will preliminary data be available?</i>	<input type="text"/>
3. Is a Health Facility Survey planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>When will preliminary data be available?</i>	<input type="text"/>
4. Is an ANC Surveillance Study planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, approximately how many service delivery sites will it cover?</i>	<input type="text"/>
<i>When will preliminary data be available?</i>	<input type="text"/>
5. Other significant data collection activity:	
Name:	<input type="text"/>
Provide a brief description of the data collection activity	
<input type="text"/>	

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.

## SUPPORT DOCUMENTS

### REQUIRED SUPPORT DOCUMENTS:

#### CONTENT:

##### **Budgetary Requirements Worksheet**

Please upload a copy of the Budgetary Requirements Worksheet. You can download a pre-populated copy from the Reports Section

##### **Explanation of Target Calculations**

Please provide an explanation of how targets in both Table 2 and Table 3.3 were calculated, i.e.: what assumptions were made, how double counting was adjusted for, etc. For Table 2, please include both downstream (direct) and upstream (indirect) calculations. For Table 3.3, please provide information on how downstream (direct) summary targets by program area were calculated. You do NOT need to provide an explanation of how partner-level targets were calculated. This example is NOT a template but simply gives one example (of many) of how this can be put together. Please feel free to submit something in your own format, as long as it addresses all of the necessary areas.

##### **Global Fund Supplemental**

In an effort to better understand and report on coordination between the Emergency Plan and the GFATM, and specifically the technical assistance that the U.S. Government is providing to GFATM HIV/AIDS grants, country teams should provide a brief description of the technical assistance (and budget amount) that will be undertaken to directly support any Global Fund HIV/AIDS grant in your country through the FY 2008 COP. Some examples of technical assistance include: support to the CCM, help with monitoring/evaluation or procurement systems, and strengthening program and/or financial management structures. See [Appendix 18](#) for a template/example.

##### **Fiscal Year 2009 Funding Planned Activities**

Please provide a one-page document that details the work that will be undertaken with fiscal year 2009 funding. This document should not reference any other document, but should be a stand-alone effort that briefly details what work will be undertaken.

##### **Peace Corps Volunteer Matrix**

Please upload the Peace Corps Volunteer Matrix. See the Management and Staffing section above for more information.

##### **Staffing Analysis**

Please upload an Excel file that includes all of the staffing database data and the completed agency organizational charts and "Program Planning and Oversight Functional Staff Chart." Additional guidance will be disseminated to country teams separately once the pilot test is completed.

##### **TB/HIV Workplans**

### DATA ENTRY:

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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 one page) in this section. You may want to enter the specific date or the author in this box.
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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 9](#).
2. Click on **Mark COP Final and Ready for HQ Review and Approval**.
3. If there are critical errors in the Quality Assurance Report, you will see a warning, alerting you that there are still critical errors. You will still be able to submit the COP with critical errors.
4. Click Submit
5. Once the COP is submitted, a confirmation email will be sent to all individuals listed in the Country Contacts as well as the OGAC Core Team Leader and COP Cleaning Team. A final copy of the Quality Assurance Report will be attached to the email.
6. Go celebrate the submission of your FY 2008 COP!