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

FY 2014

# Country Operational Plan (COP) Guidance

*November 8, 2013*

*Version 2*

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# 1. Introduction – Creating an AIDS-Free Generation, the PEPFAR Blueprint and Smart Investments

On February 12, 2013, President Barack Obama reasserted that an AIDS-free generation is an achievable goal in his State of the Union Address when he remarked:

> "We also know that progress in the most impoverished parts of our world enriches us all -- not only because it creates new markets, more stable order in certain regions of the world, but also because it's the right thing to do. In many places, people live on little more than a dollar a day. So the United States will join with our allies to eradicate such extreme poverty in the next two decades by connecting more people to the global economy; by empowering women; by giving our young and brightest minds new opportunities to serve, and helping communities to feed, and power, and educate themselves; by saving the world's

children from preventable deaths; and **by realizing the promise of an AIDS-free generation, which is within our reach.**"

The President's vision affirms and further amplifies the powerful new goal for PEPFAR and its global partners set by former Secretary of State Hillary Rodham Clinton in November 2011, creating an AIDS-free generation. She defined an AIDS-free generation as one where "virtually no children are born with the virus. As these children become teenagers and adults, they are at far lower risk of becoming infected than they would be today thanks to a wide range of prevention tools, and if they do acquire HIV, they have access to treatment that helps prevent them from developing AIDS and passing the virus to others." While we may be many years from eliminating all new HIV infections, the former Secretary marked a clear path forward based on new scientific evidence and success in implementing effective programs.

Further, we are making great strides forward in reaching the ambitious goals set for the PEPFAR program on December 1, 2011 by President Barack Obama where he called this "the beginning of the end of AIDS" and committed the U.S. government to:

- reach more than 1.5 million HIV-positive pregnant women with antiretroviral drugs to prevent them from passing the virus to their children;
- support more than 4.7 million voluntary medical male circumcisions in Eastern and Southern Africa;
- directly support more than 6 million people on antiretroviral treatment; and
- distribute more than 1 billion condoms.

## The PEPFAR Blueprint: Creating an AIDS-free Generation

Released on World AIDS Day 2012, the PEPFAR Blueprint is the road map for how the United States will contribute to an AIDS-free generation. As described in the document, the United States is and will continue doing our part. Reaching this goal, however, is a shared responsibility, requiring the commitment and leadership of partner countries and reinforced with support from donor nations, civil society, people living with HIV, faith-based organizations, the private sector, foundations and multilateral institutions. It requires adapting to and adopting new science and evidence, both to reach more people and to capture cost-saving efficiencies. It means investing in the principle of country ownership—the end state in which partner countries lead, manage, coordinate and over time increasingly finance the efforts needed to achieve an AIDS-free generation in order to ensure that the AIDS response is effective, efficient and durable.

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

The key principles that frame *the PEPFAR Blueprint* include:

- making strategic, scientifically sound investments to rapidly scale-up core HIV prevention, treatment and care interventions and maximize impact;
- working with partner countries, donor nations, civil society, people living with HIV, faith-based organizations, the private sector, foundations and multilateral institutions to effectively mobilize, coordinate and efficiently utilize resources to expand high-impact strategies, saving more lives sooner;
- focusing on women and girls to increase gender equality in HIV services,
- ending stigma and discrimination against people living with HIV and key populations, improving their access to, and uptake of, comprehensive HIV services; and,
- setting benchmarks for outcomes and programmatic efficiencies.

These principles drive PEPFAR's work and are the foundation for the road maps that comprise the blueprint. Each road map-the Road Map for Saving Lives; the Road Map for Smart Investment; the Road Map for Shared Responsibility; and the Road Map for Driving Results with Science-contains specific goals and comprehensive action and implementation steps on how PEPFAR will support partner countries' efforts to meet these goals.

In FY 2014 COP, PEPFAR is renewing and strengthening its focus to anchor all supportive strategies, guiding principles and processes to the overarching goal of creating an AIDS-free generation. This means ensuring effective **combination HIV prevention and treatment** programs are in place, and turning the tide of the epidemics in the countries where we work. Country teams will also be asked to renew and strengthen their focus on **key populations** both most at risk of contracting HIV and most stigmatized for their risk behaviors, including men who have sex with men, people who inject drugs, and sex workers.

**Our greatest urgency is to reduce new infections with the best tools available.** In most cases, this is a matter of spending more wisely on prevention, using evidence-based interventions (as specified in the Prevention Guidance) that will have the greatest impact on new infections in the shortest timeframe. While PEPFAR also needs to invest in longer-term strategies to reduce HIV transmission, the bulk of prevention dollars should be invested with a goal of rapid impact and maximum

efficiency. This emphasis on rapid impact should save money and lives in both the near and longer term.

**PEPFAR is a global program committed to achieving an AIDS-free generation. Therefore each country team should plan its program to maximize treatment scale-up efforts of the national program.** Treatment remains central to our ongoing success in reducing morbidity and mortality and new evidence has shown that treatment is a valuable tool in preventing sexual transmission in serodiscordant couples. It is also increasingly the intervention of choice for keeping mothers living with HIV healthy and preventing new infant infections. Therefore, every PEPFAR team, whether it *directly* supports treatment or not, should make strong treatment support, - technical assistance and/or service delivery, a priority for PEPFAR, as described below.

### Technical Assistance as Catalyst to Prevention and Treatment Service Delivery Coverage

When considering how we support countries to scale-up treatment and prevention activities, PEPFAR programs take different approaches. In many countries, particularly in Africa, PEPFAR, along with the partner government and the Global Fund are often working together to directly fund service delivery, especially in the hardest hit/lowest income countries. In other countries where PEPFAR works, especially outside of Africa, key services are most often funded by Governments or the Global Fund with PEPFAR providing technical assistance and/or catalyzing innovation. PEPFAR's role as a technical assistance provider should be seen as playing a key role in supporting how governments can increase service delivery coverage, especially for key populations. In summary, the goals of the PEPFAR Blueprint apply to all PEPFAR programs, regardless of whether PEPFAR directly funds service delivery or PEPFAR provides technical assistance to service delivery providers. The goal of saving lives through scaling up effective programs remains the same.

### Making Smart Investments

Now more than ever, PEPFAR needs to ensure smart investments of every dollar. This requires both technical efficiency in program implementation and efficient allocation of resources, i.e. investing in what works. Evidence-based investments must be made strategically, with consideration and joint planning of allocations with other donor and country-level financial investments and plans. Additionally, making smart investments also means making tough decisions to close out programs that may have previously been valued, but today are not of highest priority for the national program.

While there are always new decisions to make in response to emerging data and technical innovations, recommendations for changes in practice *within* a program area are typically made by subject matter experts, aided by normative guidance and are more straightforward than guidance on allocations across an entire program. For instance, when scaling-up HIV treatment programs, PEPFAR and WHO guidance recommend integration of routine screening for TB into HIV services because it is highly effective and thus should be prioritized. However, OGAC and Agency Headquarters have traditionally provided little formal direction on allocation decisions across program areas and have relied on country teams to make decisions informed by local conditions and this may have hindered the recommendation advancing into program and being funded.

In order to achieve the greatest value for our investments, PEPFAR must move more quickly to allocate our resources based on the impact of the interventions and on the complementarity of our programs with those funded by the national government and/or external funders, such as the Global Fund. PEPFAR teams should therefore be asking: 1) has the country team made evidence-based decisions based on impact on the individual and public health, as well as the outcome and impact goals articulated by the country; 2) how is the epidemic changing and is the PEPFAR program properly targeting areas along the continuum of services that people need; and 3) are PEPFAR investments fully maximized within the national response and coordinated with the other key HIV funders.

### Making Smart Investments Also Means Reducing Funds Elsewhere

There are numerous competing demands placed on PEPFAR field teams from both in-country stakeholders and headquarters. In making funding decisions, PEPFAR teams must prioritize among competing demands and make tough decisions that support funding strategic, scientifically sound investments that rapidly scale-up core HIV prevention, treatment and care interventions and maximize impact.

Given discrete resource envelopes and high demand for many services, PEPFAR teams should consider the following in deciding not only where to invest, but where to reduce or eliminate funding:

- The FY 2014 Planning Level Letter sent to each country team is tailored to each country context. This contains specific information on how to take the COP Guidance and Technical Considerations and apply it to the specific country context.
- PEPFAR programming must have impact. In the past, teams have been hesitant to eliminate a lower-priority program altogether, so have reduced funds to allow

the program to continue, but at a sub-optimal level. If a program is a lower priority, reducing the funds to the level where the partner can't really impact the epidemic is not appropriate.

- Inertia and perceived long-term funding commitments to agreements or contracts "tie up" the bulk of a team's funding, and the team struggles to find funding to address emerging needs or priorities. When a team identifies a critical priority, they should budget for that first, rather than first budgeting for legacy programs because of existing agreements.
- Prioritizing country ownership does not mean using PEPFAR funds to support activities that lack an evidence base, even if the country supports them. PEPFAR teams must ensure PEPFAR's programmatic integrity is maintained.

# 2. COP Preparation, Planning and Decision Making

This COP Guidance document translates PEPFAR's strategic goals into more specific guidance to help PEPFAR teams prioritize and budget for HIV/AIDS activities in the countries where they work. This guidance should go hand-in-hand with the FY 2014 Planning Level Letters sent to each PEPFAR team. These letters further outline priorities tailored for each PEPFAR program.

## 2.1 What is a COP

The Country Operational Plan (COP)[1] is the vehicle for documenting U.S. government annual investments and anticipated results in HIV/AIDS and is the basis for approval of annual U.S. government bilateral HIV/AIDS funding in most countries. The COP also serves as the basis for Congressional notification, allocation, and tracking of budget and targets and as an annual work plan for the U.S. government. In twenty-two countries with Partnership Frameworks (PFs), PF implementation plans provide the strategic direction for annual COP development. Beginning in the FY 2014 COP, countries with expired PFs or other strategies, or whose strategic documents require revision, will utilize the PEPFAR Blueprint to provide the necessary strategic guidance for setting COP priorities as they plan with country stakeholders. The next phase of partnering with host countries will be guided by the recently released sustainability plan guidance which

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

will inform future COPs. Data from the COP are essential to PEPFAR's transparency and accountability to key stakeholders.

The most important part of the COP process is the interagency country-level planning process, including portfolio reviews, partner performance reviews, partner consultation, analysis, and planning. All U.S. government agencies responding to the HIV/AIDS epidemic in each partner country come together as one PEPFAR team. Under the leadership of the U.S. Ambassador in country, this team develops one annual work plan in the form of the COP, which is reviewed by an interagency headquarters teams and then approved by the U.S. Global AIDS Coordinator.

Several multi-country platforms develop Regional Operational Plans (ROPs). This guidance applies to those programs equally (except where noted), whether ROPs are explicitly referenced or not. Please note there is ROP-specific guidance for the Executive Summary and the Technical Area Narratives intended to help these geographically complex programs better explain their PEPFAR investments. Please see these sections for ROP-specific guidance.

FY 2014 is the first year in a two-year planning cycle, and thus is a 'Full COP' year. The FY 2014 COP will be reviewed and evaluated by the Office of the Global AIDS Coordinator (OGAC) and Agency Headquarters as the strategic direction and program plan for a given country or region for both FY 2014 and FY 2015.

### 2.1.1 Which Programs Prepare a FY 2014 COP?

The following programs are required to complete a FY 2014 COP: Angola, Botswana, Burma, Burundi, Cambodia, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Ghana, Guyana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Papua New Guinea, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zambia and Zimbabwe. Regional Operational Plans are required from the Asia Regional Program, and Caribbean, Central America and Central Asia field teams.

Smaller PEPFAR programs that do not complete a COP/ROP will account for PEPFAR resources through the preparation of a Foreign Assistance Operational Plan. The Office of U.S. Foreign Assistance Resources (F) at the Department of State coordinates the development the Foreign Assistance Operational Plans. HHS/CDC programs in countries/regions that do not prepare COPs will account for their resources through CDC Country or Regional Assistance Plans.

## 2.1.2 COP Timeline

All COPs/ROPs must be submitted by March 3, 2014. In past years, late submissions have resulted in significant delays in the review and approval processes, and ultimately slow down the process for pushing out funding to the field. Requests for extensions will not be granted.

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| FY 2014 Planning Level Letters Sent to Country | October 2013 |
| COP Guidance released | October 2013 |
| 2014 Technical Considerations Released | October 2013 |
| Country-specific IM templates available to Operating Units | November 2013 |
| Early Funding (Pre-COP) Requests Due | November 18, 2013 |
| COP Module opens in FACTS Info | January 2014 |
| COP/ROP Due | March 3, 2014 |
| COP Cleaning | March 2014 |
| COP Reviews | April 2014 |
| COP Review Follow-up, Resolution of Questions/Issues, Approval* | May-August 2014 |

*COPs will be approved in tranches after COP review feedback, questions and conditions have been adequately responded to and receive satisfactory review by DPs and the Global AIDS Coordinator. In correlation with COP approvals and resolution of issues, funding will be notified to Congress on an as needed basis and be made available to implementing agencies as available/possible.

## 2.1.3 Required COP Elements

The table below outlines which elements are required for the FY 2014 COP/ROP. Items marked with an asterisk (*) will not be required in the FY 2015 "lite" COP for continuing activities, and should therefore be written as a two year narrative. Items marked [New] are requirements that have been added or significantly modified for the FY 2014.

| COP Elements | Required/Optional |
|---|---|
| **Operating Unit Overview Items** | |
| Executive Summary [New guidance for ROPs] | Required |
| Population and HIV Statistics | Required |
| Partnership Framework/Strategy Goals and Objectives | Required for all OUs with officially approved PFs or |

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| | strategy documents |
| Global Fund/Multilateral Engagement [Revised Questions] | Required |
| Public-Private Partnerships | Required if OU has PPPs |
| Surveillance and Surveys [Revised Format] | Required |
| **Indicators** | |
| National Level | Required |
| Technical Area Level | Required |
| Policy Tracking Table | Required for all OUs with officially approved PFs or strategy documents |
| Implementing Mechanism Level | See IM Section- Required |
| **Technical Area Narratives** | |
| Care* | Required |
| Governance and Systems* | Required |
| Prevention* | Required |
| Treatment* | Required |
| **Implementing Mechanisms** | |
| Implementing Mechanism (IM) Overview Narratives* | Required for all IMs |
| Budget Code Narratives must include the "10 Required Elements" and be responsive to relevant BC specific questions *- Narrative not new but note new guidance | Required for all IMs |
| Mechanism Details:<br>• Partner name<br>• G2G tick box and Managing Agency<br>• Funding Agency<br>• Procurement Type<br>• IM Name<br>• Mechanism IDs<br>• Agreement Timeframe<br>• TBD Indication<br>• IM Outlay Plan [New for all IMs]<br>• New IM tick box<br>• GF tick box & Q's<br>• Construction Renovation tick box and project plans<br>• Motor Vehicles tick box and numbers<br>• Total Mechanism Pipeline as of Dec 31, 2013<br>• FY 2013 Outlay Rate | Required for all IMs |
| Funding Source allocations, including applied pipeline | Required for all IMs |

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| figure | |
| Budget Code Allocations | Required for all IMs |
| IM level Indicators and Targets [New for all IMs] | Required for all IMs and ALL Agencies |
| Crosscutting Budget Allocations [New prog. areas added] | Required if applicable |
| Crosscutting Budget Allocation: Gender Activity Check-list [New] | Required if Gender- GBV or Gender Equality crosscutting is ticked |
| Crosscutting Budget Allocation: Key Populations Check-list [New] | Required if Key Populations is ticked |
| Key Issues | Required if applicable |
| Implementing Mechanism Outlay Plans for all IMs [New] | Required for all IMs (including TBDs) |
| Vehicle Information | Required if applicable |
| Construction or Renovation Project Plan | Required if applicable |
| Global Fund Engagement | Required if applicable |
| Government to Government Funding | Required if applicable |
| **Management and Operations** | |
| 3 Narratives | Required |
| Agency Costs of Doing Business, including total and applied pipeline figures | Required |
| Staffing Data | Required |
| **Supplemental Documents** | |
| Ambassador's Letter | Required from all OUs |
| Budgetary Requirements Justification | Required if COP budget does not meet hard earmarks or 8% funding limit |
| Health Care Worker Salary Table | Required if applicable |
| Treatment Calculator | Required if applicable Due January 15, 2014 |
| HIV Medicines and Diagnostics Form | Required if applicable |
| Clinical Cascade Worksheet for Target Setting and Budgeting [New] | Required if applicable |
| FP/HIV Integration Narrative [New] | Required if applicable |
| Local Civil Society Funding and Planning Participation Overview in FY 2014 COP [New] | Required from all OUs |
| Evaluation Plans [New] | Required if applicable |
| Laboratory Construction or Renovation Project Plan Supplemental [New] | Required for BSL-3 and enhanced BSL-2 |

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|---|---|
| | laboratory projects |

Elements no longer required in the COP:

- Agency Outlay Plans

### 2.1.4 New PEPFAR Guidance Documents

Along with this guidance document and the Technical Considerations, several new PEPFAR guidance documents have been developed since the FY 2013 COP and/or are underway. These documents are described in greater detail throughout this guidance and are specifically highlighted in section 9 of the COP Guidance:

- PEPFAR Guidance for Sustainability Planning
- PEPFAR Monitoring, Evaluation, and Reporting Strategy, Operational Guidance and Indicator Reference Guide (MER)
- PEPFAR Data Quality Standards of Practice
- PEPFAR Evaluation Standards Guidance
- Updated PEPFAR Gender Strategy
- PEPFAR Quality Strategy (PQS)
- PEPFAR Linkage, Engagement and Retention Strategy (PLERS)
- PEPFAR Reassessing Care Priorities

### 2.1.5 Two-Year COP Cycle

FY 2014 is the first year in a two-year planning cycle, and thus is a 'Full COP' year. The FY 2014 COP will be reviewed and evaluated by OGAC and Agency Headquarters as the strategic direction and program planning for a given country or region for both FY 2014 and FY 2015.

Teams must anticipate that they will not be writing Technical Area Narratives, Implementing Mechanism Narratives, or Budget Code Narratives in the FY 2015 COP for continuing activities. Therefore, to the extent possible, these narratives should be written in the FY 2014 COP to cover the next two years of planned activities. All budget allocations submitted in the FY 2014 COP will cover FY 2014 funds only.

## 2.2 Coordination during COP Planning

### 2.2.1 Coordination with Host Country Government

The U.S. government is firmly committed to the principles of country ownership and alignment with national programs, including harmonization with other international partners and in-country stakeholders. As a result, the COP should fall within national strategies and where applicable, to the PEPFAR Partnership Framework. Moreover, sharing of PEPFAR priorities and COP planning information is an essential aspect of enabling effective national coordination, leadership and management efforts, leveraging resources, and fostering sustainability of HIV/AIDS programs. Consultation and collaborative planning with the partner government is necessary to ensure that priorities are shared, prioritized interventions are pursued and for approval of the strategic direction of the PEPFAR program by the partner government. Key in-country stakeholders include: government authorities (e.g., Ministries of Health and Finance, National AIDS Council, and local government authorities), local multi-sectoral coordinating bodies, multilateral partners (e.g., Global Fund, UN agencies), civil society, including people living with HIV/AIDS, and other relevant stakeholders, like the private sector.

As PEPFAR teams approach planning for the FY 2014 COP, it is important that there be transparency in the budgeting and planning process to ensure sustainable service delivery for the continuum of care for those infected and affected by HIV/AIDS. Country teams, the partner government and local stakeholders must know, at a minimum, the available financing from PEPFAR (accounting for prior year and current year planned resources the Global Fund and the government (inclusive of other bilateral and multilateral aid). Ideally, this information is complemented by information on interventions funded and which implementing partners are contracted to provide these services, including the geographic location of these partners.

At the same time, procurement-sensitive information contained in the proposed COP must be protected to adhere to U.S. government competitive acquisition and assistance practices. Please note the following guidelines:

- Unredacted FY 2014 COPs should be shared on a "need to know" basis, as determined by the Ambassador or his/her designee. In the spirit of Partnership Frameworks and furthering country ownership, the U.S. government team may share the entire FY 2014 COP with partner government officials that have responsibility for COP approval and relevant Global Fund officials, subject to the following instructions:
    - Electronic copies of the unredacted COP should not be distributed to the government, in order to prevent inadvertent distribution beyond those with a legitimate “need to know” for planning and coordination purposes.

- With Agency and Mission clearance, hard copies of the full COP may be shared with the partner government reviewers, but all copies should be retrieved following the review period. In the event that hard copies of the unapproved COP are not returned, PEPFAR teams should make every effort to exchange these with a hard copy of the final approved COP.
- Specific funding levels for any award which is "To Be Determined" (TBD) (whether at the prime or sub-partner level) should be redacted (deleted) from the hard copy of the COP to be reviewed by the partner government. However, aggregate dollar amounts for TBD award(s) within one program area (as opposed to by mechanism) may be summarized for the partner government, e.g., "In the PMTCT program area, we plan to add $2 million through new awards."

- If these conditions cannot be met for whatever reason, then only information at the overall program area level may be shared (e.g., aggregate funding levels and targets). Information on activity-level funding mechanisms may not be shared unless the conditions set forth above are met.

- Final redacted COPs from previous years are available online at www.pepfar.gov Funding levels for unnamed TBD awards in these prior-year COPs will remain redacted as described above.

### 2.2.2 Coordination with Donors and Multilateral Partners

PEPFAR teams should continue and expand engagement with bilateral donors and multilateral stakeholders in the COP development process, especially during high-level strategic direction planning and to help set priorities for the FY 2014 COP. Teams are expected to seize opportunities to align national, Global Fund, UNAIDS, and bilateral donor investments with PEPFAR planning and implementation. Teams are required to engage as fully as possible in the key strategic planning processes, in particular the UNAIDS Investment Approach (See Section 2.3.1) and Global Fund Concept Note (See Section 7.2.4), as these are pivotal opportunities to collectively utilize data to prioritize interventions in a coordinated and efficient manner.

The Global Fund New Funding Model provides flexibility to develop a Concept Note according to national planning timelines, and also more funding level predictability through indicative resource allocations. It is important for PEPFAR's COP development to be integral to this Global Fund planning (Country Dialogue), so that the country's entire funding envelope can be considered. Multilateral engagement should strategically align resources, yield cost savings, fill gaps, and reduce potential duplication of co-funded activities or partners.

Teams are also encouraged to consider including multilateral partners at other stages in the COP development process, for example when conducting portfolio reviews, reviewing Annual Program Results and Semi-Annual Program Results (APR and , respectively) conducting site visits, organizing technical assistance visits (TDYs), and revising technical area guidance. For additional guidance and model examples of Multilateral Engagement see Section 7.2.4.

Additional updates and resources on the Global Fund's New Funding Model can be found here: http://www.theglobalfund.org/en/activities/fundingmodel/

### 2.2.3 Coordination with Civil Society and PLHIV

One of the major goals outlined in the PEPFAR Blueprint is to increase local civil society involvement in HIV/AIDS planning and implementation. Country ownership is characterized by government, communities, and civil society that together are able to lead, prioritize, implement and be accountable for a country's health response. While all these country-level actors are critical, PEPFAR's vision explicitly seeks to ensure that local civil society voices, particularly those people living with HIV (PLHIV), key populations, and generally those who use health services, are represented in the country-level AIDS response. As part of the COP process, PEPFAR teams are expected to expand their engagements with local civil society as a way to spur greater local civil society engagement by partner-country governments. Local civil society organizations include non-governmental local organizations and networks/ coalitions –professional associations, faith-based organizations/FBOs, community associations, and not-for-profit organizations at national, district and local levels. Coalitions, networks or forums of people living with HIV (PLHIV) are critical groups to include in the consultation.

Overall, there are three steps that each country team should follow in the COP planning process. First, prior to COP submission, PEPFAR teams should hold a meeting, early in the planning process, with civil society, including both PEPFAR implementing organizations and organizations representing communities living with and affected by HIV. At this meeting, teams should outline the proposed goals, priorities and targets of PEPFAR for the upcoming year, particularly regarding how they support country HIV/AIDS plans and align with WHO guidelines and epidemic needs. Country Teams should also highlight changes from prior year programs proposed as part of the COP submission, and the expected impact on users of the program.

As part of this consultation PEPFAR teams can ask headquarters for impact modeling that projects changes in the rates of HIV with different levels of antiretroviral treatment

(ART), VMMC, testing and other interventions as a discussion tool. Teams should consider presenting changes in PEPFAR targets and strategies over time including ways in which civil society has been engaged in the implementation of the national HIV program. Lastly, if the proposed COP includes support for advocacy efforts by civil society groups to increase the government's transparency and accountability, increase quality and uptake of services or promote greater shared responsibility these should be shared as part of the engagement. As part of this meeting, country teams should also solicit written comments from civil society representatives on these priorities. Country teams should also consider reaching out to civil society later in the COP development process if specific inputs or feedback would help to enhance the COP submission.

Second, as part of the final FY 2014 COP submission, PEPFAR teams must include a separate narrative supplemental document documenting how civil society has been involved, the comments made by civil society, and the way in which the Country Team has considered these comments as part of COP planning. Please include in this document estimated amount of funding that **is planned to** directly fund local civil society organizations (as prime recipients and if feasible as sub-recipients). Please also indicate what percent of the total FY 2014 COP funding this represents [total amount of FY 2014 COP funding minus M&O budget]. This supplemental document submission should be included in the document library. Please see Section 10.6 of the COP Guidance on supplemental documents and posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles.

Finally, following completion of the COP process, PEPFAR teams should provide a formal written response to civil society, documenting the ways in which comments were considered in the process and, if not included, the reasons for their exclusion.
Given PEPFAR's commitment to supporting country ownership, to the greatest extent possible in each country context, this engagement should take place through existing, representative mechanisms for local civil society engagement at the country level. Beyond the COP planning process, the PEPFAR team should encourage country counterparts to involve civil society, particularly PLHIV, key populations, and those who use services, in planning for HIV/AIDS programs. In addition, PEPFAR teams should work through other mechanisms to involve local civil society, such as the Global Fund's Country Coordinating Mechanisms (CCMs) or other existing representative consultative bodies at country level.

### 2.2.4 Coordination among U.S. Government Agencies

A key feature of PEPFAR is its whole-of-government approach that rests on a robust and productive U.S. government interagency response. In practice, this requires U.S. government agencies working in a country or region to plan, implement, and monitor a

unified country program as one U.S. government team. In most cases, a PEPFAR Coordinator leads the coordination and facilitates a process that supports this principle**. It is essential that all** U.S. government **agencies working on HIV/AIDS programs in a country be included in all levels of discussion regarding the COP.** For agencies that have in-country programs but no direct in-country presence, this includes communication through email and telephone. In addition, dialogue with the interagency country support team at headquarters is encouraged to ensure a well-vetted COP is reached prior to submission. Country programs may have several sources of U.S. government HIV/AIDS funding (e.g. State, USAID, GAP funds); however, all HIV/AIDS programming decisions are to be made as an interagency U.S. government Team. If any agency does not have staff or activities in-country, the country team may still draw on the expertise of a non-presence agency to benefit the program and may use the COP process to solicit that agency's expertise.

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

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

## 2.3 Important Resources for COP Preparation and Planning

This guidance and its appendices, as well as other documents critical to program planning and COP submission are posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles. These documents can also be found in the FACTS Info PEPFAR module and on www.pepfar.gov.

Other channels of communication to strengthen COP planning, including work with CSTLs and weekly COP clarification calls, are important. Based on questions from the

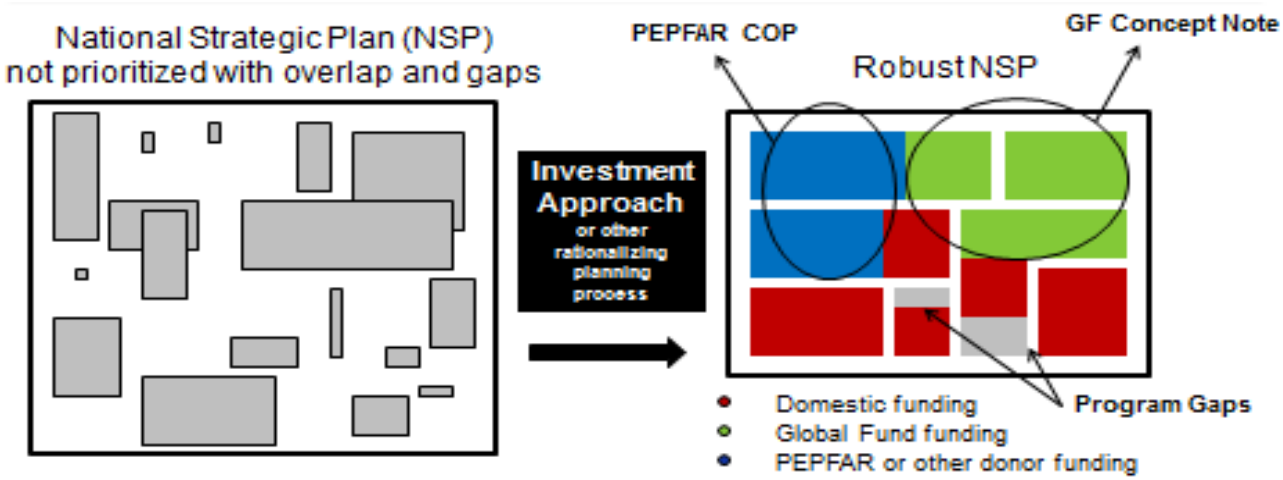
field, headquarters develops "COP Clarifications" notes to answer issues on the COP guidance. "COP Clarifications" will be disseminated through News to the Field and on the PEPFARii.net site under HQ > Planning and Reporting Cycles.

### 2.3.1 Analysis of UNAIDS' Investment Framework

The UNAIDS Investment Approach is a country--owned and -led process that can help ensure ongoing PEPFAR efforts are aligned strategically, high-impact, and non-duplicative within a national response. To ensure countries are successful, PEPFAR has committed to working with UNAIDS as they support governments to build investment thinking into their national planning process.

National Strategic Plans (NSPs) should provide the basis for planning, but not all NSPs easily lend themselves to a dialogue with donors and decision-making around resource allocation, programmatic focus, and scale-up of services. The Investment Approach is designed to support this kind of dialogue and decision-making, and can help in the development of Global Fund concept notes and PEPFAR COPs, by addressing the questions that countries struggle with:

- Does the response match the epidemic?
- Are programs adequately scaled?
- Are there unnecessary costs or opportunities to gain efficiencies?
- Are there duplicative or overlapping services?
- Are programs sustainable?
- What are political or policy barriers?




The Investment Approach process results in the development of an Investment Case, which summarizes key information on the national response and gaps, and

recommended action points. The Investment Case essentially "makes the case" for where, how, what, and how much to invest in HIV.

UNAIDS Country Coordinators (UCCs) have been asked to include PEPFAR country teams and other donors when convening government and country stakeholders in planning the development and implementation of an Investment Case. PEPFAR teams are encouraged to engage in Investment Approach processes as a means to promote transparent, evidence-based, and rational programming and resource distribution at a country level. Countries are using a variety of entry points to introduce an Investment Approach, including sustainable financing discussions, review of national strategic and operational plans, application for or re-programming of Global Fund grants, and development of health sector plans.

PEPFAR teams should engage in this process at the strategy, planning, policy level, and technical level. Key PEPFAR participants will include the PEPFAR Coordinator, the SI advisor, and relevant technical advisors. If not already engaged, PEPFAR Coordinators should contact the UCC in their country and discuss plans for the implementation of an Investment Case. If you have questions about engaging the UCC or the Investment Approach process, please contact the Multilateral Diplomacy team at OGAC for assistance.

UNAIDS has developed resources and tools to facilitate the Investment Approach process. There are also central mechanisms available that can receive field resources and can help with the facilitation and development of Investment Cases. In addition, there are limited central resources available through the 5% Global Fund Technical Assistance withholding for countries requiring supplemental assistance. Please contact the Multilateral Diplomacy team at OGAC for assistance.

Supporting documents can be found here:

Investing in HIV more strategically - A four-step self-assessment and decision making tool, UNAIDS. This resource is currently being built and can be found at: https://drive.google.com/folderview?id=0BzeeufmkBxDxSVN0bmQ4TzRBVWs&usp=sharing

Global Fund Information Note: Strategic Investments for HIV programs: http://www.theglobalfund.org/documents/core/infonotes/Core_HIV_InfoNote_en/

http://www.unaids.org/en/resources/publications/2012/name,72628,en.asphttp://www.unaids.org/en/resources/publications/2012/name,72628,en.asp

## 2.3.2 Strategic Budgeting and Portfolio Reviews

In 2012, an interagency field and headquarters team analyzed how teams developed their COP budgets, and noted that most teams took a "bottom-up" approach, where activity managers submitted ideal budgets for their activities, which led to a total budget well over the amount allocated to the program. The field teams then spent a great deal of "unproductive" time balancing the overall budget. These negotiations are often not strategic, and create tension among field teams.

After a review of best practices the tools below were developed to help teams to "optimize" the interagency process. These both reduce time spent on budgeting, while also making interagency efforts more strategic and meaningful, including:

- Process and Tools for more strategic "Top-Down" budgeting
- Improved Portfolio Review Process and Tools
- Strengthened Country Support Teams; and
- Country Support Calendar.

### *Before COP Planning Starts*

The COP planning process is a critical time for teams to make program adjustments, and prepare for the year ahead. Teams should enter the COP planning process with a good understanding of their progress and priorities, and leave with a clear mandate for action in the upcoming year.

Too often, individual team members enter the COP process with little understanding of progress and priorities outside of the activities they directly manage. At the end of the COP process, individuals have little more than a budget level for their activities, and perhaps some general targets. This results in a weakened program and budgeting outcomes.

A cohesive and strong COP is the result when teams draw on the technical and program management strength of the PEPFAR team. A successful collaborative COP planning process begins with a vision for what can be achieved in the year to come. With a focus on reducing the amount of time spent positioning and resolving disagreements in COP budgets, PEPFAR teams must enter into the COP planning process having discussed the overarching program goals and priorities, and with a strong understanding of where the program stands in achieving its goals. Two important tools to facilitate a successful COP planning process are robust portfolio reviews and strategic Country Support Team engagement.

Portfolio Reviews

Country teams have been expected to conduct annual portfolio reviews, however there has been little guidance defining the expected process and outcomes. As a result, many portfolio reviews are driven by internal agency processes that focus primarily on providing feedback to the partners. While this is an important aspect of the portfolio review process, it is insufficient in helping the PEPFAR team as a whole improve their understanding of the entire PEPFAR program, and where it stands in achieving its goals.

After review of several different portfolio review processes and tools the 2013 COP Guidance provided teams with a Portfolio Review package that is now formally recommended for teams to use and adapt.

The Portfolio Review helps teams review the major program goals, and look at the individual partners or activities that contribute toward those goals along the following four categories:

- Achievements (Performance) – What has a partner or activity achieved in the past year? This explores how our partner is performing against what we have asked them to do in their agreement.

- Alignment (Strategy) – How well is the partner or activity aligned to PEPFAR's current strategy and goals? While a partner may be performing well at what we asked them to do, perhaps new evidence has shifted our strategy, and we need to make sure our partners are shifting as well.

- Financial Performance – Does the partner have a pipeline? What are their costs, and how do they compare with other partners/activities?

- Sustainability/Country Ownership – If this is an international partner, are they building local capacity to take over the project at some point? If this is a local partner, are they fully capable of managing and sustaining their programs?

The Portfolio Review encourages interagency, host government and partner participation and discussion, while also making sure that any final feedback to partners is filtered through and cleared by appropriate COTRs or AOTRs from the funding agency. Teams are encouraged to work with their Country Support Team Leads to determine suitable headquarters involvement in portfolio reviews.

This approach also encourages teams to conduct their portfolio reviews outside of the COP planning cycle if possible. This helps separate the review from budgets, and gives

partners an opportunity to respond and make adjustments based on the feedback outside of the process in which their budget levels are being considered. However, as there may be several months between the portfolio review and the COP planning begins, teams should develop a Portfolio Review report which captures some of the major themes, issues and discussions that emerged from the portfolio review.

Strategic Country Support Team Engagement

HIV/AIDS science and policy are constantly evolving. Stronger headquarter country support team collaboration can help bring new guidance, information on new initiatives and expectations for adoption of new approaches to the country team well in advance of the formal COP review. By engaging field teams during key points in the year, for example, around APR/SAPR and portfolio reviews, country support teams (which usually consist of headquarters points of contact across implementing agencies, Deputy Principals, SI advisors, and relevant TWG representatives) can help field teams as they discuss and debate how best to apply new strategies to their programs, and what appropriate program adjustments need to be made. When country support teams help field teams throughout the year, surprises during COP reviews can be eliminated.

Country Support Team Leads are working with HQ agencies and TWGs to improve country support teams, and PEPFAR has developed a country support framework to help country support teams better understand their roles, and recommendations on key points for them to engage field teams.

While there will not be a one-size-fits-all approach, there is an expectation for a minimum level of engagement and standardization to the Country Support Team process. Existing, highly functioning Country Support Teams will not be expected to change, but in programs where there is no existing, limited, or consistent Country Support Team activity, the FY 2014 COP guidance on COP planning helps country teams:

- Clarify the purpose and role of Country Support Teams;
- Standardize membership of the “core” Country Support Team;
- Recommend how TWGs can best participate and contribute to Country Support Teams;
- Set minimum standards for Country Support Team engagement with field teams around APR/SAPR, COP, and other key HQ/field touch points; and
- Gather feedback from the field on how well the Country Support Team process is working.

## *COP Planning and Development*

While there are many more things that can be done to help your team get on the same page, the portfolio reviews and country support teams are two good starting points for the actual COP planning and development process itself. Again, the premise of this approach is that by getting the team on the same page, and with a better process and tools, the COP budgeting process can take less time and have a more strategic outcome.

Conducting a Top-Down Strategic Budgeting Process

A top-down strategic budgeting process has the potential to reduce time spent in budget negotiations, with an improved outcome. The central ingredient for this approach to succeed is a strong, small leadership team with a shared vision for the PEPFAR program; small teams that can set priorities for the coming year and strategically align the budget to fund priorities.

The following outlines a top-down budgeting process, and suggests tools that can be adapted for teams to use. The make-up of leadership teams will vary, as will the priorities in each country; however, the basic framework of the process can be adapted to each country's context:

- Step 1: The budgeting process is linked to the Portfolio Review through an executive summary presentation of the Portfolio Review and discussion. The minimum expectation is that the portfolio review executive summary will provide summarized data for the leadership team on:
    - Strategy: Overarching progress on major strategic themes/initiatives
    - Performance: Specific Program Performance and Achievements
    - Issues: Issues/Challenges/Areas of concern, and the U.S. government team's plan for addressing
    - Financial: Pipeline/Financial Performance
    - Sustainability: Summary of progress on country ownership, sustainability, and/or local capacity
    - Depending on the timing of the portfolio review vis-a-vis the budget discussions, the PEPFAR Team may want to provide the leadership with a brief update on any progress made since the portfolio review.
- Step 2: Priority Setting Exercise
    - The leadership team should discuss ranked priorities for the upcoming year. Specific country priorities should also be found in the Country Planning level letter. **The expectation is that country teams are consulting with partner governments and other donors during this priority setting process**. Ideally, as governments and donors (i.e. Global Fund and PEPFAR) use and participate in national processes such

as the Investment Approach to inform priorities, the planning burden for all may be reduced.
    - Priorities may be defined as budget codes, or themes that cut across budget codes, or in some cases, an individual project that is a high priority. Teams may choose to have a mixture of approaches in their priorities, or agree to use a specific system of budget categories.
    - Ideally, the outcome of this exercise provides a prioritization framework that covers every program area and activity. For large programs, leadership teams may want focus primarily on the highest priorities, and leave a few catch-all categories for the remaining, lower-priority activities.
  - The leadership team should provide high-level bullets on expectations for each priority to guide the team. Bullets may set goals for targets, or transition, or other programmatic or financial guidelines.
- Step 3: Data Gathering
  - The team puts together background data on the priorities. This includes:
    - SI data on historical targets and achievements
    - Financial data on pipelines
    - Historical budget data
  - Data should be put together by the PEPFAR Coordination Office, with support from the SI Advisor and agency financial POCs
- Step 4: Priority Budgeting Exercise
  - A budgeting team designated by the leadership (or the leadership themselves) should conduct a process of setting budget levels by priority, starting with the first priority, and moving through the priorities until they reach the end of the list. It may be prudent for the budgeting team to reserve a small amount of funding to support opportunities later identified by the TWGs as potential add-backs.
  - Through this budgeting exercise the country team should designate for each priority the level of funding (both new funding and applied pipeline) and, where relevant, further expectations for targets or costs.
  - The budgeting team may also want to include a summary of any challenges they foresee with the budget (i.e. lower priorities having to take significant reduced budget levels, etc.)
- Step 5: Leadership Approval of High-Level Budget. The country team technical staff should present their budget breakdown to the PEPFAR leadership team in country for final approval. The teams may also want to present this budget to the Host Government as well. In some cases, the team may also want to present this budget for feedback from the Country Support Team DP/ADPs.

    - At this stage, it will be easier to make budget adjustments before activity and partner levels are set.
    - NOTE: In step 1-5, no activities or agency-level budgets should be discussed (unless there is a one-off activity that for a clear reason is singled out as a priority for that year.)
- Step 6: Activity Level Budgeting
    - TWGs are provided with a budget level and the bullets from the leadership team for each priority. They are expected to budget activities within this budget level that meet the expectations set out by the leadership and, if they choose, recommend potential additions to their guidance level. The budgeting team might limit such additions to a set number of items (1 or 2 per TWG) or a set percent of the guidance level (up to 10% above guidance, for example), and TWGs should include estimates of outcomes, impact, and key assumptions in these proposals.
    - If there are problems at the TWG level, the budgeting team should try to resolve the issues first and forward to the leadership team if there is no resolution.
    - While it may be necessary to consult with partners at this stage, there must be no guarantees of budget levels to partners.
- Step 7: Activity Level Budget Approval
    - The budgeting team should review the results of the activity-level budgeting exercise by each of the TWGs. Based on the priorities identified in step 2, the data gathered in step 3, and the quality of proposals received from the TWGs, the budgeting team should allocate any previously unallocated funds to selected proposals. They should ensure that the activity level budget meets the guidelines set by the leadership team.
    - Engagement of Government and leadership will depend on the expectations/traditions within each country.
- Step 8: Detailed partner-level Narrative Development/targeting
    - Once the activity-level budget is approved, Activity Managers can then go to partners with activity level budgets.
    - Disputes between partners should be resolved at the budgeting committee table.

### 2.3.3 Expenditure Analysis Data for Program and Partner Performance Planning

The PEPFAR Expenditure Analysis (EA) Initiative evolved from the recognized need for timely expenditure data linked to results to improve management and increase efficient

operations of PEPFAR programs. By employing tools to quantify programs, improve accountability, and maximize smart investments, PEPFAR is achieving more with finite resources. Country teams are strongly encouraged to analyze EA data to increase the value and sustainability of PEPFAR investments, and share this analysis with country and multilateral partners.

### Program efficiencies

Countries that have completed an expenditure analysis are required in FY 2014 to illustrate how EA data and other empirical cost data were used in determining program allocations and specifically reference the unit cost estimates in setting budgets relating to achievement of the World AIDS Day targets. Teams are asked to summarize how they used the EA data in the Technical Area Narratives (TANs). These budget allocations should reflect attempts to achieve efficiency from a variety of perspectives. Please see HSS Technical Considerations 4.11 for specifics.

### Resources for Country Teams on use of Expenditure Analysis

The Finance and Economics Working Group (FEWG) has developed several resources for country teams to facilitate understanding and use of EA data. Formal EA guidance and FAQs has been distributed to each country team in conjunction as part of the EA launch in country and is also available on PEPFARii.net. The FEWG is responding to feedback from Phase I of EA on the difficulty of translating EA results and other available cost data into the PEPFAR budget codes by developing a budgeting tool patterned off of the process and instruments used by the PEPFAR Mozambique Country Team. The Budget Allocation Calculator is an optional tool available for all OUs in the FY 2014 COP. Currently the Calculator is in final development and will be available in early December on PEPFARii.net. To use the tool, teams will enter key EA/cost data and proposed targets and the tool will generate budget allocations that correspond to the traditional PEPFAR budget codes. If your OU has not yet participated in the PEPFAR EA process you can use other available financial and/or economic data with some key adjustments. **A comprehensive set of instructions will be provided along with the release of the Budget Allocation Calculator. This tool seeks to simplify a highly complex process and will take time to fully adopt and improve. If your country is interested in utilizing the tool during the COP planning cycle, please contact the FEWG to organize technical support or a demonstration. It should be noted that the budget tool provides an index value to assist teams and provide an objective basis for allocations, but does not provide rigid benchmarks; budgets should be guided by fiscal data and determined in overall program context.**

## Considerations for other PEPFAR-Funded Economic Analysis Activities outside of the EA Project

PEPFAR Teams are increasingly seeing the value in funding activities that help Governments and other stakeholders analyze the costs of program activities. FY2013 COP saw a significant increase in such activities. To ensure these activities are not duplicative, and indeed result in useful data, the FEWG will be reviewing these activities as part of the COP review process. As these activities may be in different budget codes, the following guidance is provided to help teams as they consider these activities.

There are several types of economic analysis and evaluation activities that can inform program planning; each produces different information that is appropriate for different questions. In describing a proposed COP activity, country teams should clearly articulate the following:

1) What is the policy or programmatic question/decision that this analysis/activity will answer?
2) How does this fill an information gap (in other words, articulate how this information complements other PEPFAR-funded economic analysis and evaluation activities (current/prior/proposed), existing information and other activities in country,
3) High level description of the implementation and timeline,
4) How the information and findings will be used or will inform the decision or policy, and for whom.

Activities related to the Health Financing Building Block of the Health Systems Strengthening WHO Building Blocks (e.g. to strengthen or create innovative financial systems, building of government capacity to manage and mobilize resources, or supporting innovative financing schemes) should also be considered to support scale up of services and promote country ownership. In describing the proposed activity, country teams should clearly articulate how the activity will support the HIV response or scale up of HIV/AIDS program (including which interventions or services impact health outcomes). If the goal of the activity is to promote country ownership, a clear description of the conceptual framework and linkages to key dimensions of country ownership, and high level description of the implementation and timeline and milestones should be included. Country teams should also articulate how the activity will support the national strategy or priorities. Linking activities to specific metrics for monitoring progress is essential where these metrics exist.

Particular attention will be paid to activities that support expenditure or resource tracking at country level. Given the institutionalization of the PEPFAR Expenditure Analysis Initiative and also PEPFAR's support of activities such as National AIDS Spending Assessments (NASA) and National Health Accounts (NHA) in the past, and collaboration between PEPFAR and the Global Fund, it is critical to clearly demonstrate that any activities that support tracking or analysis of expenditures is coordinated and complementary to and coherent with the PEPFAR Expenditure Analysis Initiative. Narratives must be clear on how the data has been used in the past and will be used in the future. A high level description of the implementation, timeline and results should be included.

### 2.3.4 Pipeline Documents and Budget Points of Contact

Teams should utilize currently available HQ and country resources on pipeline and financial status, as well as key budget points of contact at Agency HQs to strengthen their understanding of the fiscal status of their program in order to support their COP planning and submission.

Specifically, teams should review the PEPFAR Pipeline Definitions sheet posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles and revisit the quarterly Pipeline Reports supplied by OGAC, as well as any corresponding internal analyses conducted by the team related to this report and the tracking of funds over the past fiscal year. The Pre-COP Approval Memo should also be revisited and shared widely amongst the team upon receipt, and should influence your final COP submission.

For optimal planning, teams should also rely upon the information they can access via the FACTS Info ad-hoc reports list (located in the Budget Module). For budget related purposes, the following prior year reports available within the Budget Module of FACTS Info will prove to be helpful: Standard COP Matrix Report (especially for FY 2013 COP); Standard Pre-COP Matrix (particularly for FY 2014 COP); Summary of Planned Funding by Agency; Agency Cost of Doing Business and Budgetary Requirements Worksheet (specifically for FY 2014 COP in order to access the current status of the country's earmark requirements).

**The aforementioned resources should be reviewed and utilized by all team members and the inclusion of the in-country financial staff is highly encouraged. Full integration of financial staff will lead to a fully developed and integrated COP submission.**

**Teams that determine the existence of excess pipeline are advised to request fewer FY 2014 funds to support FY 2014 COP activities than recommended in the planning level letter and utilize older FY funds, pipeline, before asking for new FY 2014 funds.**

Teams should also reach out to and utilize their respective agency headquarters financial staff during COP planning. Agency headquarters' financial staff can assist teams in a variety of tasks including, but not limited to: verify financial records and unobligated and un-subobligated balances; provide comprehensive guidance about the application of pipeline to FY 2014 COP mechanisms, and other matters. The OGAC M&B team is also available as a Headquarters resource, but teams should always check-in with Agency Headquarters financial staff first. Teams can contact their CSTL if they want to confirm their agency headquarters financial staff's contact information or be liaised with the OGAC Management & Budget team.

### 2.3.5 Country Support Team and CSTL

The Country Support Team Lead (CSTL) and Country Support Team members, including the Strategic Information (SI) Advisor, Agency-specific country support staff, OGAC and Agency Headquarters' financial staff, and Technical Working Groups (TWGs) are important participants and can help support the COP process. The CSTL is your main point of contact at OGAC and for the PEPFAR interagency team at HQ, and should be substantially involved. Engaging the SI Advisor early in the process to assist with target setting and with planning of Strategic Information activities is also essential.

The Country Support Team members can help with strategic planning of activities and reviewing and finalizing the COP. If you would like assistance from the Country Support Team or one of the TWGs, please contact the CSTL for your country. The FY 2014 Technical Considerations, drafted by the TWGs, is a companion document to be used in conjunction with this FY 2014 COP Guidance.

As in previous years, the guidance and its appendices contain critical information that informs program planning and will be posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles in the FACTS Info PEPFAR module, and subsequently on www.pepfar.gov.

Other channels of communication to strengthen COP planning include working with CSTLs, and participating in the COP clarification calls via teleconference. Based on questions from the field, headquarters will develop COP Clarifications to answer questions raised by PEPFAR field teams about the COP guidance on COP Clarification calls and via email. COP Clarifications will be disseminated through News to the Field

and will be posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles.

### 2.3.6 PEPFARii.net Share Point Site

#### Communications

Communications regarding all future business cycles (e.g. COP/APR/SAPR guidance and clarification call notes) will now be stored and shared on the new PEPFARii.net SharePoint site within the Planning and Reporting Cycles page (https://www.pepfarii.net/OGAC-HQ/pr/SitePages/Home.aspx), rather than on PEPFAR Plan B. For the FY 2014 COP, you will be able to find the guidance, clarification call notes and other related documents by following this link (https://www.pepfarii.net/OGAC-HQ/pr/Add%20File/Forms/COP.aspx).

Users who do not yet have access to PEPFARii.net will need to be provided access to the site. See Appendix 10 for further information on how to access PEPFARii.net and how to ask for any additional help with the site.

#### Collaborating on COP Materials in PEPFARii.net

The individual Operating Unit pages owned by each PEPFAR country team on the PEPFARii.net site provides a myriad of helpful tools and features to assist you in the preparation of COP materials, such as collaborating with your colleagues on the creation of Technical Area Narratives. For example:

- PEPFARii.net helps to ensure **version control** by allowing users to "check-out" documents, or lock them for editing.
- Users may also **edit documents simultaneously** with their colleagues and later merge their edits.
- Links to documents stored on the site can be emailed, rather than sending the file itself, helping to ensure all users are viewing the same version of a document and **reducing email clutter**.
- Users can **search** for site content, such as files published on the site.
- Users can **easily locate content** that has been loaded to the site by applying filters to metadata values such as the agency, the reporting cycle, the fiscal year, the file category, and who modified the document.

#### Managing Tasks and Timelines in PEPFARii.net

PEPFARii.net provides several features that allow users to easily manage the COP submission process by providing greater visibility into the COP submission tasks and timeline. For example:

- Users may utilize the **tasks** functionality to assign and communicate tasks to their colleagues, as well as track progress toward completion of those tasks.
- The **calendar** feature can be utilized to track the timeline of the COP process, including key milestones. Users may also connect their team's calendar on PEPFARii.net to their Microsoft Outlook calendars.
- Users can share newsworthy events such as key accomplishments or actions using the **announcements** feature.
- **Links** to useful resources may also be loaded to your team's page, helping to provide your team with a complete central resource for all COP collaboration and resource needs.

## 2.4 COP/ROP Submission Via FACTS Info – PEPFAR Module

All country teams will submit their COP for FY 2014 using the FACTS Info – PEPFAR Module. This software system is the primary source for tracking and reporting of foreign assistance data and is jointly operated by the State Department and USAID. OGAC has worked with the Office of U.S. Foreign Assistance Resources at the Department of State (State/F) to ensure that PEPFAR-specific planning and reporting requirements are represented in the PEPFAR Module and that all PEPFAR implementing agencies have appropriate access to the system.

### 2.4.1 Guided Self Training and Where to Go for Help

This Guidance is intended to describe "what" should be contained in your COP and will not describe "how" to use the FACTS Info – PEPFAR Module. Details on how to access and use FACTS Info are described in the PEPFAR Module training and user support materials that are available in the News and Tutorials section of FACTS Info and posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles. Also, please consult with your local OU Administrator, Coordinator or Point of Contact to identify all individuals who attended in-person training in the fall of 2011. These staff members should serve as your local training expert and help resource for PEPFAR-Module questions.

### 2.4.2 FACTS Info Templates for Data Entry

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

Module. **OGAC intends to open the PEPFAR Module COP section in January 2014. Prepopulated templates for new IMs will be available.** The intent is to allow teams to gain access to the prepopulated templates and share these templates with their partners in advance of opening the system in January for data entry/upload. Blank templates will also be made available in October, however, please note that **blank templates CANNOT be used for existing mechanisms**. Teams are required to use prepopulated templates for existing mechanisms in order to maintain the mechanism ID number and history.

| Template Name | Function of Template | Planned Release Date | Where to find the template |
|---|---|---|---|
| Blank Implementing Mechanism Template | For new IMs created in FY 2014 COP, has all elements that will be asked for in FACTS Info and is organized in a way that corresponds to the FACTS Info Tabs for each IM. When the full COP Module is open you can upload this template to FACTS info to create a new IM rather than entering data directly on the screen in FACTS. | Late November 2013 (Indicator section pending DP approval) | FACTs Info only |
| Pre-populated Implementing Mechanism Template | Format is similar to the Blank IM template but this is specifically for continuing IMs, this template is 'run' in FACTs info in a special early release section. Use to update existing IMs created in previous FYs. When the full COP Module is open you can upload this template to FACTS info to create a new IM rather than entering data directly on the screen in FACTS. | Late November 2013 (Indicator section of template pending DP approval of MER) | FACTS Info only |
| New Partner Template | If you don't find a partner's name in the Partner List please fill out this form and | Currently Available | posted on the FY 2014 COP Planning |

| | | | |
|---|---|---|---|
| | submit to PEPFAR-Module-support@state.gov per the guidance on New Partners in Appendix 3 on Building Partner Capacity and Sustainability. | | section of the PEPFARii.net site under HQ > Planning and Reporting Cycles. and in the "Help Documents" section of FACTS Info |
| Blank or Pre-populated Global Fund /Multilateral Engagement Template | You can use this template answer the questions in the GF/ME section of the COP and upload the data to FACTS Info rather than data entry on the screen. | Early January 2014 | FACTS Info only |
| Blank or Pre-populated PPP Template | | Early January 2014 | FACTS Info only |
| Blank or Pre-populated Surveys & Surveillance Template | | Early January 2014 | FACTS Info only |
| Blank or Pre-populated Policy Tracking Table Template | | Early January 2014 | FACTS Info only |
| Blank or Pre-populated TAN Template | | Early January 2014 | FACTS Info only |
| Pre-populated Technical Area Indicator Template | | Indicators pending DP approval of MER | FACTS Info only |

### 2.4.3 FACTS Info Narrative Character Counts

Please note all character counts are inclusive of spaces and FACTS Info does not accommodate any formatting such as bold, underline, italics, or bullet points.

| COP Element | FACTS Info Character Count |
|---|---|
| Executive Summary | 45,000 |

| | |
|---|---|
| Global Fund/Multilateral Engagement- Question 1 | 3,000 |
| Global Fund/Multilateral Engagement- Questions 2-5 | 2,000 |
| Target Justification- Technical Area level | 2,250 |
| Technical Area Narratives | 30,000 |
| IM Overview Narrative | 1,800 |
| Budget Code Narrative | 3,500 |
| Target Justification- Implementing Mechanism level | 2,250 |
| TBD Narrative | 1,800 |
| M&O Narratives | 2,250 |

### 2.4.4 Checking Your Work and Highlight on Key Reports

In addition to systems checks, the FACTS Info system offers multiple options for 'checking your work'. In many countries there are multiple U.S. government team members who enter data in FACTS Info and even more that enter data into templates that are uploaded to FACTS Info that collectively become the COP. By utilizing key reports you can ensure the COP submission (i.e. what is in FACTS info) is what the country team intended to submit. Checking your work can also lessen the need for extensive clarifications between OGAC, Agency Headquarters, and country teams after COP submission. We urge all teams to heavily utilize the reports available in both the Standard Reports section of the COP module and within the Budget section of FACTS Info in the 'ad-hoc' reports section where you can customize reports.

A Voice Over Power Point (VOPP) is available on ad-hoc reports to help you navigate and utilize this feature. All VOPPs can be found on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles.

#### Highlight on Key Reports

- Standard COP Matrix Report- Shows all IMs along with Agency, Total Mechanism Pipeline, Funding Source (including Applied Pipeline) and amounts, Budget Code Funding amounts, and crosscutting allocations. Aside from the Full COP report (which is a narrative MS word document), this report is the most useful snapshot of critical information entered into FACTS Info. Note this report does not include: Indicators or Targets.
    - Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

- Full COP Report- This MS Word report pulls all the data entered in the COP. While the format can seem unwieldy at times and result in very long COP documents this is the best way to review the Full COP with all accompanying Narratives. Running this report and using the 'search-find' feature in MS Word is often the most efficient.
    - Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

- Summary of Planned Funding by Agency- Shows the allocations of the full programmed COP budget by funding account and implementing agency. In addition, can also show pre-COP allocations by agency, total submitted agency FY 2013 outlay rate, total submitted agency mechanism and applied pipeline.

- Summary of Planning Funding by Budget Code- Shows the allocations of the full programmed COP budget by budget codes. This report can be filtered by implementing agency. Also, indicates the total budget code allocation "on hold."

- Budgetary Requirements Worksheet (BRW)- Shows FY 2014 funding investments towards hard earmarks and within key budgetary considerations. This report should be run throughout the COP planning process as a check to see if earmarks and other budgetary considerations are being met.

- Agency Cost of Doing Business (CODB)- Shows the agency-specific allocations across the 11 CODB cost categories by funding source.
    - Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

- Best Target/Indicator Report include:
    - COP Targets and Justifications Data
    - Full COP Report
    - Mechanism Partner Report (new for FY 2014 COP)
    - Indicator Trend Report

## 2.5 Technical and Programmatic Reviews

Technical and programmatic reviews are scheduled to review the soundness of the COPs and alignment/compliance with guidance, country fiscal year planning letters and global directives. During this inter-agency review process, reviewers highlight key issues of concern that may require clarifications, revisions or technical assistance prior to approval of the COP.

**Overview:**

Upon submission of a team's COP in FACTS Info, COPs are 'cleaned' or checked by CSTLs and SI Advisors in coordination with country teams. This process ensures that subsequent reviews are of good data that is responsive to the COP Guidance requirements.

Technical reviews begin shortly after COP cleaning is completed. During technical reviews, all HQ level TWGs review the COP submission thoroughly to ascertain the focus within each technical area, assess the technical rigor, efficiency of technical investments, and fit within the national program. The technical review process and logistics are coordinated by each TWG's Co-Chairs. All issues, concerns and program highlights are compiled by each TWG, by country, and are submitted for consideration during the programmatic review.

The programmatic review is where the Deputy Principals (DP), TWG, Management & Budget, SI, Multilateral Engagement and Country Support perspectives of the country's COP all come together. A multi-hour extensive review (face-to-face meeting) is held for each COP and is chaired by a DP in coordination with a Lead and Secondary Reviewer who have all taken a very in depth look at the full COP submission. The country team participates in a portion of this review via phone and often offers clarifications on questions that arise during the course of the review. Notes are taken and follow up items flagged for the country team after the review.

A coding system has been developed to elevate programmatic review recommendations that may require further review or clarification by the country team before COP approval. As such, the terms yellow and red lights are used if a mechanism or technical area has conditionality for approval. At the conclusion of each programmatic review, the DPs finalize all recommended yellow or red lights and stipulate clear follow up items to 'lift' any lights, which are communicated to the country team by the CSTL.

- Yellow Light: A "Yellow Light" means that additional information is needed before an activity can be approved. In some cases, a Yellow Light indicates that the activity appears contrary to policy and requires clarification. In many cases yellow lights are resolved and funding approved after conditionalities are met or explanations received.

- Red Light: A "Red Light" means that the activity does **not** meet policy guidelines and is not eligible for approval.

Final determination of yellow and red lights will be made by way of recommendation from PEPFAR Deputy Principals to the Global AIDS Coordinator.

# 3. FY 2014 COP Technical Priorities

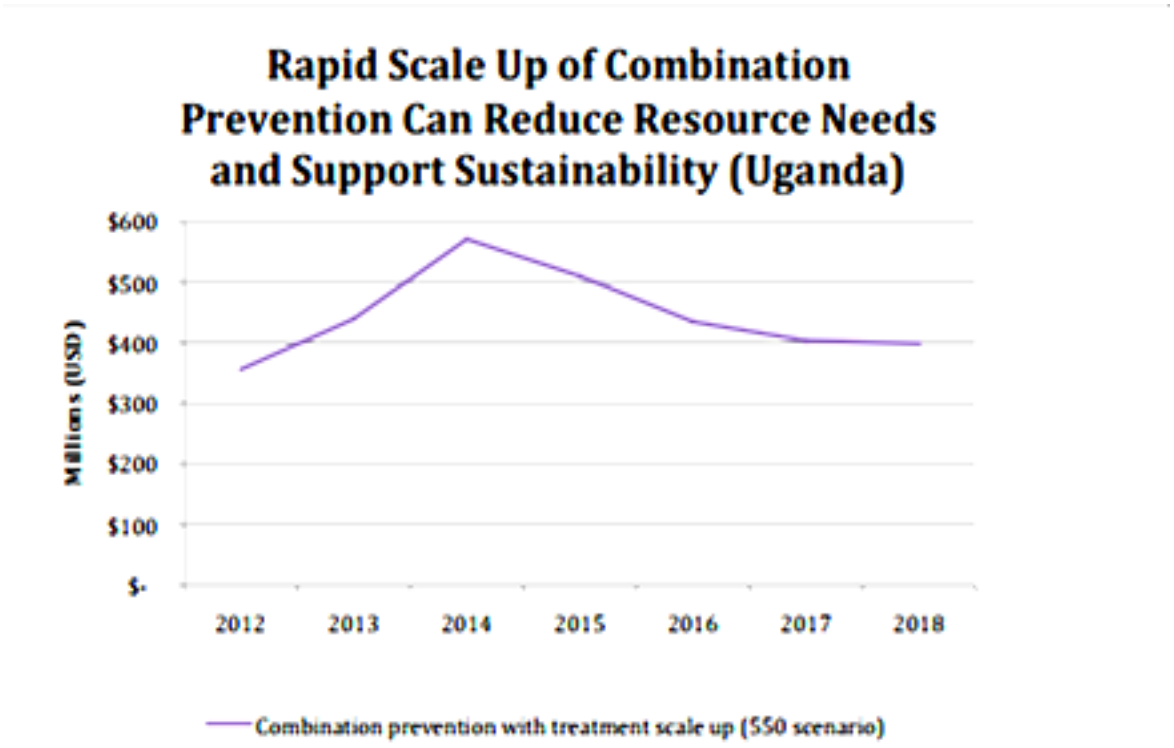
In order to achieve both PEPFAR's ambitious targets and the vision of an AIDS-free generation, PEPFAR programs often need to prioritize among competing activities and issues. **The following section presents PEPFAR's FY 2014 technical and population priority areas, presented here along the continuum of care. Each priority may not be appropriate for each country or regional program; teams are asked to carefully consider the local epidemiology, donor landscape and national government plans and strategies in their countries as they apply these priorities.** Importantly, FY 2014 planning level letters sent from the Global AIDS Coordinator to U.S. Ambassadors in PEPFAR country teams also provides tailored country or region-specific priorities for the PEPFAR program. The FY 2014 PEPFAR Technical Considerations provide further information on how to implement programs.

All the priorities support implementation of the PEPFAR Blueprint and will contribute to an AIDS-free generation. An AIDS-free generation entails that first, no one will be born with the virus; second, that as people mature, they will be at a far lower risk of becoming infected than they are today; and third, that if they do acquire HIV, they will get the treatment and support that keeps them healthy and minimizes the likelihood of their transmitting the virus to others.

## 3.1 Increase Treatment Coverage for All Eligible PLHIV

Rapidly and strategically increasing coverage of HIV treatment for all eligible PLHIV, both to *reduce AIDS-related mortality* and to *enhance HIV prevention,* is a cornerstone of the PEPFAR strategy to achieve an AIDS-free generation. In addition to saving lives, rapid scale up to high coverage of treatment is a key component of a combination prevention strategy and has the potential to reduce long-term resource needs and support sustainability, as outlined in the PEPFAR Blueprint. While the upfront investment associated with scaling up combination prevention is high, and new resources to do so a constant challenge, the expected impact in lowering adult HIV incidence rate is substantial, as depicted in PEPFAR Blueprint modeling scenarios. Therefore in each context where PEPFAR supports treatment costs directly, or contributes technical guidance to national stakeholders, it is important that PEPFAR teams continue to advocate for the joint resources to make treatment coverage rates realized. These up-front investments do not result in ever-increasing costs; indeed, up-front investment can result in lower out-year costs. For example, as is illustrated by the Uganda estimates in the below graph, the impact of these upfront investments leads to a decline, and then flattening, of annual costs. Fewer new services are required and the number of newly infected individuals falls substantially. These costs continue to decline as the new infections continue to decline.

High community levels of treatment and PMTCT coverage with ART for all pregnant and breastfeeding women combined with *active support to ensure long term retention and adherence* is essential to achieve the long term impact and persistent control of the epidemic. This rapid increase in coverage must also be pared with ongoing surveillance including incident assays for detecting developing local hot spots of infection so these can be quickly addressed.




The challenge ahead is to scale up effective combination prevention quickly enough to have a transformative impact on the epidemic and continue the ongoing effort to ensure national AIDS responses are sustainable over time. This requires strategic reallocation of existing resources toward high-impact interventions, such as treatment, and a shared commitment to increased and sustained investments, led by countries and with support from donors and other partners.

Rapid increase in ART coverage reduces infectivity, making it is possible to bring the number of annual new HIV infections below the annual increase in patients on ART—achieving what many have called a programmatic "**tipping point**" in the epidemic response. The tipping point is not an end in itself, but rather a metric of progress in meeting the needs of the epidemic. Of equal importance is program coverage. Scale-

up of treatment programs to achieve a tipping point ratio of less than 1.0 will lead to increased coverage, but the growth may be insufficient in countries with currently low coverage rates to meet treatment needs.

**PEPFAR country teams are expected to work with national governments and other key stakeholders, including the Global Fund to set aggressive and achievable treatment targets in all countries with a PEPFAR portfolio. The targets should be sufficient, in as short a time as possible, to substantially improve coverage and achieve a tipping point ratio of 1 or less -- the point at which the number of net new persons on ART each year exceeds the number of new infections. PEPFAR country teams are also expected to work with national governments, GFATM, and other donors to budget appropriately to meet the targets, and to define the PEPFAR contribution to the total target.**

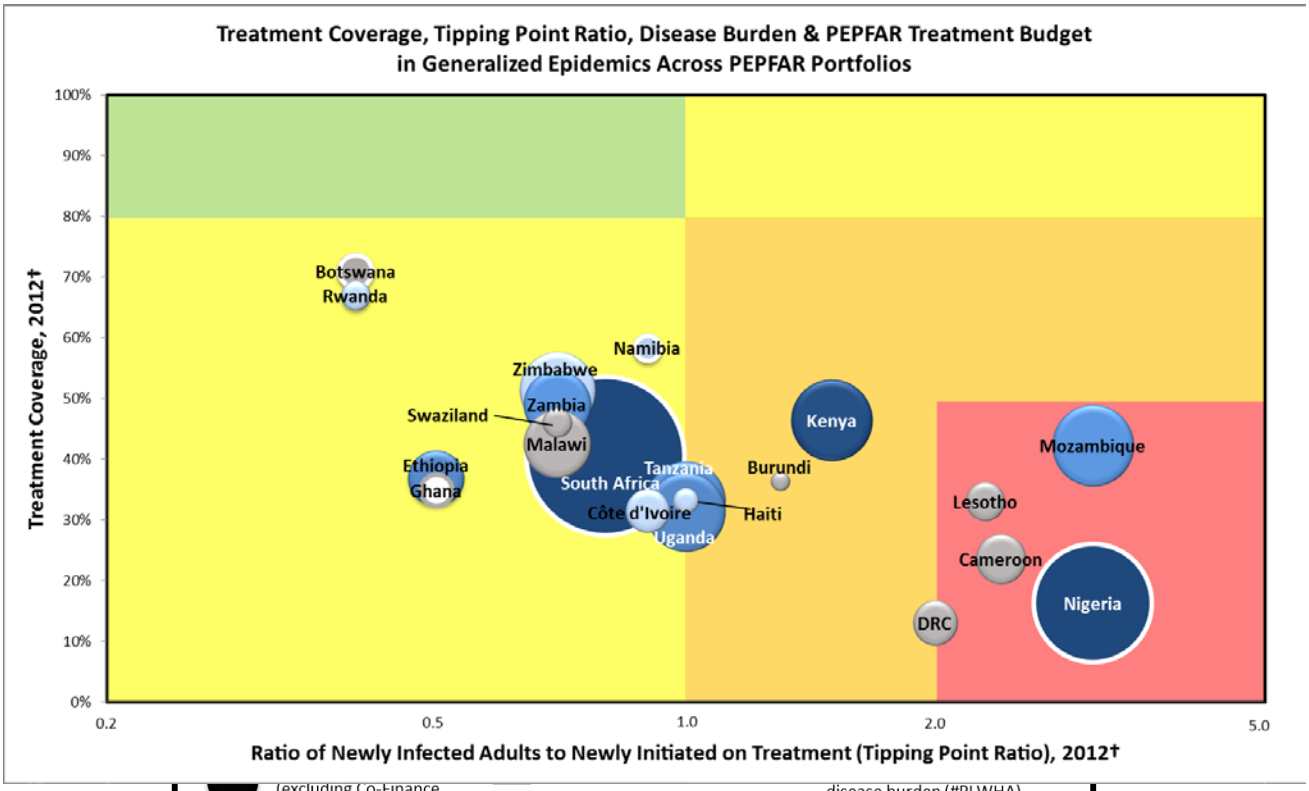
$$\textbf{Tipping Point Ratio} = \frac{\text{\# new infections in year X}}{\text{\# net new patients on ART in year X}}$$

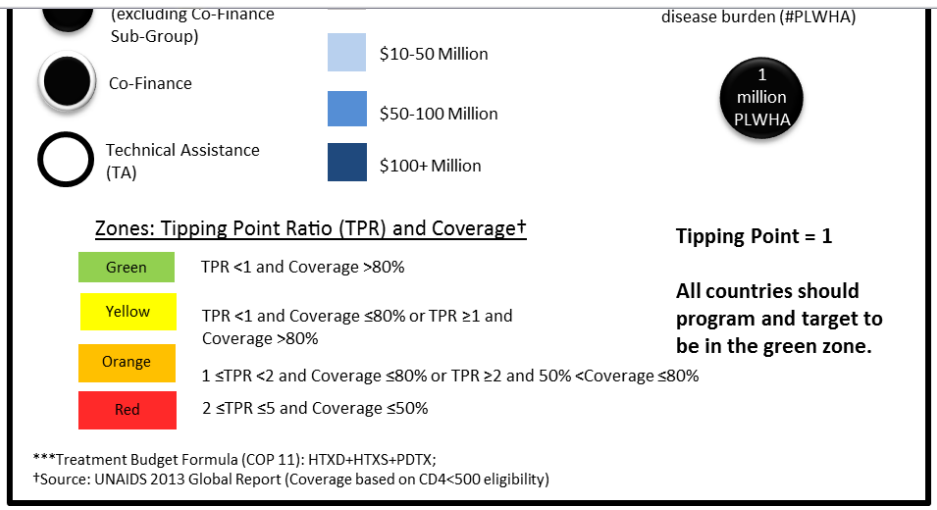
**This recommendation can be realized if PEPFAR, Global Fund, major other financiers and domestic resources are jointly planned for meet the nationally set targets.**

**All Long Term Strategy countries with generalized epidemics are expected to support and complete an AIDS Indicator Survey (AIS) in the 2014-2015 time frame. This is also recommended in other settings across the PEPFAR portfolio. Conducting population-based HIV-focused surveys is a priority for PEPFAR as a means of monitoring epidemics and HIV program impact.** PEPFAR should help support AIDS Indicator Surveys (AIS) though coordination with other donors and using new or old FY funds to ensure that routine AIS are conducted and sample sizes are based on HIV prevalence and are large enough for significant findings to be measured. The surveys must include real time HIV testing, real time CD4 cell counts and viral load to inform program about access to services, HIV prevalence, incidence through the incidence assay, and community viral load and degree of suppression. The Kenya AIS serves as an example that can be adapted to other country contexts.

OGAC expectations for targeting and budgeting are driven by epidemiologic context, PEPFAR level of investment and portfolio type (Long Term Strategy, Co-Financed, and Technical Assistance). The graphic below depicts treatment coverage (at CD4 ≤ 500 cells/$mm^3$), tipping point ratios, HIV/AIDS disease burden, and the level of investment

for countries with PEPFAR portfolios and generalized epidemics. **PEPFAR country teams should support governments as much as they are able within the funding envelopes available, in setting and financing targets to move them into the Green Zone on the graphic, where overall coverage of treatment is 80% or greater (at a CD4 ≤ 500** cells/mm$^3$**) and where the tipping point ratio is 1 or less.**



| Data on Graph and Other Relevant Information | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Country | Adult Tipping Point Ratio (2012)† | Treatment Coverage (2012 CD4 < 350 Eligibility)‡ | Treatment Coverage (2012 CD4 < 500 Eligibility)† | Disease burden (PLWHA (2012)† | PEPFAR Treatment Budget (COP 2011)*** | Total PEPFAR BUDGET (COP 2011) | Global Fund HIV/AIDS Funds Disbursed (2012) | Domestic HIV Spending (2011)†† | PEPFAR + GFATM $ / PLWHA | GDP per capita (2012)† |
| Botswana | 0.4 | 95% | 71% | 340,000 | 9,073,641 | 84,376,709 | - | 295,267,584 | 248 | 7,191 |
| Rwanda | 0.4 | N/A | 67% | 210,000 | 33,663,460 | 115,428,378 | 111,100,000 | 16,635,507** | 1,079 | 620 |
| Ghana | 0.5 | 58% | 35% | 240,000 | 752,824 | 15,000,000 | 21,900,000 | 8,087,144* | 154 | 1,605 |
| Ethiopia | 0.5 | 60% | 37% | 760,000 | 66,901,633 | 287,952,388 | 48,200,000 | N/A | 442 | 470 |
| Swaziland | 0.7 | 82% | 46% | 210,000 | 6,510,810 | 38,800,000 | 3,100,000 | 29,912,310** | 200 | 3,044 |
| Zimbabwe | 0.7 | 79% | 51% | 1,400,000 | 14,310,400 | 57,500,000 | 130,500,000 | 28,061,184 | 134 | 788 |
| Malawi | 0.7 | 70% | 43% | 1,100,000 | 2,414,816 | 65,000,000 | 67,500,000 | N/A | 120 | 268 |
| Zambia | 0.7 | 81% | 49% | 1,100,000 | 71,249,521 | 306,694,631 | 64,300,000 | N/A | 337 | 1,469 |
| South Africa | 0.8 | 83% | 41% | 6,100,000 | 190,269,450 | 548,740,851 | 101,800,000 | 1,019,700 | 107 | 7,508 |
| Namibia | 0.9 | 90% | 58% | 220,000 | 19,681,885 | 102,622,181 | 30,400,000 | 168,791,104* | 605 | 5,668 |
| Côte d'Ivoire | 0.9 | 49% | 32% | 450,000 | 41,812,000 | 105,180,308 | 4,200,000 | 9,477,423** | 243 | 272 |
| Haiti | 1.0 | N/A | 33% | 150,000 | 38,246,211 | 158,542,998 | 15,700,000 | 1,608,233 | 1,162 | 771 |
| Uganda | 1.0 | N/A | 31% | 1,500,000 | 99,946,571 | 298,388,372 | 55,100,000 | N/A | 236 | 547 |
| Burundi | 1.3 | 58% | 36% | 89,000 | 825,707 | 8,500,000 | 13,200,000 | 1,775,383* | 244 | 251 |
| Kenya | 1.5 | 73% | 46% | 1,600,000 | 172,649,013 | 517,287,175 | 58,900,000 | 134,682,272* | 360 | 862 |
| DRC | 2.0 | 29% | 13% | 480,000 | 1,053,000 | 36,250,000 | 74,700,000 | 2,759,539* | 231 | 1,244 |
| Lesotho | 2.3 | 56% | 33% | 360,000 | 1,275,000 | 29,200,000 | 20,500,000 | N/A | 138 | 1,193 |
| Cameroon | 2.4 | 45% | 24% | 600,000 | 11,491 | 14,250,000 | 15,000,000 | 14,395,254* | 49 | 1,151 |
| Mozambique | 3.1 | 45% | 42% | 1,600,000 | 56,720,000 | 268,789,597 | 42,100,000 | N/A | 194 | 579 |
| Nigeria | 3.1 | 32% | 16% | 3,400,000 | 152,755,036 | 488,614,281 | 73,100,000 | 125,139,584* | 165 | 1,555 |
| Tanzania | 1.0º | 61% | 33% | 1,500,000 | 96,220,948 | 357,193,489 | 100,600,000 | N/A | 305 | 609 |
| Guyana | N/A | N/A | 52% | 7,200 | 3,277,331 | 14,881,575 | 700,000 | N/A | 2,164 | 3,584 |
| South Sudan | N/A | N/A | 4% | 150,000 | - | 14,546,000 | 15,300,000 | N/A | 199 | 862 |
| Note: Guyana and South Sudan are not included in the graph because data on net new infections was not available (N/A) | | | | | | | | | | |
| ºDue to concerns about data validity, the ratio shown for Tanzania was calculated using the the increase in new patients on ART directly supported by PEPFAR in 2012 | | | | | | | | | | |
| *2010 data **2009 data ***Treatment Budget Formula (COP 11): HTXD+HTXS+PDTX | | | | | | | | | | |
| †Source: UNAIDS 2013 Global Report ‡Source: WHO Global Update on HIV Treatment 2013 ††UNAIDS 2012 | | | | | | | | | | |

Regardless of portfolio type, PEPFAR teams working with countries in the **Green Zone** *should focus efforts on maintaining the tipping point and high coverage and mapping of potential hot spots.* Improving treatment coverage in all hard-to-reach populations, including pregnant and breastfeeding women, pediatrics, key populations, and in

patients co-infected with tuberculosis, should remain a priority for countries in this zone. Maintaining and improving quality of services, and improving retention and adherence should be priorities for all countries, regardless of the epidemiologic context, but should be especially prioritized in settings where programs to impact the response have been long established. (see Section 3.1.6 for more information on Quality in Clinical Services).

Countries in the **Yellow Zone** are (1) countries with tipping point ratios one or less but with treatment coverage of less than 80%, or (2) countries with treatment coverage at 80% that have not yet reached the tipping point. PEPFAR teams working with countries in the Yellow Zone should develop a plan in coordination with national governments to rapidly increase coverage to 80% and/or increase the number of net new persons on ART each year to reach a tipping point ratio of 1 or less and to bring the country into the Green Zone. Overall, it is expected that countries in the Yellow Zone, especially those with substantial PEPFAR and GFATM investments, should be able to move into the Green Zone over a short time period (1-3 years).

Countries in the **Orange Zone** are (1) those with tipping point ratios between 1 and 2 and coverage of less than 80%, or (2) those with tipping point ratios of more than 2 and coverage of 50-80%. PEPFAR teams working with countries in the Orange Zone should develop a plan in coordination with national governments to accelerate the treatment response, improve coverage, and achieve the tipping point as rapidly as possible. Depending on the size of epidemic, disease burden, and available resources it is expected that countries in the Orange Zone, especially those with substantial PEPFAR and GFATM investments, should be able to move into the Green Zone in 3 years or less.

Countries in the **Red Zone** have tipping point ratios between 2 and 10 and treatment coverage below 50%. PEPFAR teams working with countries in the Red Zone should develop a plan in coordination with national governments to re-evaluate and improve PEPFAR and national treatment scale-up strategies. Disease burden available resources and system gaps in capacity may be significant impediments to scale-up in Red Zone Countries, but scale-up in this setting has the biggest potential for epidemiologic impact. Geographic priority setting is recommended for all countries and is especially important in countries with low coverage and higher tipping points. *Geographic targeting of program effort to areas with high concentrations of people in need of treatment can be used to help make the best use of scarce resources.* Countries in the Red Zone, especially those with substantial PEPFAR and GFATM investments, are expected to make measureable and significant progress in achieving better coverage and a lower tipping point over each COP cycle.

PEPFAR country teams with Long-Term Strategy portfolios across all zones should, and are expected to prioritize budgetary allocations to treatment and related budget codes in the context of other available non-PEPFAR resources, to achieve ambitious treatment goals. Possible exceptions are country teams with Co-Financed Portfolios. Increasing proportional or absolute budgetary allocations to treatment may require that lower impact programs and interventions be de-prioritized and funding reduced. Deviations from this approach will require approval from the Global AIDS Coordinator. Country teams with Long-Term Strategy Portfolios are required to fill out the Treatment Budget Calculator, found in the FY 2014 Country Operational Plan Guidance Supplemental Documents on pepfarii.net and also in Section 10.1 to ensure adherence with this guidance. **A list of country categories can be found in section 5.2.1.**

All teams with treatment portfolios are also expected to complete the Clinical and Treatment Cascade Worksheet, found in Section 10.4. This form will ensure that country teams and headquarters staff both understand the planned year-over-year targets across the Continuum of Care, and the relationship to budget allocations in the context of other available resources including the GFATM.

PEPFAR country teams with **Co-Financed Portfolios** working with countries already in the Green Zone should support transition of financing and management to countries at a pace to maintain high overall coverage and the tipping point ratio, to continue to improve coverage for hard to reach populations, to maintain and improve quality, and ensure retention and adherence. PEPFAR country teams with Co-Financed Portfolios working with the Yellow and Orange Zones countries should support a transition process that allows for and encourages scale-up overall and for hard to reach populations. Transition is not recommended for countries in the Red Zone.

Most PEPFAR country teams with **Targeted Assistance (TA) and Technical Collaboration (TC) portfolios** are expected to have a very limited role, if any, in providing direct treatment-related service delivery. In these programs, financial investments are often more limited, with a focus on capacity building, technical assistance, or other health systems strengthening investments. **PEPFAR system strengthening investments should directly support the national *strategy and should be synergistic* to that of the national response and of other donors.**

**Moreover, funded programs should be clearly linkable to the scale up of combination prevention, including treatment. Finally, the new MER indicators should help TA & TC country teams better document the results of their work over time.**

### 3.1.1 New WHO Guidance: Expanding Coverage While Prioritizing the Sickest

The World Health Organization (WHO) recently released the *2013 Consolidated Guidelines on the Use of Antiretrovirals for the Treatment and Prevention of HIV Infection*. These guidelines significantly expand eligibility for ART and promote simplified treatment regimens. The new guidelines recommend increasing CD4 eligibility criteria to ≤ 500 cells/mm$^3$ for ART initiation regardless of WHO clinical stage. In addition, ART is recommended for HIV-infected partners in serodiscordant partnerships regardless of CD4 count, all HIV-infected children below five years of age and all HIV-positive pregnant and breastfeeding women (Option B or B+, see Section 3.2 on PMTCT).

There are numerous benefits to starting patients on ART earlier (with CD4 counts ≤ 500 cells/mm$^3$) in the absence of other indications, including reduced rates of HIV-related morbidity and mortality, reduced maternal to child transmission, potential reductions in the incidence and severity of non-AIDS-defining chronic conditions (e.g., cardiovascular disease, kidney disease, liver disease, certain cancers, and neurocognitive disorders), and reduction in infectious complications (e.g., tuberculosis). Furthermore, ART substantially reduces sexual transmission in serodiscordant couples, reduces the waiting time for ART initiation, and may also improve retention in care.

Nevertheless, while there are strong clinical reasons for increasing the CD4 eligibility threshold, the decision needs to be placed within the context of each country's current response to the epidemic. The decision to increase CD4 eligibility criteria to ≤ 500 cells/mm$^3$ for ART initiation should be made as part of an overall national strategy. Teams must follow the national guidance, and when countries decide on a direction, support the national process for roll out. WHO and PEPFAR continue to support prioritization of the sickest patients (WHO clinical stage 3 or 4, or CD4 ≤350 cells/mm$^3$) for ART initiation. In settings where adoption of a CD4 threshold of 500 would divert resources away from large numbers of patients with lower CD4 counts, a more gradual transition towards expansion of ART coverage should be considered. Additional information on the WHO 2013 Consolidated ARV Guidelines can be found at: http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf and PEPFAR recommendations for implementation can be found in the FY 2014 PEPFAR Technical Considerations.

Special attention needs to be paid to anticipating commodity needs for breast feeding women separately from the commodity needs for pregnant women who are initiating ART throughout the transition from Option A to Option B+. For example, during the first quarter of Option B+ implementation in Malawi (Q3 2011), about 26% of all those initiating ART were initiated during breastfeeding. In the subsequent two quarters (Q4

2011 and Q1 2012), there was a dramatic increase in those receiving ART during breastfeeding to about 42% of all women initiating ART. For the subsequent 4 quarters (Q2 2012-Q1 2013) those initiating during breastfeeding stabilized at about 27% of all women initiating ART.

### 3.1.2 Pediatric and Adolescent Treatment

An estimated 330,000 children were newly infected in 2012 alone and more than 3 million children are currently estimated to be living with HIV.[2] ART coverage for children under 15 years remains disproportionally low at 34%.[3] HIV progresses very rapidly among infants and children, and without treatment, half of infected children will die by age two years due to HIV and HIV-related increases in common childhood illnesses such as pneumonia, diarrhea and sepsis. There is a tremendous gap in the coverage of treatment for children and adolescents that needs to be addressed in order to reach the global goal of a 90% decrease in new infections among children by 2015 and to provide treatment to all HIV-infected children.[4] Although effective PMTCT programs will reduce numbers of infected children over time, HIV-infected children currently have limited access to HIV services and HIV-related morbidity and mortality among children remain high. As ART access for pregnant and breastfeeding women expands with the transition to Option B and B+ policies, countries have an opportunity to expand and decentralize pediatric care and treatment services in a family-centered, "one-stop-shop" service delivery model that will reduce pediatric morbidity and mortality.

The graph below (UNAIDS 2013 Global Report) represents the achievement in PEPFAR-supported countries, as reported in 2011, towards providing ART to HIV-infected children under age 15 years who were eligible for treatment. Greater emphasis and more aggressive targets are needed in most countries in order to achieve universal treatment coverage for children in need of ART.

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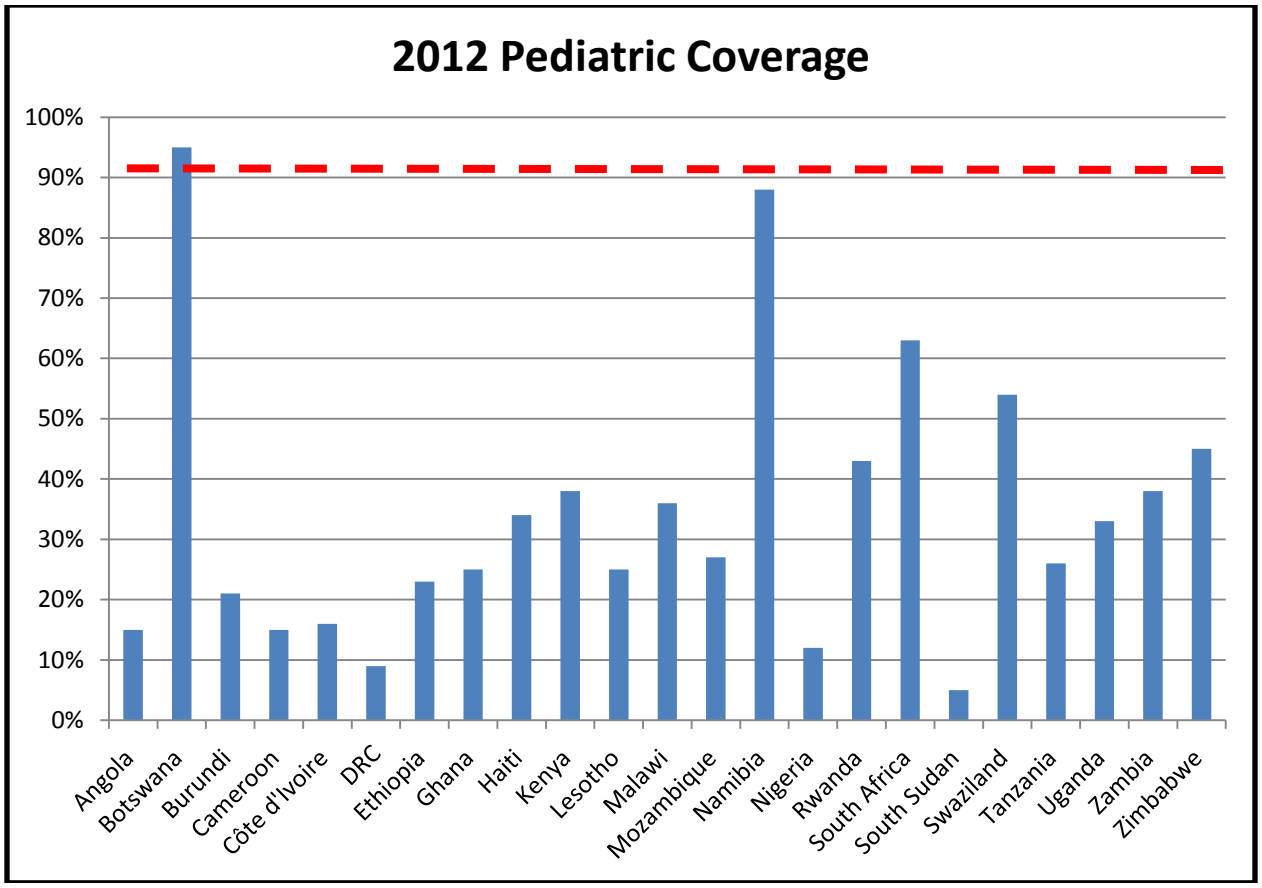
[2] World AIDS Day Briefing, UNAIDS, 2012[2] Global Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, UNAIDS 2013 and World AIDS Day Briefing press release Nov 2012

[3] 2013 Progress Report on the Global Plan. UNAIDS, 2013

[4] UNAIDS. Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. 2011.




*Red Line represents the 90% coverage goal

The table below shows the gap between the number of children that would need to be on treatment to reach 90% (almost universal) coverage of all children in need of ART and the number of children on ART in 2011. The countries highlighted in yellow account for the largest global burden of pediatric HIV.

| Country | Percent of children on antiretroviral therapy (2012) | Number of children on antiretroviral therapy (2012) | 90% coverage goal |
|---|---|---|---|
| Angola | 15% | 2,903 | 17,418 |
| Botswana | 95% | 10,261 | 9,721 |
| Burundi | 21% | 2,023 | 8,670 |
| Cameroon | 15% | 4,992 | 29,952 |
| Côte d'Ivoire | 16% | 5,620 | 31,613 |
| DRC | 9% | 4,751 | 47,510 |
| Ethiopia | 23% | 17,677 | 69,171 |
| Ghana | 25% | 3,504 | 12,614 |
| Haiti | 34% | 2,265 | 5,996 |
| Kenya | 38% | 55,439 | 131,303 |
| Lesotho | 25% | 5,395 | 19,422 |
| Malawi | 36% | 36,441 | 91,103 |
| Mozambique | 27% | 27,164 | 90,547 |
| Namibia | 88% | 11,340 | 11,598 |
| Nigeria | 12% | 31,556 | 236,670 |
| Rwanda | 43% | 7,597 | 15,901 |
| South Africa | 63% | 140,541 | 200,773 |
| South Sudan | 5% | 553 | 9,954 |
| Swaziland | 54% | 7,431 | 12,385 |
| Tanzania | 26% | 32,407 | 112,178 |
| Uganda | 33% | 35,453 | 108,000 |
| Zambia | 38% | 34,084 | 80,725 |
| Zimbabwe | 45% | 46,874 | 93,748 |

(UNAIDS 2013 Global Report)

In order to meet this challenge, there are four key PEPFAR priorities for expanding infant, pediatric and adolescent treatment that are detailed in the pediatric and adolescent technical considerations.

1. Improved case finding of infants, children and adolescents exposed to or infected with HIV
    - Scaling-up early infant diagnosis (EID) systems to provide HIV virologic testing at four to six weeks of age, minimize delays in return of results for HIV-exposed infants, and strengthen linkage to care
    - Ensuring pediatric testing beyond EID, through policies that promote opt-out provider-initiated testing and counseling (PITC), especially in inpatient pediatric wards, malnutrition clinics, TB clinics, OVC programs and other outpatient settings with increased HIV prevalence
    - Implementing and monitoring family-centered or index patient approaches to HIV testing in adult ART, OVC, MNCH, school health, social services, and malaria programs
    - Setting aggressive numeric pediatric HIV testing targets to motivate implementing partners to improve pediatric case finding
    - Ensuring adequate and consistent supply chain for EID and PITC commodities

2. Implementing new WHO treatment guidelines for all children
    - Ensuring implementation of universal and immediate ART initiation for all HIV-infected children under 5 years, regardless of CD4 count or percentage
    - Ensuring that treatment guidelines for older HIV-infected children and adolescents (age 5 years and older) are aligned with adult treatment eligibility criteria
    - Setting aggressive numeric disaggregated treatment targets
    - Ensuring that pediatric HIV services are decentralized along with adult HIV services and made available at the lowest-level possible with skilled health care providers
    - Ensuring consistent supply of efficacious, easy to use regimens with optimal pediatric formulations

3. Retention and linkage of infants, children and adolescents in life-long care and treatment

    - Collecting and analyzing data with age disaggregation whenever possible to improve program planning and identification of gaps in program services

- Ensuring quality improvement activities that address the challenges of following mother-infant pairs and loss to follow-up of children and adolescents

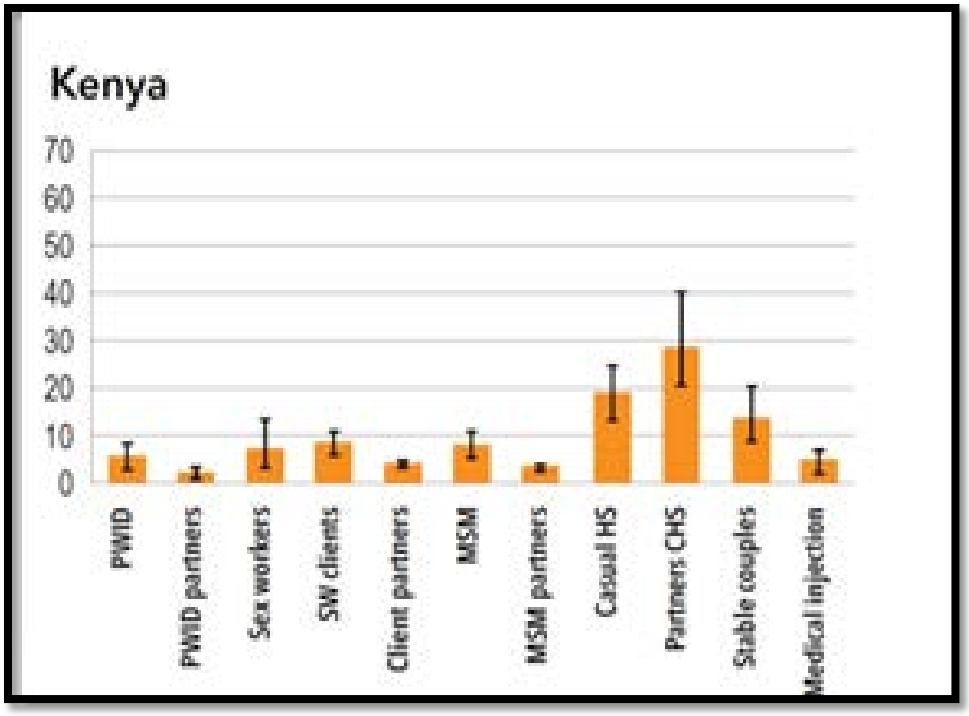
4. Expanding training for healthcare providers and community health workers to build capacity for pediatric HIV testing, care, and treatment and to monitor impact of training through quality improvement, supervision, and mentoring support
    - Improving program quality and outcomes for HIV-exposed and HIV-infected children
    - Supporting national programs to strengthen policy and regulatory mechanisms to build human resource capacity for pediatric HIV services, including through support of task sharing

### 3.1.4 Key Populations

Key populations (sex workers, men who have sex with men, transgender persons, and people who inject drugs) typically have higher HIV prevalence than the general population and account for a large proportion of new infections in most of the world. In light of the growing evidence that ART dramatically reduces the risk of HIV transmission, ensuring access to treatment services for key populations is essential for reaching an AIDS-free generation. Modeling studies commissioned by the World Bank have shown scaling up treatment coverage for key populations, in addition to existing preventive interventions, will lead to overall declines in HIV.[5] Given the presence of key populations in every country and their very high HIV prevalence in most countries, the scaling up of ART should include much stronger efforts to support access to treatment and care for key populations.

The graphic below is drawn from the 2013 UNAIDS regional report[6], "Getting to zero: HIV in eastern & southern Africa" and demonstrates the important contribution key populations make to the burden of HIV, even in countries with generalized epidemics.

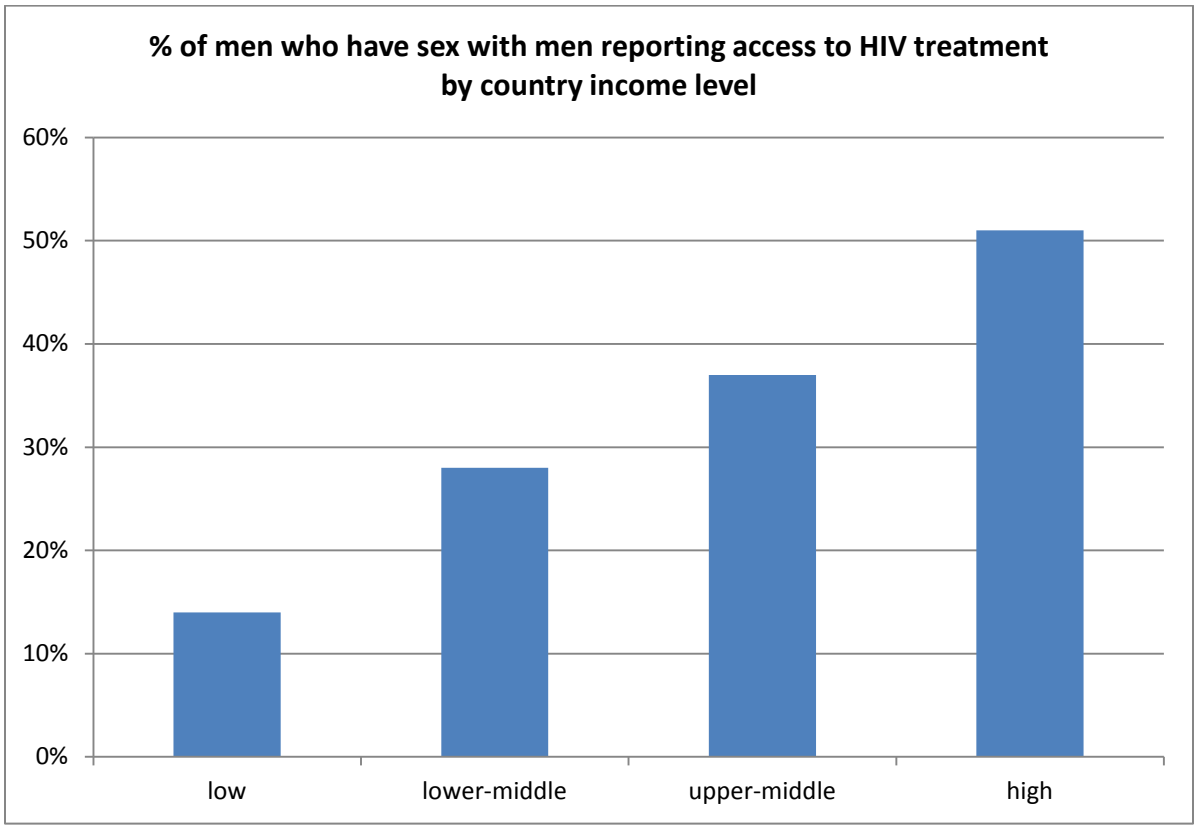
[5] http://www.worldbank.org/en/news/press-release/2012/11/28/increased-targeting-key-populations-can-accelerate-end-global-hiv-epidemic
[6] http://reliefweb.int/sites/reliefweb.int/files/resources/Getting%20to%20Zero.pdf




Discrimination and hostility from health workers deter many key populations from seeking health services. A 2010 international survey found that 56 percent of PLHIV reported experiencing negative attitudes from health workers because they belonged to a stigmatized group; one in four reported being afraid to seek services due to the risk of social disapproval or active discrimination.[7] ART programs should support a non-stigmatizing clinical environment that enables key populations to have consistent and safe access to treatment services, including both facility and community-based care and support.

Whether PEPFAR directly funds treatment or provides technical assistance for ART provision, it is crucial that country teams promote appropriate scale up of treatment coverage for key populations. Global data demonstrate significant inequities in ART access for key populations that must be addressed in order to curb the epidemic. For example, only an estimated 4% of the PLHIV who inject drugs worldwide were receiving ART in 2009, when overall ART coverage among PLHIV globally was estimated at 18%. The graphic below illustrates the deficit in ART coverage for {MSM or PWID}.

[7] UNAIDS 2010

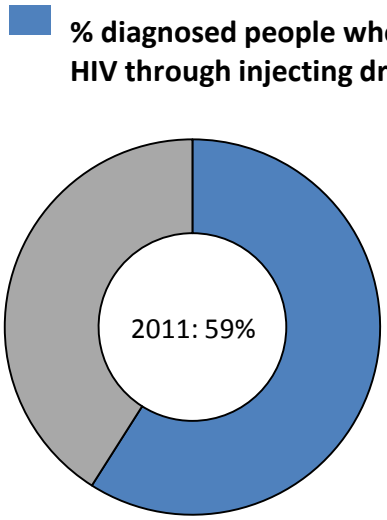


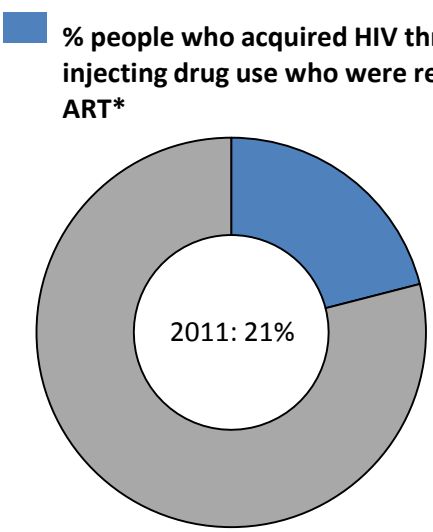

Source – Adapted from WHO Global Update on HIV Treatment, 2013

Reaching key populations with treatment is a high priority for PEPFAR, and country teams should strive for full coverage. Teams should agree on a credible size estimate for each specific key population and use this to determine the target for treatment coverage of key populations (See text box). When no reliable population size estimate is available, teams are encouraged to determine appropriate Key Populations treatment targets based on best available data.

**SIZE ESTIMATE of KP * HIV PREVALENCE of KP * 80%* = Minimum TARGET for number of KPs on ART**

*80% is the estimated amount of KP who would be eligible for ART




*adapted from WHO Global Update on HIV Treatment 2013

The table below provides examples of ART target setting for SWs and MSM in a few countries:

| | MSM | | |
|---|---|---|---|
| | MSM HIV Prevalence | MSM size estimation | Sample treatment target |
| **Côte d'Ivoire** | 50.00% | 133,252. | 53,301 |
| **Kenya** | 18.20% | 457,932. | 66,675 |
| **Malawi** | 21.40% | 275,006. | 47,081 |
| **Nigeria** | 17.20% | 1,207,358. | 166,132 |
| **South Africa** | 9.90% | 1,810,640. | 143,403 |
| **Vietnam** | 11.20% | 285,388. | 25,571 |
| **Uganda** | 13.70% | 499,348. | 54,729 |
| **Zambia** | 32.90% | 371,111. | 97,676 |
| **Indonesia** | 8.50% | 1,095,970. | 74,526 |
| **India** | 4.40% | 2,350,000. | 82,720 |

| | Sex Workers | | | | |
|---|---|---|---|---|---|
| | SW HIV Prevalence | SW size estimation | Adult female population size | SW Size Estimation, % | Sample treatment target |
| **Côte d'Ivoire** | 28.65% | 30,989 | 4427000 | 0.70% | 7,103 |
| **Ghana** | 11.10% | 68,332 | 6212000 | 1.10% | 6,068 |
| **South Africa** | 56.50% | 153,000 | N/A | N/A | 69,156 |
| **Indonesia** | 8.99% | 259,588 | 64897000 | 0.40% | 18,670 |
| **Haiti** | 8.40% | 51,540 | 2577000 | 2.00% | 3,463 |
| **Ukraine** | 9.03% | 47,300 | 11825000 | 0.40% | 3,417 |

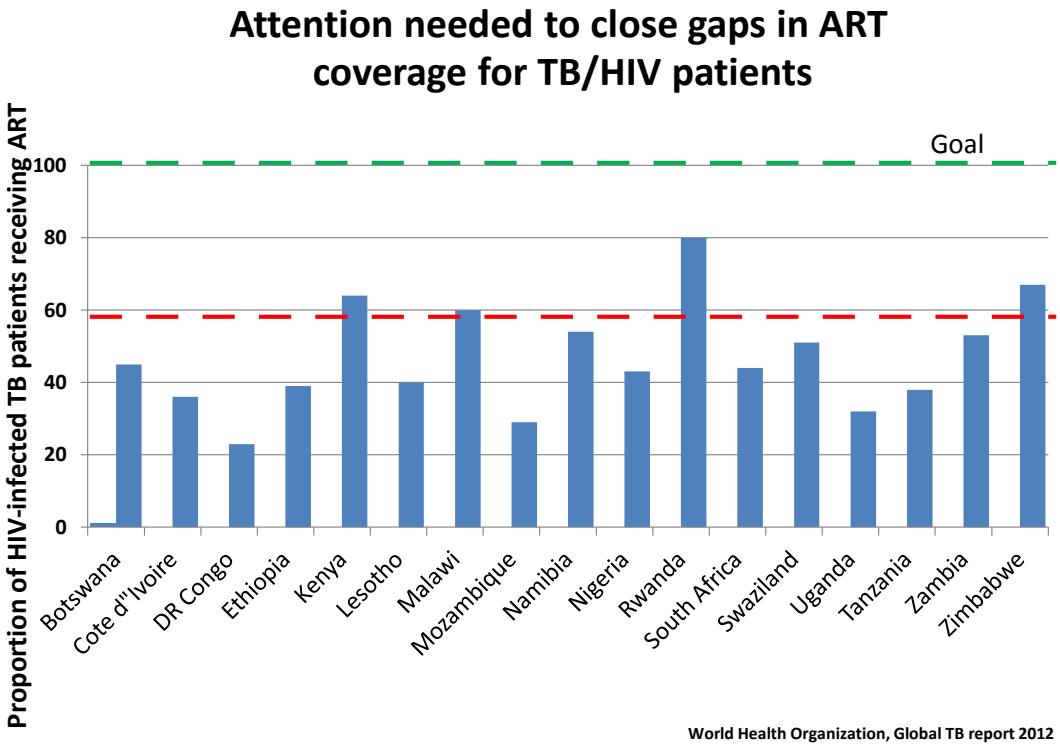
Specific strategies should be employed to reach, test, link, treat, and retain key populations in care and treatment services.[8] These strategies should include monitored linkages between key populations outreach programs and HTC, as well as between HTC and treatment. Peer outreach workers, patient navigators, and case managers can facilitate access to and uptake of ART for key populations. Training health workers on clinically appropriate and non-stigmatizing care for key populations is critical to developing an environment that enables key populations to access and adhere to treatment. Teams are encouraged to use innovative strategies such as co-location of ART services with key population-specific services such as MAT, HTC, or STI screening and treatment.

### 3.1.5 TB/HIV and ART

ART has the potential to contribute substantially to TB control. Early ART substantially reduces mortality (11%, 19%, and 34%, in the SAPIT, STRIDE, and Camelia studies,

8 http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2484_treatment-2015_en.pdf

respectively) in TB patients and prevents TB in co-infected patients.[9,10,11] However, the global response is falling short. In the graph below, the proportion of ART in co-infected patients (the blue bars) in 17 PEPFAR-supported countries is plotted against the global ART coverage. PEPFAR treatment programs should intensify efforts to identify these individuals, link them to care and treatment to reach the goal of starting 100% of TB/HIV co-infected persons on ART.




*Red line – ART coverage among eligible PLHIV

[9] Abdool Karim SS, et al. Timing of Initiation of Antiretroviral Drugs during Tuberculosis Therapy. N Engl J Med. 2010 Feb 25;362(8):697-706.
[10] Havlir DV, et al. Timing of antiretroviral therapy for HIV-1 infection and tuberculosis. N Engl J Med. 2011 Oct 20;365(16):1482-91.
[11] Blanc FX, et al. Earlier versus Later Start of Antiretroviral Therapy in HIV-Infected Adults with Tuberculosis. N Engl J Med 2011; 365:1471-1481.

HIV-infected individuals also have 20–37 times the risk of developing TB compared with HIV-uninfected individuals.[12] A recent meta-analysis of 3 randomized-controlled trials and 8 cohort studies from resource-limited countries that compared TB incidence by ART use in HIV-infected adults demonstrated that ART was strongly associated with a 65% reduction in TB incidence, across all CD4 strata. Increasing coverage of ART in PEPFAR country settings should therefore contribute to reductions in TB over time.

### 3.1.6 PEPFAR Clinical Programs: Monitoring Plus Improvement

As programs mature from an emergency to a sustained response, PEPFAR teams and implementing partners should be increasing their focus on quality and continuous quality improvement. This year, PEPFAR plans to launch a *PEPFAR Quality Strategy* (PQS), first focusing on HIV Clinical Services. The PQS provides country teams with guidance and tools to develop, implement and/or strengthen quality in HIV clinical services with partner governments through a Quality Management, Quality Assurance, and Quality Improvement approach. Technical assistance will be available from headquarters to support implementation.

Integrating quality in overall ART program approach may, for example, facilitate improvement of coverage and scale-up by focusing programs and partners on identification of critical bottlenecks and the institution of real-time improvements. This type of process is also particularly important to systematically ensure linkage from HIV diagnosis to Care and Treatment, retention on ART, and life-long viral suppression. **This year PEPFAR is also developing the forthcoming PEPFAR Linkage, engagement & retention, complementing the model and the principles outlined in the PQS. The strategy sets expectations for retention outcomes in PEPFAR supported programs and provides guidance, best practices and specific tools for implementation.**

Other specific programs related to quality assurance that should be strongly considered for support:

- National plans to ensure and measure quality for clinical services as governments and local partners take on increasing financial and clinical management of the HIV response

[12] World Health Organization. Global Tuberculosis Control 2009: Epidemiology, Strategy, and Financing. Geneva: WHO; 2009

- National framework for support and supervision of ART programs under the umbrella of the national HIV and/or health quality strategy;
- Harmonized quality management (QM) and quality improvement (QI) activities among country teams and implementing partners, which are in alignment with national, Ministry-led, quality plans and initiatives;
- Performance measurement data used for quality improvement at the site level;
- Standardized, periodic supportive site supervision and regular program reviews as an integral part of U.S. government-supported ART programs;
- Geographic alignment processes to focus service provision in areas with highest concentration of HIV transmission, prevalence, and numbers of people in need of services;
- Efficient and effective algorithms for treatment failure monitoring;
- Surveys for HIV drug resistance; and
- National pharmacovigilance systems

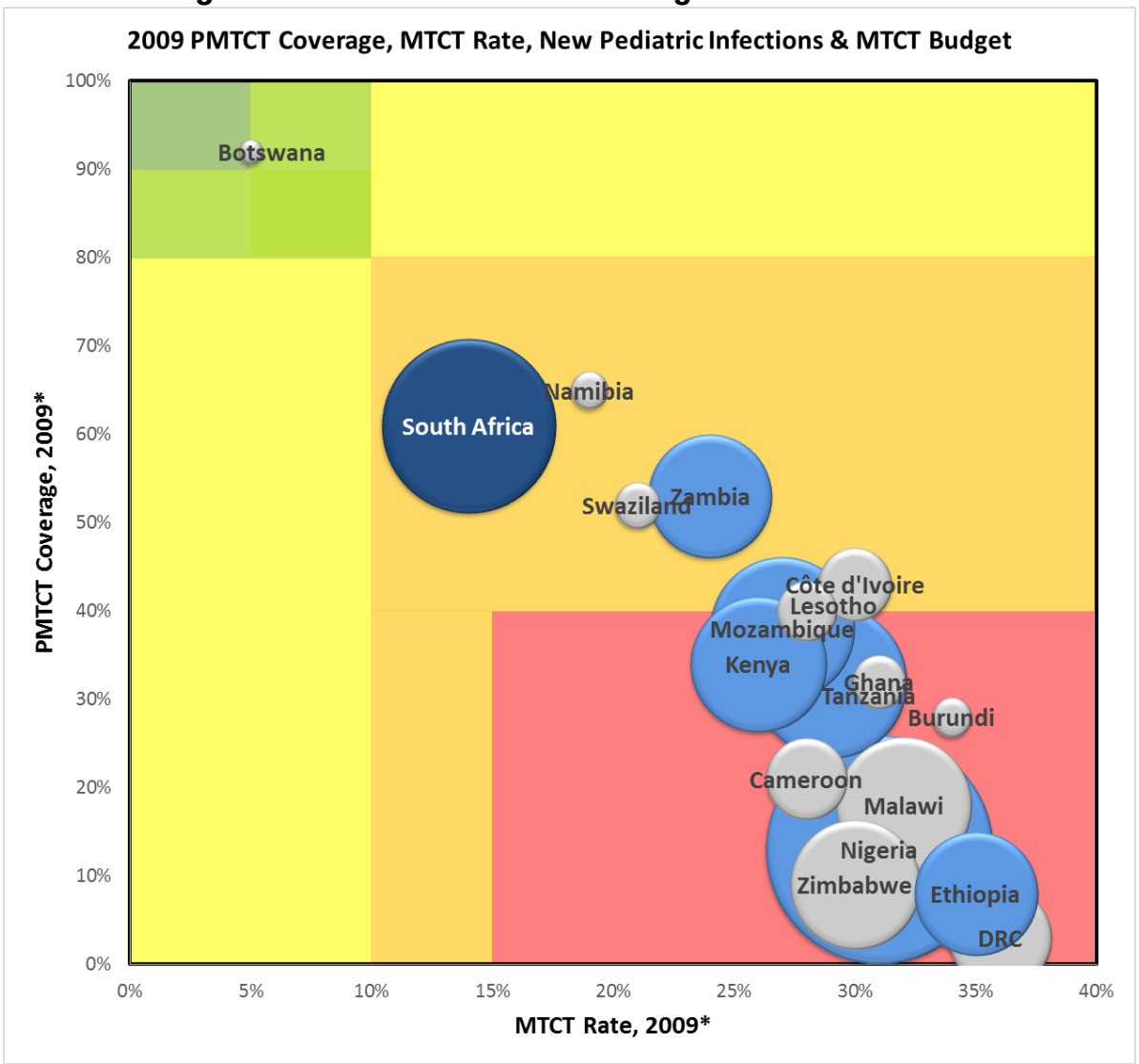
## 3.2 Increase PMTCT Coverage, Effectiveness and Retention

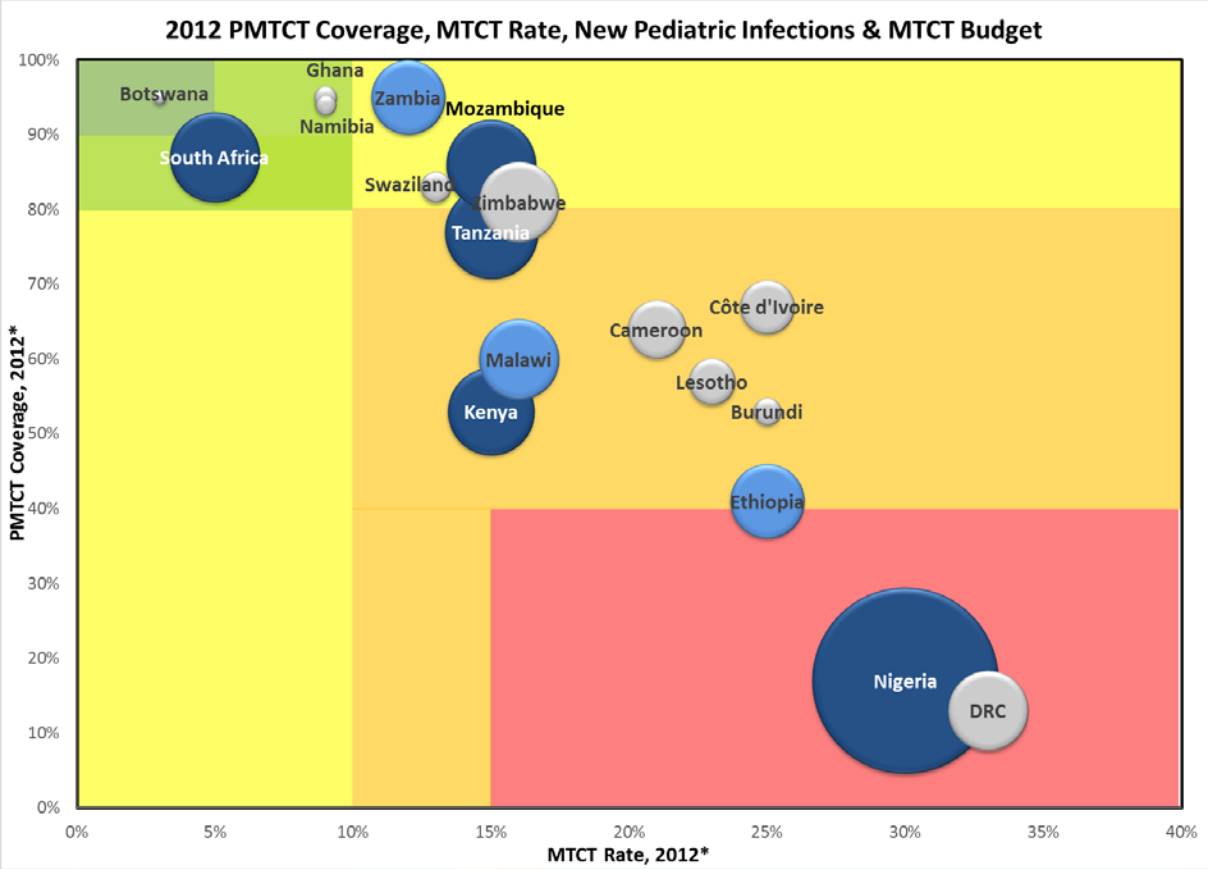
President Obama and Secretary Kerry have emphasized that PMTCT is among the most effective evidence-based interventions needed to achieve an AIDS-free generation and PEPFAR programs should reflect this priority. Antiretroviral treatment of pregnant and breastfeeding women for PMTCT and maternal health is the core intervention to achieve the ambitious goals set forth by PEPFAR, UNAIDS, and other partners in the *Global Plan Towards Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive* (Global Plan).

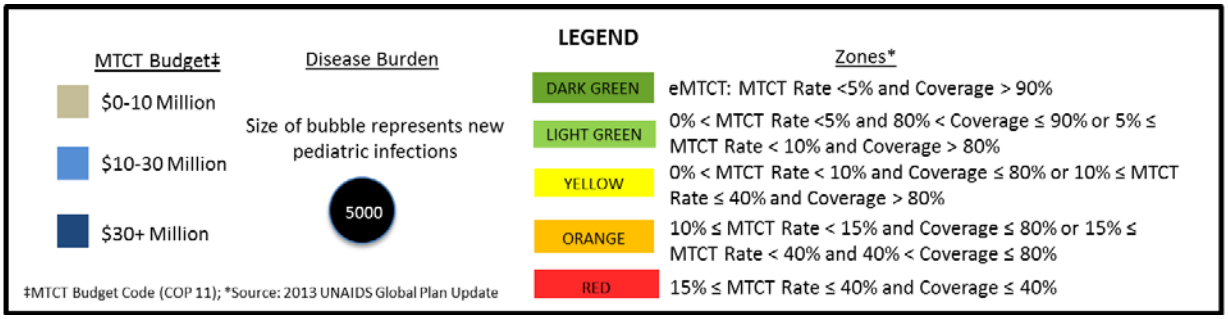
Tremendous progress has been achieved since the launch of the *Global Plan*, with several countries now approaching virtual elimination of vertical transmission (eMTCT) while improving maternal health. A remarkable improvement in the coverage and quality of PMTCT services has been achieved across the highest burden countries – with the overall MTCT rate shifting from 26% in 2009 to 17% in 2012, and the proportion of eligible pregnant and breastfeeding women receiving ART for their own health increasing from 25% in 2009 to 59% in 2012 (UNAIDS, 2013). In order to achieve the Global Plan targets – a 90% reduction in the number of new pediatric infections and a 50% reduction in AIDS-related maternal mortality by 2015 (from 2009 baseline) – PEPFAR programs should continue to provide support for high quality, comprehensive PMTCT services, including facility- and community-based interventions, primary prevention of HIV among women of childbearing age in areas of high prevalence, as well as improving access to voluntary family planning services for all women – regardless of their HIV status.

Given the risk of MTCT during pregnancy and breastfeeding, there is an urgency to initiate all HIV positive pregnant and breastfeeding women on triple ARVs (ART) as soon as possible after identification (Option B or B+). Regardless of their entry point (PMTCT or Treatment program), treatment services, ARVs, and related commodities for eligible pregnant and breastfeeding women should be forecasted, costed, and adequately budgeted for in PEPFAR-supported programs (these costs should also be included in the Treatment calculator and Clinical Cascade worksheet instructions-sections 10.3 and 10.4).

OGAC expectations for targeting and budgeting are driven by epidemiologic context, PEPFAR level of investment and portfolio type (Long Term Strategy, Co-Financed, or Technical Assistance). The graphic below depicts PMTCT coverage, final MTCT rates, burden of new pediatric infections, and the level of investment across the 21 countries representing 90% of the global burden of new pediatric infections. **PEPFAR country teams should support governments in setting and financing targets to increase PMTCT coverage and move them towards virtual elimination of new pediatric infections. The goal is to move countries into the Green Zone on the graphic below, where PMTCT coverage is 80% or greater (90% for eMTCT), and final national MTCT rate is less than 10% (<5% for eMTCT). PEPFAR should also support countries to ensure that all eligible pregnant and breastfeeding women have access to lifelong ART for their own health.**






**All PMTCT programs**, regardless of zone, should be supporting comprehensive PMTCT services in facilities and communities per WHO guidelines:

*Prong 1:* At a minimum all programs should be educating pregnant women about their risks of acquiring and transmitting HIV during pregnancy, promoting condom use, and ensuring access to free or socially-marketed condoms in every PMTCT site.

*Prong 2:* Comprehensive voluntary family planning (FP) services should be integrated in all PMTCT sites and women should be offered FP services regardless of their HIV status.

*Prong 3:* PEPFAR should support countries to implement 2013 consolidated WHO guidelines for PMTCT with a focus in all countries on improving retention in the PMTCT cascade.

*Prong 4:* Dried blood spot (DBS) sample collection for early infant diagnosis (EID) should occur at every PMTCT site, and PEPFAR should support systems to improve results-return. All HIV positive infants should be immediately enrolled in pediatric care and treatment programs. PEPFAR should support countries to ensure that all women requiring lifelong ART for their own health receive it and should support strategies known to improve adherence.

PEPFAR teams working with countries with high coverage of PMTCT services and low final MTCT rates are in the **Green Zone.** These countries *should focus efforts on maintaining and improving the quality of all prongs of PMTCT programs,* as well as improving retention and adherence. Constant quality improvement should be a priority for all countries, regardless of the epidemiologic context, but should be especially prioritized in settings with a mature response (See Quality under section 3.1.6).

Countries in the **Yellow Zone** include those with high PMTCT coverage rates (>80%), but final MTCT rates of over 10%. PEPFAR teams working with these countries should support nationally endorsed strategies known to improve retention in the PMTCT cascade, including use of mentor mothers or expert patients, decentralization of ART services to lower-level health facilities, laboratory sample transport networks, and use of point-of-care technologies for CD4. Countries currently in the yellow zone receiving substantial PEPFAR and Global Fund support are expected to transition to the green zone within 1-2 years.

Countries in the **Orange Zone** include those with moderate PMTCT coverage (40-79%) and final vertical transmission rates of >10%. PEPFAR teams working with countries in the Orange Zone should work with national governments to review existing PMTCT acceleration plans and identify innovative approaches to address bottlenecks and revamp rapidly expand PMTCT coverage. Improving quality should also be a key focus,

with the goal to improve retention in the PMTCT cascade. Countries currently in the orange zone are expected to transition to the yellow zone within 1-3 years.

Countries in the **Red Zone** have PMTCT coverage of <40% and final MTCT rates of >15%. Targeted expansion of high quality PMTCT services in these countries has the greatest potential for epidemiologic impact. Strategic scale-up and geographic priority setting is recommended for all countries, but it is especially critical in countries with low coverage and higher MTCT rates. *Geographic targeting of program effort to areas with highest burden of new pediatric infections is critical to maximizing impact with limited resources.* Countries in the Red Zone, especially those with substantial PEPFAR and GFATM investments, are expected to make measureable and significant progress in achieving better coverage and a lower MTCT rate over each COP cycle and a decline in the number of new pediatric infections nationally.

In FY 2014, PMTCT Acceleration Funds have been rolled into PEPFAR base budgets, rather than given as one-time funds, but U.S. government investments in PMTCT should not be reduced. **All PEPFAR teams that received PMTCT Acceleration or Plus-up Funds in prior years should maintain their PMTCT budget allocation at FY 2011 or increased levels in FY 2014** and ensure that budgets are adequate to meet PMTCT targets**.**

All teams with PMTCT portfolios are expected to complete and submit with the COP the Treatment and Cascade Calculator, found in the FY 2014 Country Operational Plan Supplemental Documents on pefarii and also in Section 10.4. This form will ensure that country teams and headquarters staff understand the planned year-over-year PMTCT, testing, and treatment targets and the relationship to budget allocations in the context of pipeline and other available resources including the GFATM.

### 3.2.1 Support Countries to Initiate All HIV Positive Pregnant Women on Antiretroviral Therapy (Option B/B+)

The new consolidated guidelines from WHO recommend two options: 1) initiation of lifelong triple antiretroviral regimens for all HIV-infected pregnant women and breastfeeding women regardless of CD4 count or WHO stage (option B+), or 2) providing ART during the mother-to-child transmission risk period for pregnant and breastfeeding women with HIV and then continuing lifelong ART for those eligible for treatment (Option B). HIV exposed infants would receive prophylaxis with Nevirapine for the first six weeks of life, regardless of feeding modality.

This approach avoids delays in the initiation of antiretroviral drugs for PMTCT as CD4 testing is not required before choosing between ART for prophylaxis or lifelong therapy and simplifies ARV regimens. Option B+ provides long term prevention of transmission to partners, maternal health benefits, and prevention of transmission in future pregnancies. PEPFAR programs should ensure that all implementing partners support a service delivery model that initiates pregnant and breastfeeding women on ART as soon as possible after identification in order to maximize reduction of MTCT risk while protecting maternal health.

Option A is no longer a WHO-endorsed approach to PMTCT; PEPFAR programs should support countries in transitioning to Option B/B+. While countries are in transition from the Option A strategy of tiered antiretroviral regimens based on maternal CD4 counts, PEPFAR programs are expected to ensure that all ART-eligible women receive lifelong therapy, and to document this as they report disaggregated ARV regimens delivered.

PEPFAR programs should work closely with Ministries of Health and other partners to determine how best to assist with planning and transitioning to option B or B+ in their countries. Implementation of B or B+ should decrease barriers to PMTCT and HIV treatment as services are simplified and decentralized. Antenatal clinics are a frequent point of entry for women to healthcare systems. Scaling up PMTCT programs facilitates reaching HIV positive and negative women with HIV prevention services, and linking mothers and infants to MNCH, SRH, and family planning services. Decentralization of treatment services for pregnant and breastfeeding women to lower level ANC facilities through the PMTCT platform should also extend HIV testing, prevention, and treatment services to male partners and children. PEPFAR teams should work with countries to develop family-centered models of service delivery while addressing the system-level requirements needed to support those models (e.g., enabling regulations for task sharing; pre- and in-service training aligned with required competencies at the service delivery point). PEPFAR should encourage close cross-collaboration between the PMTCT program and treatment and strategic information programs to ensure high quality services and accurate data collection. PEPFAR should also support the meaningful engagement of civil society organizations representing people living with HIV, especially women, in the development of these service delivery models, and as key partners in efforts to monitor PMTCT services in communities and facilities to ensure that the highest quality of care is achieved.

PMTCT programs should include methods to ensure initiation, retention, and adherence to medication for HIV+ pregnant and breastfeeding women, mothers, and infants on ARVs; monitoring of PMTCT sites to ensure quality service delivery; and integration of PMTCT with ART and HIV prevention services for women, their partners, and children. PEPFAR programs should work closely with ongoing MCH programs to ensure maximum

efficiency in use of resources. PEPFAR partners should systematically link HIV exposed and infected children with OVC services wherever available and voluntary family planning services should be made available to all ANC clients – regardless of HIV status – and deliberately integrated into both PMTCT and HIV platforms.

## 3.3 Close Gaps in HIV/TB Collaborative Activities

Tuberculosis (TB) remains the most common cause of death among people living with HIV in sub-Saharan Africa. TB/HIV collaborative activities reflect the key concepts of coordination, collaboration, integration and systems strengthening

Ending HIV-associated TB among PLHIV is possible through a combination of widespread ART coverage, early identification and treatment of TB, isoniazid preventive therapy (IPT), and infection control activities. These high-impact interventions will be critical to achieving the AIDS-Free Generation goals and need to be integral to COP planning and program implementation.

PEPFAR has made important strides in expanding the number of patients with TB tested for HIV; yet there is more work to be done. In many PEPFAR supported countries, especially in Sub-Saharan Africa, HIV prevalence among people with TB ranges from 40-80%. According to the 2009 revised WHO ART guidelines, all people with TB disease and HIV infection (hereafter TB/HIV) should be initiated on ART irrespective of their CD4 count. This is critically important, as a growing body of evidence suggests that initiating ART soon after starting anti-TB treatment significantly increases survival among people with TB/HIV. TB clinics are therefore high yield sites for identifying persons living with HIV eligible for ART. Despite the WHO recommendations, only 46% of PLHIV diagnosed with TB were started on ART in 2011. This represents a huge missed opportunity to avert preventable deaths among almost 250,000 PLHIV.

The PEPFAR Blueprint for an AIDS-free Generation highlights PEPFAR's commitment to scaling-up TB/HIV scale-up as a smart investment in places where HIV is prevalent. PEPFAR teams should develop programs and allocate sufficient resources to mount a comprehensive response across the spectrum of TB/HIV activities.

In a resource-constrained environment, PEPFAR teams must define priorities and make intentional resource allocation decisions that are driven by certain impact.

Across the cascade of TB/HIV services, the COP should reflect these priorities:

1. Ensure HIV testing for persons diagnosed with TB and immediate access to ART for patients with TB that are infected with HIV.
2. Support integration of TB/HIV care and treatment to ensure linkage and retention.
3. Implement, track, and report on TB screening of PLHIV, follow-up for PLHIV that screen positive, and provide isoniazid preventive therapy (IPT) for PLHIV who do not have active TB disease.
4. Support TB infection control measures to prevent transmission of TB in healthcare and community settings.
5. Expand interventions to improve early diagnosis and treatment of TB among PLHIV and support scale-up of Xpert MTB/RIF assay.
6. Strengthen TB/HIV program monitoring and evaluation (M&E)
7. Ensure that children and other vulnerable populations (people in prisons, miners, people that use illicit drugs or abuse alcohol) are included in all TB/HIV program components.

## 3.4 Focus HIV Testing and Counseling on Identifying PLHIV and Linking to Care and Treatment

Knowledge of HIV serostatus is fundamental to the prevention, care, and treatment of HIV. Increasing knowledge of serostatus among PLHIV and getting those PLHIV effectively linked to care, should be the focus of all PEPFAR-funded HTC programs.

HTC programs should be strategic, with an emphasis on testing those populations with highest prevalence and the greatest number of undiagnosed PLHIV, and attention to yield of PLHIV per program. All programs should strive for early enrollment in care and treatment for PLHIV, both for the benefit of the individual, and to achieve maximum prevention benefits; special attention should be paid to identifying PLHIV eligible for immediate treatment. In most cases this includes discordant couples, PLHIV with TB, and in countries supporting PMTCT Option B+, pregnant women. As countries come into alignment with new WHO guidelines, PEPFAR HTC programs should prioritize additional populations eligible for immediate treatment, such as children under 5 years of age (see section 3.1 on Treatment for Health and Prevention).

FY 2014 COP-supported HTC programs should focus on:

1. Using prevalence data, treatment targets and existing service coverage to set targets for HTC;
2. Using a range of cost-effective and innovative approaches to make HTC accessible and acceptable to a wide range of populations, including key

populations (PWID, SW, MSM/ TG) and adolescents at risk who may not be served by traditional HTC programs; and

3. Implementing explicit strategies to ensure that individuals, couples, and families are linked with appropriate follow up HIV treatment, care and support, and prevention services based on their serostatus. All PEPFAR programs should be working to link 100% of HIV positive people to care and treatment, and measuring rates of linkage between testing and treatment programs.

## 3.5 Focus sexual prevention on specific populations at high risk and scale up key interventions

At the level of national strategies, PEPFAR prioritizes the scale-up of condom programming, PMTCT, VMMC and treatment as the most effective investments both for preventing new infections and for treating people living with HIV.

At the level of implementation, PEPFAR recognizes that effective HIV prevention requires packages of interventions, tailored to the specific populations most at risk of acquiring and transmitting HIV. These packages may need to include behavioral and structural components, as well as the above-mentioned biomedical components, in order to successfully avert new infections.

All PEPFAR prevention programs should be consistent with the 2011 PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections, as well as with guidance documents for more specific populations. In FY 2014 and going forward, PEPFAR-funded prevention programs should:

1. Use local epidemiology to identify specific populations most like to acquire and transmit HIV;
2. Address these populations with specific packages of interventions that include at a minimum promotion, and where appropriate provision, of condoms as well as documented links to clinical interventions;
3. Measure coverage of these interventions using the best available data on population size; and
4. Strengthen and improve access to institutions and services, especially primary health care institutions.

Sex workers (SW) and people living with HIV (PLHIV) should be priority populations in every PEPFAR program unless government or other donors are already providing prevention activities for them. All PEPFAR OUs should periodically collect data on MSM/TG populations. Where warranted by data or context (e.g. existing or growing

drug trade route), data should be collected on people who inject drugs (PWID). All studies of key populations (MSM/TG, SW, and PWID) should be conducted in a way that minimizes risk to members of those populations. PEPFAR teams should ensure programs for these key populations when warranted by the data.

### 3.5.1 Scale up Voluntary Medical Male Circumcision

Voluntary medical male circumcision (VMMC) is a one-time, relatively quick procedure that reduces men's risk of heterosexually acquiring HIV for a lifetime. In 14 priority countries with generalized HIV epidemics where male circumcision is uncommon (either nationally or regionally) VMMC has the potential to dramatically reduce the rate of new HIV infections at a cost savings. Mathematical modeling suggests that if 8 out of 10 adult men will choose to become circumcised within 5 years, approximately 3.5 million new HIV infections may be prevented in 15 years, saving as much as $16.5 billion in HIV care and treatment costs. In 10 of the 14 priority countries, one case of HIV may be prevented for every 10 or fewer men who become circumcised in this scenario. VMMC programs also offer unprecedented opportunities to engage men in health education and counseling, notably HIV testing and counseling services. Furthermore, men who are identified as HIV-positive by VMMC programs are referred for HIV care and treatment, broadening the potential community-level HIV prevention benefits of the program. As HIV prevalence decreases in men as a result of becoming circumcised, women's probabilities of encountering HIV-infected partners are also reduced. In fact, almost half of the new HIV infections that may be prevented are among women, if scale-up is rapid, as described in the above modeling scenario. Women with circumcised male sex partners also have reduced risk of sexually transmitted infections, including carcinogenic strains of HPV, and cervical cancer.

The Male Circumcision Technical Working Group (MC TWG) is encouraging PEPFAR VMMC programs and implementing mechanisms to focus demand creation efforts toward males 10-29 years of age, and HIV negative men at particularly high risk of heterosexual HIV acquisition, such as men in discordant heterosexual relationships. This new focus on creating demand among a lower age group is based upon refined modeling exercises being undertaken at the time the 2014 COP Guidance documents are being cleared. Additional information will be forthcoming to assist PEPFAR teams with engaging partner governments in discussions of the benefits of focused demand creation among 10-29 year old males. **To clarify, PEPFAR-supported VMMC services must remain available to males 30 years and above; this new recommendation only pertains to focusing demand creation efforts on those 10-29 years of age.**

Safety and quality are the highest priorities for VMMC programs, and mechanisms for assessing and ensuring ongoing quality and safety of services must be in place. PEPFAR's MC TWG conducts interagency external quality assurance (EQA) assessments to objectively gauge the safety, quality, and compliance of programs with clinical standards of care, international best practices, and PEPFAR Policy Guidance. Though EQA assessments may occur on an as-needed basis, continuous quality improvement (CQI) self-assessment should be routinely conducted at all PEPFAR-funded sites and coordinated with EQA assessments, where and when EQA activities occur.

The pace of scale-up of the VMMC program increased dramatically in FY 2013 with the assistance of additional central funding to boost performance toward PEPFAR's target of 4.7 million VMMC s through December 2013. PEPFAR country teams are expected to further this expansion of services in 2014 and beyond by fully funding and actively supporting the most ambitious VMMC programs that they can responsibly manage. Countries that must limit their FY 2014 target due to funding constraints, once all considerations of pipeline reprogramming and reallocation of resources have been taken into account, should alert the HQ Male Circumcision Technical Working Group (MC TWG) of the funding gap and consequent target shortage. A fully funded budget must reflect an appropriate unit price and meaningful target, both of which should be discussed with the MC TWG prior to submission of the 2014 COP and based upon recommendations outlined in the 2014 Technical Considerations for VMMC Programs. The 2014 COP should include activities, and appropriate funding, that reflect the WHO's pre-qualification (PQ) of the PrePex device in FY 2013, and the anticipated PQ of Shang Ring in early FY 2014, as applicable. Introduction and incorporation of device-based VMMC services are likely to result in increased costs, such as training, supply chain, and communications-related costs. Country teams should be in frequent contact with the MC TWG through their CSTL as they encounter successes and difficulties, including those related communications, as the MC TWG established a Communications Sub-group to provide communications-specific TA to VMMC programs.

### 3.5.2 Condom Promotion

Condoms are an integral part of PEPFAR's prevention, care and treatment portfolios. Safe, effective and affordable, condoms should be actively promoted and available wherever PEPFAR-supported programs come into contact with sexually-active adults. This includes all clinical sites and community programs, unless those activities are focused exclusively on children. Male condoms should always be part of these promotion and distribution activities; female condoms should be included where programs can be successfully initiated and maintained.

All condom promotion programs should include, at a minimum, instruction in condom use with appropriate models. Where possible, beneficiaries should have the opportunity to practice with models, so that staff can ensure correct use.

PEPFAR encourages a total market approach to condom programming, supporting healthy public, private and socially-marketed sectors. Certain populations need access to free condoms in order to ensure consistent and correct use; reaching these populations with condoms and condom promotion should be a top priority for all PEPFAR programs. At the same time, large populations of sexually-active adults in PEPFAR countries can afford to buy condoms, especially where strong social-marketing programs exist. These populations should be encouraged to purchase condoms, in order to build strong habits of condom use and maintain the sustainability of condom programs long-term. For more information on condom programming, see the PEPFAR 2014 Technical Considerations.

### 3.5.3 Key Populations

PEPFAR and UNAIDS define key populations (KP) as men who have sex with men (MSM), transgendered individuals (TG), sex workers (SW), and people who inject drugs (PWID). These populations are a focus for HIV programming because they tend to have high rates of infection *and* because they are typically deeply stigmatized and marginalized. In many countries around the world, these populations are targeted with extreme levels of violence and abuse. These factors can make it difficult for some members of KP to access critical HIV services.

Every PEPFAR prevention portfolio should include programs and/or technical support for relevant key populations in the country or region. Effective national programs for key populations should aim for coverage of at least 80% of the population and should address the following key elements:

- Implementation of core HIV prevention interventions, including community mobilization and empowerment; peer outreach and education; targeted behavior change communication; risk reduction counseling and skills training; HIV testing and counseling; condoms and lubricant promotion and distribution; STI screening, prevention, and treatment; HIV counseling and testing; screening and vaccination for viral hepatitis; linkage to family planning; medication-assisted therapy for PWID; and linkage to and provision of HIV care and treatment (including adherence support).

- Training of health professionals and providers of community-based HIV services to increase the capacity for delivering high-quality prevention and care services

for key populations that are affirming, free from discrimination and ensure the confidentiality of all people who receive these services.

- Collection and Use of Strategic Information such as assessments of laws, policies, regulations and barriers that impede the implementation of comprehensive HIV prevention interventions for key populations in order to address structural barriers; size estimation activities to help countries set targets for access to HIV prevention, treatment and care for key populations; ongoing HIV/AIDS surveillance that provides epidemiologic and demographic data on key populations; and rapid assessments using multiple qualitative and quantitative methods to better understand the behavioral and HIV transmission dynamics and estimate coverage needs and costs to have an impact on the HIV epidemic.

- Epidemiological, Social Science and Operational Research to better understand HIV risk and its prevention among key populations and their sex partners; identify the most effective interventions for key populations within each epidemic context; support delivery of high-quality services; evaluate innovative strategies to improve and strengthen comprehensive HIV prevention services for key populations; promote the development and strengthening of key populations organizations that provide HIV prevention and related health services; and support laws, regulations and policies that foster effective HIV prevention efforts for key populations.

- Monitoring and Evaluation of programs and intervention through the use of standardized indicators, including those developed by WHO, UNODC and UNAIDS, for each core intervention component to monitor accessibility, availability, quality, coverage and impact.

- Commodity Procurement of condoms and condom-compatible lubricants and other commodities, including methadone, that are essential to the delivery of effective HIV prevention care, and treatment services for key populations.

### 3.5.4 Linkages

Successfully linking beneficiaries from one intervention or platform to another is critical to the overall success of all of PEPFAR's programs. Ensuring that clients testing positive for HIV in any setting are successfully linked to care programs and, when eligible, to treatment is of paramount importance.

PEPFAR partners have been increasing efforts to ensure linkages in recent years, employing a variety of tools and approaches both to help patients connect from one

service to another, and to measure rates of success. All PEPFAR country teams should be actively working with implementing partners and partner governments on activities to optimize linkages to and between clinical services, with a focus on linkages between HTC, VMMC, TB, KP and care and treatment programs. FY 2014 COP submissions should include information on these efforts in the appropriate implementing mechanism and budget code narratives.

The FY 2014 Technical considerations provide advice on linkage throughout the document and the new PEPFAR Monitoring, Reporting and Evaluating Guidance outlines indicators for tracking linkage and referral. In addition, the forthcoming PEPFAR Linkage and Retention Strategy will also provide high-level guidance to teams on strengthening and measuring linkages.

## 3.6 Linking Impact Mitigation in OVC Programs to Clinical Interventions

The following principles undergird all PEPFAR OVC programming, as per the 2012 OVC Programming Guidance:

- Strengthening families as primary caregivers of children.
- Strengthening systems to support country ownership, including community ownership.
- Ensuring prioritized and focused interventions that address children's most critical care needs.
- Working within the continuum of response to achieve an AIDS-free generation.

The fourth principle, "working within the continuum of response" speaks to linkages that are and can be made between infection related goals within the epidemic response and the socio-economic impact mitigation goals that are a specific part of the OVC mandate. **When considering OVC interventions and program implementation, all actors should intentionally consider how all of the interventions planned fit into the HIV/AIDS Continuum of Response (COR) to achieve an AIDS-free generation.**

The CoR approach addresses the lifetime needs of the target populations to assure adequate access to a wide range of prevention, care and treatment services based on the changing needs and circumstances of the families that are being served. OVC programs find their place in the continuum by considering the ways in which HIV/ AIDS is a bio-social event and how the different interventions advance the goal of an AIDS-free generation. **OVC programs can and do support the clinical goals of the response in key and mutually-beneficial ways.** For example, treatment keeps parents alive and economically productive, while economic strengthening activities help

remove barriers to accessing facility-based services. In addition, OVC community-based programming helps to reduce stigma and discrimination and create an enabling environment for people infected and affected by HIV/AIDS to access services. By addressing socio-emotional effects of the epidemic, OVC programs reduce the likelihood of children and adolescents moving from being affected by the epidemic to becoming infected with HIV.

It is important to remember that beneficiaries of PEPFAR programs and services spend most of their daily lives and make most of their decisions in their households and communities. Therefore, clinical goals are affected by what happens at a household level. OVC programs operate at the household and community level and often explicit linkages and support to clinical services are made, both for children and for caregivers. Currently, these linkages often happen in a more organic and less structured fashion. Therefore data on linkages between community-based OVC programs and clinical responses is limited. **For FY 2014 making such linkages more intentional and monitoring them for impact is a key objective for OVC programs.**

For example, including mothers from vulnerable households who are in PMTCT programs in household economic strengthening may help reduce loss to follow-up. At the same time, integration of secure attachment and stimulation messaging into these mothers' groups can help support overall healthy development for children affected by AIDS. In addition, using the new indicators required for the FY 2014 COP, OVC programs will be asked to track support activities that increase access to clinical services as well as engage activities that support the overall outcome of caregivers knowing the status of children in their care. All of these measures can help ensure that strong two-way linkages are made between clinical and OVC community-based services.

## 3.7 Strategic Information

### 3.7.1 Implementation Science and Impact Evaluation

**Implementation Science**

PEPFAR programs must continue to demonstrate value and impact to be prioritized, especially in resource-constrained environments. In order to refine programs to achieve this impact, PEPFAR has adopted an implementation science (IS) framework. IS seeks to understand and inform how to best deliver public health programs. IS

encompasses a broad spectrum of evaluations aimed at improving the effectiveness and efficiency of program implementation by testing new approaches for implementation.[13] The PEPFAR IS framework is intended to:

- Emphasize impact evaluations (IEs) for PEPFAR programs
- Ensure the dissemination and use of evidence in decision-making and the adoption of best practices across PEPFAR programs
- Prioritize analysis of costs and cost-effectiveness of programs
- Guide policy and program development
- Inform the global community on best practices
- Align with overall PEPFAR and other U.S. government standards for program evaluation

There is a distinction between the routine monitoring and evaluation of programs using PEPFAR standard Annual and Semi-Annual Program Results metrics or other indicators and PEPFAR evaluations that seek to ascertain whether changes in outcomes can definitively be linked to the program of interest. Impact evaluations, which permit the causal attribution of outcomes to programs, are the gold standard methodology underlying IS. These could include effectiveness studies that examine whether changes in program implementation produce better outcomes, or comparative effectiveness studies that compare the outcomes of different methods of implementation.

## Impact Evaluations

Impact Evaluations (IEs) aim to establish a causal relationship between program and impact by comparing actual impact to what would have happened in the absence of the program, the counterfactual scenario.[14]
PEPFAR IEs should be driven by in-country priorities, and proposals should be submitted with the COP directly into FACTS Info under supplemental documents.
The new IE review and approval process will ensure the timely review of and funding for high quality evaluations that provide real-time, programmatically linked evidence on impacts for in-country implementation. This streamlined process will not include a centralized protocol review; however, Internal Review Board (IRB) functions for studies will go through agency, partner, and country institutions as appropriate.

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[13] Padian NS, Holmes, CB, McCoy SI, Lyerla R, Bouey PD, Goosby EP. Implementation Science for the US President's Emergency Plan for AIDS Relief (PEPFAR). *Journal of Acquired Immune Deficiency*
[14] ibid

For additional guidance on submission and review please see Supplemental **FY 2014 Technical Considerations Guidance**. If you have questions, please contact PEPFAR_ORS@state.gov.

**Research Capacity Building Workshop**

The Office of Research and Science (ORS) will offer 1-2 regional IE proposal-writing workshops annually. Participating countries will be asked to bring ideas for possible IEs, which will be developed with technical assistance from the ORS team over the course of the five-day workshop. After completion, Country Teams will submit the resulting IE proposals for the FY 2014 COP into a fast-track review process.

**Ongoing/Closed Public Health Evaluations (PHE)**

As noted in last year's COP guidance, the PHE process has ended. For prior year PHEs with concepts approved between 2007–2010 and that are ongoing, please continue to follow the existing process for PHE protocol review and annual progress reporting, which is separate from the COP and detailed below. There is no additional funding for PHEs and this will be the final year OGAC will disburse central funds to countries for the purpose of conducting PHEs. Existing PHEs are expected to finalize and close out

As in prior years, all ongoing PHEs are required to submit an annual progress report via email to PHEProtocols@state.gov. Progress reports for previously approved PHE activities continuing into FY 2014 will be due on **September 15, 2014.** For all PHE activities that were completed or that ended in the previous year, closeout reports should be provided. Please see the *PHE Progress Report Guidance* on for additional information. Studies failing to demonstrate progress in the last year will be considered for termination.

- PHE Protocol Submission Guidance
- PHE Progress Report Guidance
- FY 2014 Budget Template for PHE Progress Reports

**Contact**
For PHE-related questions, please email PHEProtocols@state.gov.

## 3.7.2 Health Information Systems

With a definitive plan for moving towards an AIDS-free generation, PEPFAR is well positioned to focus additional planning on strategic investments in health information

systems (HIS) with the potential to put into place a robust technological infrastructure that could be transformational to the countries we serve.

PEPFAR is implementing a two-pronged strategy designed to address the most pressing issues in the HIS domain: (1) realizing the Third One in the Three Ones (one national M&E system); and (2) leveraging PEPFAR's investment in numerous significant yet disparate health information systems by promoting a common interoperability approach.

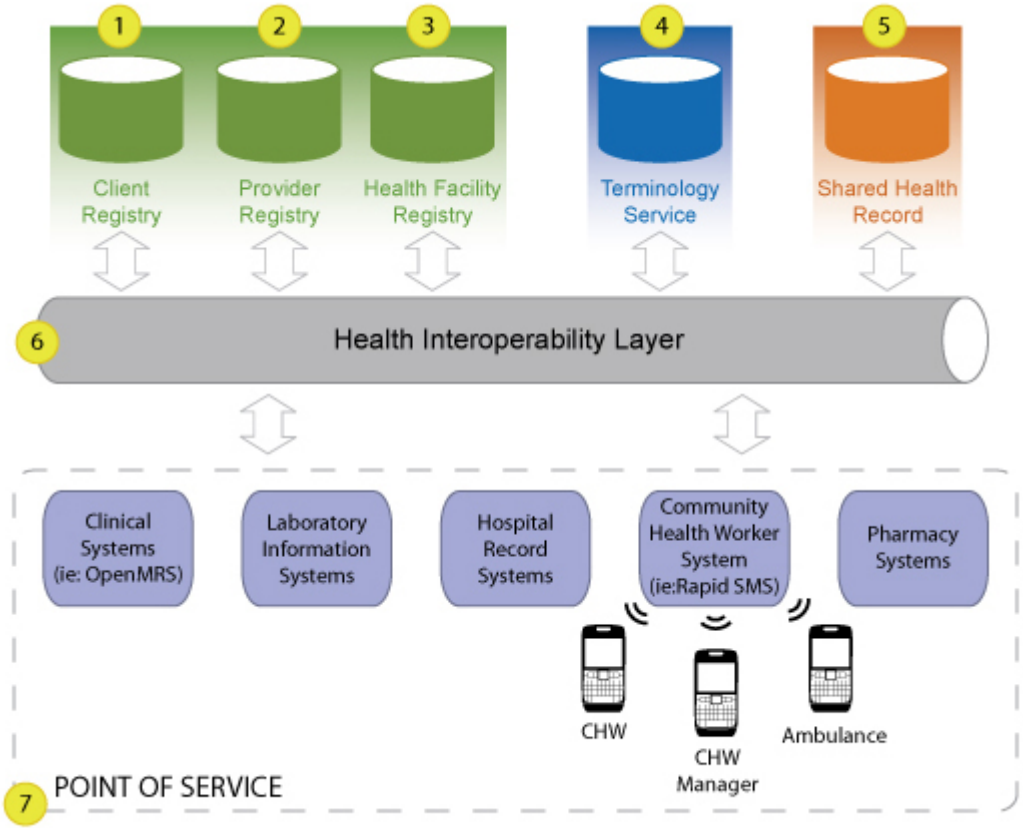
**One National M&E System** and Master Facility Lists

Alignment with (and strengthening of) host government systems has been a pillar of PEPFAR programs consistent with the principle of "Three Ones." PEPFAR prioritizes support for the implementation of national M&E reporting systems (like DHIS2). Most host government Ministry of Health information systems collect and report M&E data at the level of the health facility. In order to make PEPFAR program M&E data of greatest use to host country ministries, PEPFAR systems must be compatible with their HIS and must also be collected at the level of the local health facility. This will require that PEPFAR Implementing Partners report semi-annual and annual program results with reference to the health facility (or community – for non-facility-based indicators) in which they occur. While always implicit in PEPFAR partner reporting, facility and community level reporting will now be required. In addition to increasing our alignment with host government systems, reporting at the facility (or community) level will also further our internal program data quality goals.

In order to fully align results between the national program and the PEPFAR subcomponent, facilities will have to be referenced in a common manner, requiring the development of a Master Facility List. The World Health Organization (WHO) has determined that "Developing and maintaining a comprehensive Master Health Facility List (MFL) is a cornerstone in monitoring the health infrastructure and the services provided to the population." SAPR 2014 Guidance will contain a detailed elaboration of this process, including approaches to building MFLs and an identification of OGAC-provided systems and tools designed for country teams to use. As results will be reported by Implementing Mechanism at the facility and community level, it is important to note that beginning with **the FY 2014 COP, Indicator Targets are now required for all Agencies at the Implementing Mechanism level** (see section 7.3).

**Supporting country-led development of national technical frameworks that prioritize information-sharing (interoperability) between disparate health information systems**

Health systems depend on many types of information related to patients, health care providers, health facilities, and health conditions. This vital information is often collected within disparate systems in varying formats with little harmonization or communication between systems making it hard to know what information is most complete or up-to-date. Continuity of care relies on interoperability between the disparate systems that are supporting health services delivery. Interoperability can only be achieved through the adoption and operationalization of e-Health standards. Therefore, establishing a national framework for eHealth standards and interoperability is a PEPFAR SI priority. A common platform for systems interoperability – known as a Health Information Exchange (HIE) - makes the sharing of health data across information systems possible. Like a universal translator, an HIE normalizes data and secures the transmission of health information throughout databases, between facilities, and across regions or countries.




PEPFAR is working with WHO to define, publish, and adopt a common, open source specification and a collection of reference technologies in support of health information systems interoperability. PEPFAR country teams are strongly encouraged to become familiar with the WHO Health Systems Interoperability specification, which will be

circulated as soon as it is released, and to work with partner Ministries of Health to review and adopt this technical approach. It is anticipated that the specifications will be consistent with the data exchange profiles published through the Integrated Health Enterprise (see OHIE.org for details).

The comprehensive tracking of patients required for adherence monitoring and other key program linkages is a key outcome of HIE implementation. HIE implementation has also be shown to result in greater health workforce efficiency, lower cost of care, and improvements in the quality of care. The program also needs to pay special attention to the creation of local human capacity to ensure long-term sustainability and success, as well as focus on developing a culture of using data for decision making to ensure the full benefits of the standards-based interoperability approach are realized.

### 3.7.3 Data Quality

As PEPFAR has shifted from an emergency response to one focused on country sustainability, the U.S. government will increasingly rely on partner country systems to collect, manage, and report on data. This shift needs to be accompanied by significant capacity building to ensure that national systems can provide accurate, timely, and quality data.

High-quality data are the cornerstone for evidenced-based decision making. Attention to data quality (DQ) ensures that limited resources are used as effectively as possible, progress toward established goals is accurately monitored and measured, and decisions are based on the best available evidence. From the beginning, PEPFAR has promoted data quality improvement activities across all U.S. government programs. In support of this abiding commitment to DQ and in response to PEPFAR's emphasis on strengthening partner government systems, a new *PEPFAR Data Quality Standards of Practice* guidance is forthcoming (estimated release date October 2013). The new guidance emphasizes a unified, coordinated U.S. government approach to data quality and more importantly focuses on strengthening the capacity of national governments and local institutions to plan and carry out DQ activities. The new guidance provides a template for planning DQAs, includes an inventory of DQA resources, and provides concrete ways to work with national governments to strengthen their data quality. U.S. government SI teams should reach out to host country partners and other key stakeholders with this new guidance to renew their commitment to improving the quality of programmatic data at all levels of the system.

Significant effort is expended to collect population-level, community-based, and facility-based data; however, implementers commonly note that the information is not used effectively, if at all, for decision making. This results in a lost opportunity to improve the

quality of decisions around HIV programs and policies. Moreover, as HIV programs have expanded and matured, monitoring and reporting systems have evolved to respond to government and donor reporting requirements. Correct data interpretation and use is critical to planning, assessing, strategizing, and determining next steps in public health programs. Improved data-use practices are a component of this larger DQ strategy, and U.S. government SI teams should ensure that appropriate capacity building among country partners is supported.

The COP Submission should describe:

- How the U.S. government country team aims to strengthen national government DQ, with reference to specific activities;
- How U.S. government is working to encourage a culture of data use and evidence-based decision-making both within national government counterparts and within the U.S. government country team, with reference to specific activities;
- How the U.S. government country team is going to standardize and coordinate all DQA activities across agencies to avoid duplication and to support national DQ efforts;
- How DQA findings will be shared and used across the U.S. government county team to improve data quality within U.S. government and with national partners.

## 3.8 Fiscal Management and Pipeline Analysis

Effective management of PEPFAR funding is a foundation to the program's overall success and to meeting the urgent needs of families, communities, and nations heavily affected by HIV/AIDS around the world.

It is critical to monitor and evaluate the financial state of our country programs regularly, both to ensure the success of PEPFAR and to remain accountable to Congress and the American people.

Routine monitoring of PEPFAR funds includes, but is not limited to, the following activities and tasks: tracking and confirming financial records vis-a-vis OGAC quarterly Pipeline Reports, being aware of the status of unobligated funds, engaging financial staff in all planning stages of the PEPFAR business cycles (Operational Plan Updates (OPU), Pre-COP and COP) and proactively communicating with Headquarters staff as needed.

Through routine monitoring and regular communication with the appropriate POCs, teams will have a clear sense of their fiscal situation heading into COP planning. Teams must utilize COP planning as a time to obtain and agree upon a snapshot of all available PEPFAR funding and resources in country (e.g. partner pipelines, unobligated/non-partner pipelines, previously de-obligated funds, etc.).

From here, teams should begin discussions and determine the best mix of prior year (or pipeline) funds available, planned new (i.e. FY 2014) resources for the FY 2014 COP, and the mix between the prior year and new resources that will be programmed by mechanism. A COP proposal should account for and reflect a budget to sustain operation and execution of the activities during the FY 2014 COP implementation cycle as well as maintain a sufficient level prior year of resources to ensure the continuity of services.

### 3.8.1 Partner Reviews

Each country team is expected to review both partner performance (i.e., timely expenditure of funds, achievement of programmatic targets) and overall programmatic pipeline as an interagency team before and/or during planning its annual PEPFAR Operational Plan. Teams may direct any questions to their Country Support Team Lead.

As in prior years, partner performance and pipeline analysis reviews are intended for COP planning purposes. Teams should carefully consider and, where applicable, discuss the interagency partner performance and pipeline review process utilized during FY 2014 COP planning in their submission.

Interagency, team-based partner performance reviews are a well-established management practice, informing country teams' program planning, management, and oversight. The collection of performance data helps ensure consistency and allows teams to evaluate trends over time. Interagency country teams and headquarters personnel are thus required to monitor and evaluate partner performance on an ongoing basis throughout the year, especially through the COP, APR, and SAPR processes. Please note a partner review can be an integral component to a portfolio review, but a portfolio review is not necessarily limited in scope to a review of partners. See Section 2.3.2 for more details concerning portfolio reviews and expectations.

Teams should monitor progress informally throughout the year and conduct formal interagency reviews of all partners **at least once a year**.

Program managers are expected to monitor and evaluate partner expenditure rates ("outlay rates"), and the partner review is an appropriate venue to discuss this outlay

rate with the partner and determine whether the current outlay rate is acceptable, given the performance of the partner.

In addition to partner performance, country teams should carefully consider and manage funding for activities that will require long lead times before actual obligation and outlay. For example, country teams should not fully fund TBD mechanisms that will not be executed for several months after COP approval. The level of funding for a TBD should be directly related to the planned execution of the funds, and this same approach should be followed for all funding decisions in the COP.

# 4. FY 2014 COP Population Priorities

## 4.1 Increase Coverage and Effectiveness of Programs for Key Populations

HIV disproportionately impacts key populations (men who have sex with men (MSM), sex workers (SW), people who inject drugs (PWID), and transgender (TG) individuals) in low and middle income countries (LMIC) in all regions of the world. Data from country-specific surveillance surveys have demonstrated the existence of concentrated epidemics among key populations, even within larger generalized epidemics.

Female SW in LMIC are 13.5 times more likely to be living with HIV when compared to other females of reproductive age. MSM are 19 times more likely to be living with HIV than men in the general population, and TG individuals are almost 50 times more likely to be living with HIV than other adults. Globally, 16 million individuals inject drugs, and approximately 3 million people who inject drugs are living with HIV. Despite the disproportionate HIV disease burden, coverage of HIV prevention and treatment services for key populations is remarkably low.

Reaching key populations with effective HIV prevention and treatment services is critical to achieving PEPFAR goals. The 2011 PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections, located on pepfar.gov, lists comprehensive programs for key populations as essential prevention interventions and directs every PEPFAR program to collect data on these populations, and provide HIV/AIDS prevention, care, and treatment designed to meet their needs.

Key Populations are highly stigmatized and partner countries may be reluctant to invest in programming for them. PEPFAR teams should make breaking down these barriers a priority for both policy and programs in order to most effectively address the epidemic.

PEPFAR's expectations for the type of investment in key populations vary based on local epidemiology as well as presence and activities of other donors.

Additional guidance documents for prevention among key populations are available. These documents describe the scope of U.S. government HIV/AIDS prevention focused activities that PEPFAR will support for these prioritized populations. The guidance documents are a response to the urgent need to expand the continuum of HIV prevention, care, and treatment for key populations.

PEPFAR Guidance on Comprehensive HIV Prevention for People who Inject Drugs and PEPFAR Guidance on Combination HIV Prevention for Men Who Have Sex with Men are both available at www.pepfar.gov/guidance. Also, a useful tool on implementation of programs for Sex Workers can be accessed through the WHO at: http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/

## 4.2 Addressing the needs of Girls and Young Women across the Continuum

In Southern Africa, prevalence among young women aged 15–24 years is on average three times higher than among men of the same age (UNAIDS 2010). This disparity arises from systematic disadvantages faced by adolescent girls and young women. Many girls are forced into sexual activity and marriage at very young ages and are extraordinarily vulnerable to unintended pregnancy, HIV, sexual violence, and exploitation. Because of existing gender biases, many girls are seen as unworthy of investment or protection by their families, communities and governments.

While effective HIV prevention interventions for this group are urgently needed, there is a dearth of evidence-based interventions available. PEPFAR is committed to supporting research to address this gap, but in the meantime, PEPFAR programs in countries where girls and young women are living with high rates of risk and infection must take action now.

In these countries, PEPFAR programs should fund evidence-based activities that empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities, and economic assets. PEPFAR programs should also target the men with whom girls and young women engage in sexual activity – whether voluntarily or not – with programs that address harmful gender norms, provide HIV prevention, and link male PLHIV with services. Clinical partners must develop and strengthen innovative platforms that make HIV care and treatment services accessible and acceptable to girls and young women living with HIV. At a policy level, PEPFAR leadership in country should reach out to other stakeholders to develop longer-term

plans for addressing the needs of adolescent girls and young women, mindful that population trends across this region suggest continued growth of this cohort over the next 30 years.

**What PEPFAR programs should do now:**

- Country teams should work to support and strengthen surveillance efforts both to ensure that adolescent girls and young women are being adequately represented in samples, and so that the reasons for their higher risk are being well understood in the country context.
- Staff working on OVC, Prevention and Gender issues should work together, and with other stakeholders as appropriate, to ensure that programs complement each other and work in a coordinated way to address the various causes of HIV among adolescent girls.
- Partners providing pediatric and adult treatment and care, as well as PMTCT, should adapt and apply best practices in youth-friendly reproductive care to their country contexts.
- Results from PEPFAR's Gender-Based Violence Initiative, a pilot program to strengthen post-rape care services in Uganda and Rwanda, showed that around half of patients presenting for post-rape care were under the age of 18. Programs in Kenya and South Africa report similar distributions. Countries receiving additional central funds through either the Gender-Based Violence (GBV) Response Scale Up or the Gender Challenge Fund (GCF) to address GBV through clinical and community platforms should be actively working to meet the needs of adolescent girls. This work should also be reflected in the OVC and Prevention portfolios, with PEPFAR staff working closely together to ensure that GBV prevention and care programs are well-aligned, funded, and consistently attributed across multiple budget codes.

### 4.2.1 Family Planning

There continues to be significant unmet need for voluntary family planning and other reproductive health services worldwide. For example, in Sub-Saharan Africa one in four women who wish to delay or prevent pregnancy is not using any family planning method (World Health Organization, 2009). This same region has the highest rates of HIV, which disproportionately affects women — nearly 60% of people living with HIV in Sub-Saharan Africa are women.

Among women living with HIV, there is strong evidence to suggest that they have less access to family planning and other reproductive health services, in the face of great need and often higher maternal mortality and morbidity. Several studies have

illuminated the unmet need for family planning for women living with HIV, and suggest that levels of unintended pregnancies among HIV-positive women range from 51% to 91% (Heys et al. 2009).

A variety of global organizations, including WHO, UNFPA, UNAIDS, GNP+ and ICW, clearly recognize that access to voluntary family planning, including safe pregnancy counseling, should be part of comprehensive quality care for persons living with HIV. Women living with HIV who desire to have children should have access to safe pregnancy counseling in order to protect their own health and reduce the risk of HIV transmission to their partners and children. Women who wish to prevent or delay pregnancy should have access to a range of contraceptive options as well as full information and counseling. PEPFAR teams must seek to ensure that those in need of family planning services and referrals receive the care they need.

The Global Health Initiative (GHI) principles define several priorities for U.S. government foreign assistance programs, including integrated health programming and implementation of a woman, girl, and gender equality approach. These priorities reinforce the importance of voluntary family planning and other reproductive health services for women and families, including safe pregnancy care. PEPFAR programs should be optimized as a platform on which to incorporate these health services.

U.S. government-supported family planning and HIV/AIDS programs must adhere to the following principles:

- People living with HIV should be provided with comprehensive information on, and be able to exercise voluntary choices about their health, including their family planning choices.
- All individuals have a right to choose, as a matter of principle, the number, timing, and spacing of their children, as well as decide on the use of family planning methods, regardless of their HIV status.
- Family planning use should always be a choice, made freely and voluntarily, independent of the person‘s HIV status.
- The decision to use or not to use family planning should be free of any discrimination, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.
- Access to and provision of health services, including antiretroviral treatment, for person living with HIV should never be conditioned on that person's choice to accept or reject any other service, such as family planning (other than what may be necessary to ensure the safe use of antiretroviral treatment e.g., drug interactions).
- Women living with HIV who wish to have children should have access to safe

and respectful pregnancy counseling, antenatal, and childbirth services.

As part of comprehensive care for HIV and AIDS, field teams are expected to prioritize opportunities to use PEPFAR funds to support voluntary family planning and reproductive health (FP/RH) services. These services must meet an HIV prevention, treatment, or care purpose and/or link PEPFAR-funded activities with FP/RH activities funded from separate U.S. government accounts or other non-U.S. government sources of funds. As in years past, PEPFAR funds may not be used to purchase family planning commodities; however, male and female condoms can be purchased using PEPFAR funds.

Illustrative programming opportunities that should be actively pursued are listed below. Health workers should be provided with training as appropriate.

- Providing voluntary family planning counseling and wherever possible integrated family planning services for women, men, and/or couples in HIV prevention, treatment, and care programs – ideally co-located at the same site;
- Providing family planning clients with HIV prevention including HIV testing and counseling, particularly in areas with high HIV prevalence and strong voluntary family planning systems – again, ideally at the same site;
- Integrating family planning services (using commodities funded by sources other than PEPFAR) in PEPFAR-funded PMTCT and HIV care and treatment programs;
- Provision of HIV prevention messaging and support, as well as HIV counseling and testing (funded by PEPFAR), within antenatal care, maternal and child health, and family planning programs (funded from other accounts) for both men and women;
- Ensuring effective referral systems between these various platforms and monitoring enrollment and receipt of services when referrals are made—to capture linkages and ensure uptake of high quality services consistent with the principles for integrating voluntary family planning and HIV programs.

HIV and FP integrated program activities must respect a client's right to make voluntary and informed decisions about his or her reproductive health. The principles of voluntarism and informed choice are prerequisites for good quality of care and must form the basis of integrated programs. These principles are articulated in legislative requirements that govern the use of U.S. government foreign assistance funds and U.S. government FP assistance. In addition, as always, it is important to ensure that USG staff is aware of and properly implement the various legal and policy requirements that apply across U.S. foreign assistance at large, including those related to abortion and involuntary sterilization.

PEPFAR takes these requirements very seriously and expects compliance in all program activities. Each U.S. government agency is responsible for maintaining compliance with these requirements in their project activities, and HIV teams should contact their respective compliance teams for assistance. Ongoing, active monitoring for compliance is an essential element to ensure good quality of care for the people that PEPFAR serves.

Key Issues: Note that in the Key issues table, under "health related wraparounds", family planning is listed as an option. Please ensure that all activities that include FP integration are appropriately checked throughout your COP (See 7.5.8 Cross-Cutting Programs and Key Issues).

## 4.3 Increasing Demand for HIV prevention, care and treatment services among Men

APR data from PEPFAR prevention, care, and treatment programs across many countries and activities indicates that programs are reaching proportionally fewer sexually active, adult men than their numbers in the population warrant. For example, in sub-Saharan Africa, UNAIDS data estimate that 40% of PLHIV are adult men but across PEPFAR programs in the region, according to APR results, only 28% of those tested in FY 2011 were adult men. Because PEPFAR support for HTC in concentrated epidemics was mostly through technical assistance, it is more difficult to estimate how many men were tested with our support in those contexts, but overall data suggests that overall rates of testing of sexually active MSM and males who inject drugs or sell sex is low.

Treatment programs also reach disproportionally fewer adult men. In sub-Saharan Africa, only 32% of those PEPFAR supports on ART are men. Data presented at the 2013 Conference on Opportunistic and Retroviral Infections showed that HIV positive men tend to present for ART with lower CD4 counts and have higher mortality than women. Again, data on PEPFAR programs in concentrated epidemics is less clear, but we know challenges in reaching men exist. These issues also arise in VMMC programs, where implementing partners are often finding great demand from adolescent boys, but weak demand from adult men. These gaps are damaging – for those men who are not getting the services they need, for their sexual partners who are at greater risk for HIV, and for their families and communities.

Men fail to get prevention, care, and treatment services for a number of reasons. Gender norms across the world discourage men from seeking healthcare or disclosing an HIV positive status. Economic hardship often leads men to migrate for work, making

adherence to daily drug regimens very difficult. Stigma associated with an HIV positive status, alongside the stigma associated with other identities and behaviors (having sex with other men, using injecting drugs, selling or paying for sex) adds to men's difficulty in accessing services. Health policies and systems also fall short in effectively reaching men by overlooking their unique needs in planning and implementation of services, and through providers and facilities that can be stigmatizing towards men who do access services.

In order to increase demand for and uptake of services among adult men, PEPFAR programs and their implementing partners will need to be innovative and flexible, thinking beyond traditional public health approaches. We need to see mothers, wives, girlfriends and sisters – as well as men, themselves – as partners in our efforts to bring men into services, and continually identify and test new ways to make these services attractive and accessible.

All PEPFAR teams should be carefully analyzing the data on service uptake and adherence among adult men in their localities to better understand the gap between needs as indicated through DHS and modeling data, and services currently provided. All areas of the response from HTC through treatment should be considered. Teams should then work with implementing partners and other stakeholders to:

- understand the social, economic and gender-related barriers preventing men from accessing services;
- identify factors that facilitate service uptake and adherence for men, including adaption of successful male engagement strategies from other spheres; and
- develop an action plan which includes the service and specific population to be targeted; the proposed action or intervention; roles for all partners and stakeholders; a timeline, and steps for implementing these actions; and a method for determining the outcomes and effect on improving access for men.

These efforts should connect this target population with our efforts to improve gender equality—engaging sexually-active adult men as supportive partners and role models for gender equality.

# 5. Program Approaches

## 5.1 Global Health Initiative (GHI) and the GHI Principles

The technical priorities highlighted above are ones for which there is a change in guidance or that should receive a renewed focus by PEPFAR country teams this year. The priorities should all be considered in the context of the following approaches:

integration under GHI, the PEPFAR Blueprint, the continuum of the HIV response, and shared responsibility.

## PEPFAR and the Global Health Initiative Principles

The Global Health Initiative (GHI) provides a common foundation (including principles, targets and structures) for ensuring greater, sustainable impact of U.S. government global health investments. Using defined targets and seven core principles, GHI is a results-oriented, whole-of-government effort.

While PEPFAR's work primarily focuses on creating an AIDS-free generation, OGAC and agency headquarters Agency Headquarters recommend that country teams explore opportunities to integrate and leverage the PEPFAR platform in order to advance progress toward all the GHI targets and goals including ending preventable child and maternal deaths. In addition, PEPFAR teams should focus on the ways in which PEPFAR programs can reflect and incorporate the GHI principles, listed below, into their programming:

- Focus on Women, Girls, and Gender Equality
- Encourage country ownership and invest in country-led plans
- Strengthen and leverage other key multilateral organizations, global health partnerships and private sector engagement
- Increase impact through strategic coordination and integration
- Build sustainability through health systems strengthening and Public Private Partnerships
- Promote learning and accountability through monitoring and evaluation
- Accelerate results through research and innovation

(Note: Additional information on the Integration and Country Ownership Principles is provided below).

As mentioned in last year's guidance, all PEPFAR countries are expected to work to incorporate the GHI Principles into their COP planning processes. As such, if your country has completed a GHI strategy, please provide an update on how this COP will advance progress towards achieving the cross-cutting areas and targets defined in the GHI strategy. Similarly, for those teams that do not have a GHI country strategy, please describe how your PEPFAR program is implementing GHI principles in this COP in the Executive summary.

For more information about the GHI, please contact your CSTL, who will pass along questions to the GHI Team at OGAC, as well as to the larger GHI interagency team.

**1. Integration –** This approach should be emphasized when integration with other health programs helps attain PEPFAR's primary goals/priorities. It is a hallmark of GHI, and a way that PEPFAR can help to attain U.S. government goals in improving MCH, malaria and other health outcomes.

For example, the President's Malaria Initiative (PMI) and PEPFAR form central pillars of the GHI and have successfully worked together to promote smart integration efforts within U.S.-supported activities. To date, PMI and PEPFAR in-country teams have many integration and collaboration examples to share in which they have identified areas of technical synergy and complementarities. Building upon this practice, several country teams have been asked to engage in cross-team discussions about how to accelerate PMI's goal of reducing the number of malaria-related deaths and HIV malaria co-infection deaths. PMI and PEPFAR leadership believe that there are significant, additional opportunities for collaboration between the PMI and PEPFAR programs to: 1) capitalize on opportunities to reach populations at risk of both diseases with essential interventions; 2) ensure that there is efficient use of resources, commodities, and personnel; and 3) further reduce duplication of effort.

Similarly, in Uganda and Zambia, efforts are underway to leverage the PEPFAR platform to achieve greater maternal health outcomes through Saving Mothers, Giving Life. This public-private partnership is demonstrating that a package of focused interventions targeting labor, delivery and the 24 hours postpartum can substantially reduce maternal deaths. Since AIDS is a leading cause of death during pregnancy, PEPFAR's partnership in Saving Mothers, Giving Life helps to not only improve women's lives, but achieve programmatic goals around prevention of mother-to-child transmission of HIV (PMTCT).

Saving Mothers, Giving Life is able to build from the PEPFAR platform programmatically in many ways by capitalizing on PEPFAR's investments in HIV/AIDS ART and PMTCT Platforms; national blood safety programs; supply chain and logistics; community engagement; health systems strengthening; and linkages with the Ministry of Health and other national level capacity building activities.

Similarly, as global and national efforts are refined and targeted to speed up progress in meeting country-level child survival goals, PEPFAR teams are encouraged to ensure that relevant HIV/AIDS related technical areas, e.g., PMTCT, pediatric care and treatment, OVC, and food and nutrition, are appropriately integrated within country-led strategies and processes related to infant and child survival.

Because of PEPFAR's HIV/AIDS mandate, it is important to note that PEPFAR resources can be integrated with other programs only when PEPFAR resources are linked to

HIV/AIDS outcomes. Country teams who have proposals or questions about potential uses of PEPFAR funding should call their CSTL. These proposals will be evaluated on a case-by-case basis to ensure that the proposed use of funds is in accordance with PEPFAR's authorizing legislation and appropriations account language before submission of the COP.

**2. Country ownership** – see section 5.2 on Shared Responsibility and section 5.2.1 on Country Ownership.

**3. Continuum of the HIV response** – Focusing on the program priorities should enhance the HIV continuum of care model, ensuring that programs:

- Link to and between HIV prevention, care, and treatment opportunities within and between facilities and communities;
- Link to and between HIV services to other health sector services;
- Link to and between HIV services to broader development opportunities; and
- Ensure that holistic needs of beneficiaries, including social and emotional needs created by the epidemic, are integrated into the response.

Please see Appendix 2 for a description of the core principles for the Continuum of Response (CoR).

## 5.2 Shared Responsibility

The goal of creating an AIDS-free generation cannot be accomplished by any single actor alone. Rather, it requires countries to demonstrate political will and the effective coordination of multiple partners that are providing financing, policy support, and carrying out interventions both inside and outside of the health sector. This goal must meaningfully involve those living with and affected by HIV in all aspects of the response.

In 2012, UNAIDS introduced the shared responsibility agenda, which is intimately linked with that of *country ownership*. For the U.S. government, *country ownership* is defined by the continuum of actions taken by political and institutional stakeholders in partner countries to plan, oversee, manage, deliver, and finance their health sector and achieve health goals. These actions advance sustainable, quality health programs that are locally owned and responsive to the needs of host country nationals.

Country governments must play the role as orchestrators of a country response, conveners of all partners, and increasingly funders of their national response. Civil society, including faith-based organizations and organizations of people living with HIV/AIDS, should be active in local and national policy and accountability forums to

ensure that programs meet the needs of communities affected by HIV. Putting country leadership - both government and civil society - in an accountable position to meet the needs of their populations will further the goal of a sustainable HIV response.

To support these efforts, PEPFAR is changing the way it does business to support a broader combined impact in the global fight against AIDS. In order to create an environment where multiple partners from the community level upwards are able to join the fight, PEPFAR will continue to focus on expanding its activities around country ownership with civil society, multilateral and bilateral donors, and the private sector. By taking the following action steps, PEPFAR will serve to galvanize shared responsibility among partners toward achieving an AIDS-free generation.

### *The PEPFAR Blueprint outlines the Road Map to Shared Responsibility and includes the following objectives:*

- Partner with countries in a joint move toward country-led, managed, and implemented responses.
- Increase support for civil society as a partner in the global AIDS response.
- Expand collaboration with multilateral and bilateral partners.
- Increase private sector mobilization toward an AIDS-free generation.

## 5.2.1 Country Ownership

**U.S. Government Country Ownership Framework:** As a key principle of PEPFAR II and the Global Health Initiative (GHI), "Country Ownership" is a U.S. government policy and priority, outlined in the Presidential Policy Directive on Global Development, the PEPFAR Five-Year Strategy, and *the U.S. Government Interagency Paper on Country Ownership*. PEPFAR has previously advanced implementation of country ownership and sustainability through the five-year PFs and PFIPs[15].

> **Country ownership is defined by the continuum of actions taken by political and institutional stakeholders in partner countries to plan, oversee, manage, deliver and finance their health sector.**

The *PEPFAR Blueprint: Creating an AIDS-Free Generation* outlines a roadmap for shared responsibility in the HIV/AIDS response through four specific action steps:

[15] http://www.pepfar.gov/countries/frameworks/index.htm

- Partnering with countries in a joint move towards country-led, managed and implemented responses;
- Increasing support for civil society as a partner in the global AIDS response;
- Expanding collaboration with multilateral and bilateral partners; and
- Increasing private sector mobilization toward an AIDS-free generation.

The *PEPFAR Blueprint* states PEPFAR will work with countries to strengthen sustainability and country ownership by supporting multi-year sustainability plans that advance the capacity and national management of HIV programming, technical oversight, and financing. The *PEPFAR Blueprint* also commits PEPFAR to work with partner countries to jointly and objectively measure progress toward sustainability in the national HIV response.

During 2014, PEPFAR will support the development of Sustainability Plans as a concrete way to ensure the approach to programming PEPFAR dollars in host countries helps country stakeholders to **lead, manage, coordinate, implement**, and—over time—**increasingly finance** the national response while sustaining programmatic quality and coverage goals. Sustainability Plans are an evolution of Partnership Frameworks (PFs), Partnership Framework Implementation Plans (PFIPs), and other agreements with partner countries. They must be linked to and build on lessons learned from existing PF/PFIPs and PEPFAR strategies and be informed and shaped by those implementation experiences. A new "Sustainability Plan Guidance Document: Advancing Country Ownership in PEPFAR III" was recently released to field teams as part of the FY 2014 COP process. This document provides country teams with guidance on how "to systematically plan, implement, and monitor actions to accelerate U.S. and host country efforts to achieve a durable and effective national HIV/AIDS response."

Sustainability Plans will focus on how to shift the PEPFAR-funded HIV response in each country to support the four dimensions of country ownership: political ownership and stewardship, institutional and community ownership, capabilities, and mutual accountability[16]. This includes changes, as appropriate to the context, in how the U.S. government interagency team does business in support of a sustainable, country-owned and led HIV response, while ensuring that targets continue to be achieved.
Each country is at a different point in the HIV epidemic and response and along the country ownership continuum, and therefore the process of supporting sustainability will be unique to each country context. Countries were categorized in the FY 2013 COP Guidance into groups that broadly define the current vision for U.S. engagement and

[16] U.S. Government Interagency Paper on Country Ownership, July 2012, http://www.ghi.gov/documents/organization/195554.pdf.

level of investment. The approach to advancing country ownership differs for each category. Headquarters (HQ) intends for this segmentation to assist teams in identifying where they are positioned on the "evolution to greater local ownership" continuum.

Descriptions of Country Categories:

<table>
<tr><th colspan="3">PEPFAR Country Categories</th></tr>
<tr>
<td>Long Term Strategy (LTS):<br>- Countries in need of external support for HIV/AIDS programs for the long term<br>- Determination is made based on prevalence, resource need, Global Fund financing, unmet service needs, gaps in capacity, and U.S. geopolitical interests<br>- Support targets direct service delivery, capacity building, strategic information and health systems strengthening</td>
<td>Targeted Assistance (TA):<br>- Countries receiving specific support for key populations or priority technical areas<br>- Support targets capacity building and/or technical assistance; direct funding for service delivery to key populations likely<br>- Epidemic may move countries out of this category into long term strategy</td>
<td>Technical Collaboration (TC):<br>– Countries in which U.S. government engagement is with more developed nations and is a "peer-to-peer" relationship in health.<br>– Collaboration is established to advance specific aspects of health such as developing national institutes of health, strengthening capabilities to provide technical support to other nations, jointly sponsored research and innovation, and other collaborations of mutual benefit to both countries<br>– End goal for the U.S. government partnership</td>
</tr>
<tr><td colspan="3">Co-financing (Co-F) is a principle of shared responsibility and necessary for sustainability of health outcomes. In a subset of our countries, we have emphasized co-financing as a deliverable. This is largely in countries with growing gross national income (GNI) to increasingly self-fund (wholly or co-finance) more of their HIV/AIDS response. In this context, the U.S. government may focus on capability building efforts for programs to be financed by the country.</td></tr>
</table>

| PEPFAR Country Categories | | |
|---|---|---|
| **Long Term Strategy (LTS)** | **Targeted Assistance (TA)** | **Technical Collaboration (TC)** |
| - Burundi<br>- Cameroon<br>- Cote d'Ivoire<br>- DRC<br>- Ethiopia<br>- Haiti<br>- Kenya<br>- Lesotho<br>- Malawi<br>- Mozambique<br>- Rwanda<br>- Swaziland<br>- Tanzania<br>- Uganda<br>- Zambia<br>- Zimbabwe | - Asia Regional (Laos, Thailand)<br>- Burma<br>- Cambodia<br>- Caribbean Regional (Antigua & Barbados, Bahamas, Barbados, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St Vincent & the Grenadines, Suriname, Trinidad &Tobago)<br>- Central America Region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama)<br>- Central Asian Republics (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan)<br>- Dominican Republic<br>- Ghana<br>- Indonesia<br>- Papua New Guinea<br>- South Sudan<br>- Ukraine | - Asia Regional (China)<br>- Brazil<br>- India |

| | | |
|---|---|---|
| Co-Finance Sub-group of LTS Countries<br><br>- Nigeria<br>- South Africa | Co-Finance Sub-group of TA Countries<br><br>- Angola<br>- Botswana<br>- Guyana<br>- Namibia<br>- Vietnam | |

While there are important variations in country contexts, every country should establish short and long term goals for the sustainability of the prevention, care, treatment, and health systems strengthening response. See the Sustainability Plan Guidance for further details on this process.

For the FY 2014 COP, country teams are requested to provide an update on progress made on the dialogue and actions around increasing country ownership and sustainability of PEPFAR investments within each of the four dimensions as part of their executive summary. Examples under mutual accountability could include details on progress made in sharing or co-financing of programs or activities previously wholly supported by PEPFAR, activities previously that government budgets did not account for but now do, or processes being pursued to create the environment for transparency in the budget/resource allocation process, as country contexts dictate. In addition, country teams should provide an overview of the key activities to support country ownership and sustainability to be implemented in the FY 2014 COP. Teams should include a description of how the country team will implement the Sustainability Plan guidance through existing country coordination and planning mechanisms, and how they will monitor and measure results. Country teams should also briefly describe efforts to change the way the U.S. government is conducting business to foster a sustainable, country--owned, and -led, HIV response.

### 5.2.2 Country Health Partnerships

**Overview**

PEPFAR Country Health Partnerships (CHPs) represent the next frontier for PEPFAR to advance country ownership and sustainability. They build on PEPFAR's 22 Partnership Frameworks and the PEPFAR Blueprint for an AIDS-free Generation. PEPFAR aims to collaborate with country partners and stakeholders to entrench country ownership and sustainability by advancing a fundamental shift from a traditional donor-recipient

relationship to co-investment and true partnership. Ensuring we are in compliance with laws governing the delivery of U.S. foreign assistance, partner countries will be **afforded a formalized joint decision-making role in the allocation of PEPFAR financing and technical resources in their countries through new PEPFAR Country Health Partnerships.** This manner of partnering— which draws upon best practices from existing development models, including Millennium Challenge Corporation (MCC) compacts—signals the United States' willingness to shift engagement on a country-by-country basis to assist countries in advancing their capacity for leadership, accountability, management, and fiduciary oversight of health investments.

**Key Features:**

- **High-level bilateral political commitment with country partners:** The PEPFAR CHP will define goals, parameters, and mutual accountability for results, contextualized to the circumstances in each partner country.
- **Capacity building:** In less capacitated contexts, the PEPFAR CHP will begin with a country-led assessment to define management and leadership capacity gaps, followed by execution of a plan to address those gaps.
- **Bilateral governing entity:** A small governing entity, convened by the country government, will be established to oversee the PEPFAR CHP comprised of the in-country U.S. Ambassador and government representatives, with civil society in an advisory role. This is the third phase of the CHP.
- **Joint decision-making:** Within the budgetary allocations determined by Congress, and guided by the PEPFAR Country Operational Plan (COP) guidance, congressional mandates and statutory regulations, each governing entity will be responsible for reviewing and selecting recommended strategic PEPFAR investments. This authority may vary by country, but will increase over time as leadership and management capacities grow.
- **Multi-stakeholder partnerships:** At a later date, countries can decide to bring bilateral or multilateral stakeholders, such as Health Sector Budget Support donors, into the partnership dialogue (but not into decision-making on PEPFAR resources). Global Fund engagement also will be critical and is expected to be a part of the dialogue, by invitation of the country and through discussions with the U.S. government.
- **Budget transparency:** The PEPFAR CHPs will emphasize budget transparency by both the U.S. government and partner country, which will assist in monitoring any "crowding out" of domestic investments by donor financing to meet funding targets in the health sector.
- **Focus on results:** The CHPs would leverage real-time data on performance, including the use of innovative technologies to create dynamic feedback loops in performance. A continued focus on results will be a governing principle.

- **Private investments:** Engagement with private investment entities would be sought to catalyze sustainable private investment, with a likely emphasis on supply chains, mobile health technologies, and infrastructure.

**Redlines:** The U.S. government will retain its oversight and auditing responsibilities over program funds. The PEPFAR CHPs will be explicit about legal constraints on the country's new decision-making authority (e.g. congressional mandates). This structure would not alter the legal authorities and budgets of U.S. government agencies, including top-line budgets for HIV, but would grant countries a greater role in resource allocation and implementation decisions within those parameters at the country level. The U.S. government will also retain the ability to "rope off" some additional areas; for example, to ensure PEPFAR programming continues to target key populations that often marginalized and discriminated against (e.g., men who have sex with men, sex workers, and people who inject drugs).

**Country Selection:** We are pursuing a phased-in approach that is responsive to agreement with three countries initially, followed by a second wave of countries. Namibia, Rwanda and South Africa are first-wave candidates (**CHP wave**) because we already have embarked on a shift in roles and responsibilities for the HIV/AIDS response in these countries, and the countries have agreed to form a CHP. The political leadership in Namibia, Rwanda and South Africa has demonstrated a firm commitment to addressing their country's health needs in a sustainable manner. In the next wave of countries, PEPFAR will initiate a "preparedness period" which will ready countries to eventually negotiate terms for a CHP partnership.

**Preparing for PEPFAR CHPs:** Through the recently released sustainability planning guidance, teams have available various options to pursue, as appropriate to their context, to conduct joint country-led capacity assessments and joint planning. These will assist teams move through a continuum of ownership with the country towards the benchmarks and milestones that will signal readiness to formalize a CHP agreement. The building blocks for CHPs – joint assessments and joint planning will aim to strengthen the informal and non-binding processes teams currently engage in (**Pre-CHP wave**). CHPs represent formal, bilateral political commitments that are the goal for all priority countries.

**Timeframe:** In the following months, OGAC will engage PEPFAR implementing agencies and the initial three countries to determine the precise terms and structure of each PEPFAR CHP. While the pace for shifting to shared governing structures will vary by country, as will the capacity gaps addressed, we aim to expand CHPs to additional countries, informed by experiences in the initial countries and country government interest and leadership.

### 5.2.3 HRH Transition Planning

As part of its effort to expand access to HIV/AIDS prevention, care and treatment services, PEPFAR has been partially or wholly supporting a number of health workers in over 30 countries (country team members should refer to agency-specific guidance to determine acceptable forms of salary support – as well as other financial/non-financial incentives). Often this happens because governments are either financially and/or structurally unable to accommodate the hiring necessary to provide adequate services in a timely way. While the practice of hiring and paying health workers directly has resulted in very positive benefits in terms of timely access to quality HIV treatment and care, and may be necessary in the short-term to support scale-up goals, continuing to support health worker employment is not a sustainable practice over time. Transitioning the responsibility for health worker salaries, management, and other support systems to government, nongovernmental organizations, multilateral organizations or other entities, is a complex undertaking. Some PEPFAR countries have already experienced transitioning of PEPFAR-supported health care worker staff, while others are at initial stages.

It is recognized that there is no single sequence or formula for a successful transition. Each country team may enter the process at different points and for different reasons depending on the local context, which varies dramatically. Likewise, the level of decision making about health worker transition may also vary from country to country depending on the government system (e.g., whether it is centralized vs. decentralized, or in the process of decentralizing).

While the process of transitioning of health worker salaries, management, and other support will vary by country, there are key issues that all country teams will have to address to comprehensively and effectively manage the transition process. These include issues of finance (including salaries and benefits, management, and other support systems), policy (e.g., changes to existing policies or the development of new policies to ensure that the transition happens effectively) and Human Resources Management (e.g., workforce planning and analysis and HR Information systems). Stakeholder engagement throughout the process is critical in initiating and advancing the transition process and ensuring country ownership and sustainability. Similarly, having access to and making use of relevant strategic information for evidence-based decision-making is a crucial component to the transition process.

To assist country teams in health worker transition, PEPFAR has developed an HRH Transition Resource Guide, available to country teams on pepfarii.net in the coming months. This interactive resource is a newly developed reference to facilitate country

team planning, implementation and monitoring of the transition of PEPFAR-supported health workers. It helps country teams to address the finance, policy, Human Resource Management, stakeholder engagement and strategic information questions raised by the transition process, captures lessons learned from PEPFAR countries that have experience with the transition process, and provides examples of tools and resource available to assist in the transition process. PEPFAR's HRH TWG can be contacted for further information on making use of this resource.

### 5.2.4 Importance of The Global Fund and UNAIDS Joint Program

As PEPFAR moves aggressively to a sustainable response to HIV/AIDS, multilateral partners, especially, the Global Fund and the UNAIDS Joint Program are increasingly important. In the world's highest-burden and lowest-resourced countries, the Global Fund and PEPFAR account for over 90% of donor funding for the HIV response. PEPFAR, Global Fund, and domestically financed programs must be deeply interconnected to ensure strategic investment and to fully leverage all resources in support of the national HIV/AIDS program. In line with the shared responsibility principles, PEPFAR teams should continue to build and strengthen the relationships that sustain a collaborative engagement with multilateral partners, in order to best support partner governments and the sustainability of country-owned national programs.

**The Joint United Nations Program on HIV/AIDS (UNAIDS) and UN Family Organizations.**

The UNAIDS Joint Program[17] is an essential partner in PEPFAR's efforts to support country ownership in the HIV response. The UN efforts, led by the UNAIDS' Secretariat and supported by UN co-sponsors, are primarily directed at four streams of work where PEPFAR has a particularly strong interest and robustly participates:

- The Shared Responsibility agenda
- The Investment Approach
- Post 2015 Development Agenda

**The Global Plan for the Elimination of new pediatric infections**

[17] UNAIDS is a joint UN program consisting of a Secretariat (often referred to simply as UNAIDS) and 11 UN co-sponsoring agencies: WHO, UNICEF, World Bank, UNDP, UNODC, UNHCR, WFP, UNFPA, ILO, UNESCO, and UN Women.

The *shared responsibility agenda* focuses on high-level political engagement and multilateral diplomacy, primarily within the context of UN General Assembly (UNGA) and the African Union (AU). This agenda has successfully garnered political will and support for work that is occurring at the country level, including actions adopted by AU states on the need to increase domestic expenditures and invest more strategically. PEPFAR teams can work with UNAIDS at the county level to build and further amplify these messages for country level action.

The *Investment Framework* (as discussed in Section 2.3.1) supports governments in leading national planning dialogues.

Both the shared responsibility agenda and Investment Approach are focused on the principles important to *country ownership*, including: 1) countries demonstrating political leadership through a willingness and ability to articulate a national AIDS, health and development vision and lead the response; 2) increasing domestic investment in HIV; and, 3) improving the impact of programs by better aligning resources to high-impact interventions and targeting populations and geographical regions that are most affected by and vulnerable to HIV.

The *Global Plan* towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive was launched in July 2011 in 22 priority countries. (See Section 3.2 of the Technical Priorities for more information on partnering with the UN on the Global Plan)

*The Post 2015 Development Agenda:* The UN's work on the Post 2015 agenda is another area that will be important to the PEPFAR program over the coming years, as it will frame international development goals after 2015, just as the Millennium Development Goals (MDGs) will up to 2015. The UNAIDS Secretariat has convened "The Lancet Commission" that will closely examine potential tenets for global health. Ambassador Goosby and NIH's Dr. Tony Fauci are two of several prominent members of the commission.

OGAC will continue to work with UNAIDS to advocate for a prominent position for HIV and the scale up of HIV services. Concepts like strategic investment, country ownership, and shared responsibility will remain central to the Post 2015 agenda. This work will continue at the country level as UNAIDS works with governments to help them focus on HIV within and across a broader development platform.

PEPFAR and POCs: Country teams should keep apprised of the efforts by UNAIDS to support your host country around the Post 2015 goals and consider if, how, and where

the PEPFAR program might support these efforts in order to help shape the host government's position with regards to HIV.

The World We Want website: http://www.worldwewant2015.org/

UNAIDS PCB paper on HIV/AIDS in the Post-2015 development agenda: http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2013/pcb32/agendaitems/20130528PCB%20discussion%20paper_AIDS%20in%20post%202015_27%20May_Final%2019H30.pdf

OGAC submission to the global post-2015 health consultations: http://www.worldwewant2015.org/node/298415

Post-2015 Development Agenda Sharepoint Site
The Bureau of International Organization Affairs (IO) welcomes Department and USAID personnel interested in learning more about the UN Post-2015 development agenda to visit our Post-2015 Sharepoint Site.

http://io.p.state.sbu/teams/2015DevelopmentAgenda/default.aspx

The site includes useful background information on the various UN processes as well as recent talking points and ALDACs.

If you would like more information on the Department's role in the Post-2015 process, please contact S/GAC for the appropriate State Department contacts.

### Working with the Global Fund

The Global Fund is a critical multilateral vehicle for shared global responsibility and support of country leadership to control the three diseases. The U.S. government's substantial contribution to and engagement with the Global Fund is necessary to reach more people with quality services, expand the geographic reach of U.S. government investment, and promote a shared responsibility among donors, host countries, and implementers for financing country responses to the three diseases.

Achieving the necessary health impact is clearly beyond the capacity of any single country, donor, or partner. Because of this, PEPFAR is placing increased focus on and support for the Fund within the context of one national strategy, and with clear transparency and communication with governments and other partners in country.

A critical tenet of shared responsibility is to ensure that all resources are used as efficiently and effectively as possible. With strong U.S. encouragement, the Global Fund has taken a number of actions over the last two years to internally transform the Fund and reorient the organization as an active investor. Resulting improvements in timely and effective grant making, increased engagement, and accountability on the part of Global Fund Secretariat and country partners will increase the impact of resources on the ground and improve more lives. Moving forward, PEPFAR teams should look to institutionalize joint planning, harmonize monitoring and reporting, and expand high-impact technical assistance for Global Fund programs (See Section 7.2.4).

# 6. Mandatory Earmarks; Budgetary and Reporting Requirements

PEPFAR will continue to meet previously stipulated Congressional earmarks and fulfill the expectations around other key priority areas while we await formal Congressional action extending prior requirements as well as enacting a FY 2014 appropriations bill. OGAC continues to communicate with Congress about their expectations and will make teams aware of any shifts for programmatic focus.

Please note: earmarks/budgetary considerations can only be satisfied via programming of current year (FY 2014) funds. The application of pipeline cannot be counted towards a team fulfillment of earmark requirements or other budgetary considerations.

## 6.1 Mandatory Earmarks

In anticipation of Congressional action extending certain PEPFAR requirements, we will continue to require country programs to meet the legislative earmarks required in FY 14 and program funds to priority interest areas as previously identified by Congress. Planning for such activities should be fully integrated into the COP planning process. This funding should complement and enhance the country program, reflect sound and effective allocations to partners with high outlay rates and associated results and ultimately allow for PEPFAR to continue meeting Congressional expectations.

Teams should utilize the Budgetary Requirements Worksheet (BRW) report in FACTS Info to review the allocation of funds among the budget codes and the status of fulfilling the mandatory earmarks and budgetary considerations listed below.

### 6.1.1 Orphans and Vulnerable Children

PEPFAR must devote at least 10% of program resources in prevention, care, and treatment funding globally to OVC programs.

Former focus countries (with the exception of Vietnam and Guyana) *must* spend at least 10% of their prevention, care and treatment subtotaled budget on OVC; justifications from these countries for amounts less than 10% will not be considered. OVC programming is essential for all countries/regions, but those with smaller OVC populations and concentrated epidemics may submit justifications for spending less than 10%. If your program submits a justification, it should be uploaded to the document library as a 'Budgetary Requirements Justification.'

The OVC budgetary requirement is calculated by dividing the total HKID budget code funding by all prevention, care, and treatment funding:

$$\frac{\text{OVC (HKID)}}{\text{(Subtotal, Prevention, Care and Treatment)}} \geq 10\%$$

If after the submission of all FY 2014 COPs/ROPs the 10% global earmark is not reached, your CSTL will be in touch to discuss how the program can reach this mandatory earmark with FY 2014 resources.

### 6.1.2 Care and Treatment Budgetary Requirements and Considerations

At least 50% of the total global prevention, care, and treatment resources must be dedicated to treatment and care for PLHIV, according to the following formula:

$$\frac{\text{Care \& Treatment for PLHIV (HBHC + HTXS + HTXD + PDCS + PDTX + HVTB)}}{\text{(Subtotal, Prevention, Care and Treatment)}} \geq 50\%$$

Should a team not meet this requirement in their COP planning, a justification must be submitted. Justifications should be uploaded to the FACTS Info document library as 'Budgetary Requirements Justification'

If after the submission of all FY 2014 COPs/ROPs the 50% global earmark is not reached, your CSTL will be in touch to discuss how the program can reach this expected mandatory earmark with FY 2014 resources.

## 6.2 Other Budgetary Considerations

While it does not rise to the level of "hard" earmarks in authorizing legislation, our partners in Congress may use the annual appropriations process to emphasize priorities

from their unique perspectives and to indicate levels of funding for those priorities which they expect the program to achieve, sometimes referred to as "soft" earmarks. It is vitally important that teams are responsive to these concerns. If any such provisions are enacted for FY 2014 within the FY 2014 appropriations bill, OGAC and the implementing agencies will communicate any changing or new expectations for teams to incorporate such provisions in their planning processes.

### 6.2.1 Tuberculosis

As tuberculosis (TB) remains the most common cause of death among people living with HIV in sub-Saharan Africa, implementation of the package of evidenced-based interventions is a very high-impact, life-saving smart investment of resources and is a priority for PEPFAR programming in areas with the greatest burden of co-infection.

PEPFAR has been critical to advancing TB/HIV, with demonstrable results. During the period 2005-2011, WHO estimates that 1.3 million lives were saved as a result of implementation of the package of interventions.

Ending HIV-associated TB among PLHIV is possible through a combination of widespread ART coverage, early identification and treatment of TB, isoniazid preventive therapy (IPT), and infection control activities. These high-impact interventions will be critical to achieving the AIDS-Free Generation goals and need to be integral to COP planning and program implementation.

However, progress has been slower than in other areas of clinical care. There remain important gaps is screening for TB and HIV and assuring effective linkages across TB and HIV services and programs. Rates of ART for co-infected TB patients are lagging behind in many countries. Efforts to overcome barriers to effective service-level integration need ongoing attention as do efforts to explore and adapt models of integration that are country context-specific.

Investment in TB/HIV should therefore be maintained PEPFAR-wide.

Please refer to FY 2014 COP Technical Considerations for further programming guidance.

As Global Fund high-impact countries with the greatest burden of TB and HIV co-infection begin to transition existing grants and new ones to align with the New Funding Model (whether NFM early applicants, interim or standard applicants), PEPFAR teams should also seek opportunities to engage with Ministries, CCMs and other partners to develop robust proposals for TB/HIV activities.

## 6.2.2 Food and Nutrition

Food and nutrition support is a critical component of successful HIV/AIDS care and treatment. HIV and malnutrition interact in a vicious cycle. For many PLHIV, the infection causes or aggravates malnutrition through reduced food intake, increased energy needs, or poor nutrition absorption. Malnutrition can hasten the progression of HIV and worsen its impact by weakening the immune system, increasing susceptibility to opportunistic infections and reducing the effectiveness of treatment. Malnutrition and food insecurity remain highly prevalent in most countries where PEPFAR supports programs, particularly in Sub-Saharan Africa. Nutrition support is a critical component of a comprehensive response to HIV/AIDS.

While the contributions of programs such as Feed the Future, Title II Food Programs, the World Food Program and others cannot be counted toward PEPFAR's food and nutrition directive, country teams are expected to closely coordinate with these key counterpart programs to ensure maximum complementarity of their and our respective investments.

Teams are encouraged to focus resources on this critical priority commensurate with the degree of HIV-related food insecurity and/or malnutrition among PLHIV and to fully consider opportunities for complementary programming with Feed the Future, World Food Program, etc. **While it does not have a separate program budget code, field teams should carefully and comprehensively quantify the level of financial commitment to food and nutrition represented in OVC, care and support, PMTCT, and treatment programs.** The narrative below is intended to assist teams in ensuring they effectively program activities to both meet country needs and respond to Congressional expectations.

The Food and Nutrition Technical Working Group (F&N TWG) has identified three critical areas of programmatic focus for teams to consider as they develop a nutrition portfolio within their COP:

### Nutrition Care

Nutrition assessment, counseling, and support (NACS) is an essential component of a comprehensive response to HIV care and treatment. Ensuring that basic nutrition assessments and effective nutrition counseling occur consistently and accurately creates a foundation on which all other nutrition activities are based. Therapeutic and supplementary feeding is a critical component of HIV care and support and is most effectively utilized when provision is based on anthropometric criteria. Provision of

therapeutic and supplementary feeding support, particularly in resource-poor settings, should be prioritized to assist the most vulnerable individuals as follows:

1. Replacement/complementary food to HIV-exposed infants up to 2 years of age
2. Supplementary food to underweight HIV+ women in pregnancy and lactation
3. Supplementary food to OVC with evidence of growth faltering (wt/ht <-2 z-score)
4. Supplementary food to HIV/AIDS patients w/ BMI <18.5

Finally, establishing linkages and two-way referral support between clinical treatment centers and community support services is essential to foster sustainable and comprehensive care and support for PLHIV.

## PMTCT and HIV-Free Survival

HIV-free survival (infants who remain alive and HIV-free) is the ultimate goal of PMTCT and infant-feeding programs. WHO recommends ARVs for PMTCT during ante- and perinatal periods and throughout the duration of breastfeeding. For countries implementing Option B+, ARVs will be given to mothers throughout the antenatal period and for life. HIV-infected mothers are encouraged to breastfeed exclusively for 6 months and to continue breastfeeding for a minimum of 12 months and beyond until a safe and adequate replacement diet is available. Programmatic emphasis should be placed on pre- and postnatal counseling surrounding infant feeding, nutrition and testing; and maternal nutrition and health. Special attention should be given to link counseling to early infant diagnosis to discourage premature weaning. Regular assessment, counseling, and support should be provided, particularly to encourage EID and exclusive breastfeeding for the first six months of life and appropriate complementary feeding from six months of age and beyond and to provide post-weaning support at 12 months and beyond. Establishing a continuum of care linking clinical and community services should allow for tracking of mother-infant pairs, a focus on improving maternal nutrition status, and provision of basic child survival interventions until at least 24 months of age.

## Economic Strengthening, Livelihoods and Food Security

Through provision of NACS and other services, care and treatment facilities assist in meeting the needs of PLHIV, their families and OVC. However, these services are not able to address underlying issues, such as generalized food and economic insecurity, that can compromise treatment success and long-term survival of PLHIV, nor are they able to address needs for OVC and their caregivers. Therefore, there is a need to link NACS clients with wrap-around services that address their current economic

strengthening /livelihoods/food security (ES/L/FS) needs and the basic needs of children and families. Efforts are needed to identify promising ES/L/FS practices that can be effectively targeted, scaled-up and linked to clinical services to sustainably improve the economic and food security status of HIV/AIDS-affected households. Coordinating programming of PEPFAR nutrition activities and wraparound services with broader food security/nutrition programs, such as those implemented through Feed the Future, will assist in comprehensively addressing the nutrition needs of PLHIV and their families. Programs that link PEPFAR's nutrition activities to these food security programs provide an opportunity for individuals and households to increase their food security over time, and to be less likely to need nutritional supplementation or assistance from the government or other actors in the future.

### Monitoring and Evaluation

With the scale-up of NACS activities, monitoring and evaluation data are needed to assess the effectiveness of interventions, inform and improve program design, report results, identify successful and unsuccessful approaches, and plan and budget for expansion of activities as needed.

The NACS TWG has collaborated with international stakeholders to develop a set of harmonized nutrition and HIV indicators. All indicators in this set are included in the UNAIDS Indicator Registry (www.indicatorregistry.org). Some of the indicators are included in the PEPFAR NGI set and the latest version of the GFATM M&E Toolkit. The set was designed to be a flexible resource for use by national governments and programs to enhance the monitoring and evaluation of their NACS response. The intention is that country teams will select those indicators from the set that are specifically applicable to the design and status of their NACS programs. Collecting data for these indicators will provide necessary information needed to improve the effectiveness and quality of NACS services.

Technical support for developing a robust set of indicators that can assist in monitoring and evaluating the NACS response can be provided by the NACS TWG as needed.

## 6.2.3 Abstinence and Be Faithful Reporting Requirement

*Field teams are reminded that the budgetary requirement ("hard earmark") for Abstinence and Be Faithful (AB) programs in the original PEPFAR authorizing legislation is no longer in place and has been superseded by a reporting requirement for countries with generalized epidemics.*

If AB programmed activities do not reach a 50% threshold of all sexual prevention funding in any country with a generalized epidemic, OGAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS info.

The Abstinence and Be Faithful reporting threshold for countries with generalized epidemics is calculated by dividing the total HVAB budget code funding by the sexual prevention funding (HVAB + HVOP):

$$\frac{\text{AB (HVAB)}}{\text{Sexual Prevention (HVAB + HVOP)}} \geq 50\%$$

## 6.2.4 Strategic Information

### Central Support for SI – HVSI Budget Code

An important consideration when determining the overall COP planned budget is how much to allocate towards Strategic Information (SI). International standards suggest approximately 5-10 percent of the total budget should be dedicated to SI. Some exceptions may include countries with very large planned budgets, which may have a lower percentage in SI, while some technical assistance countries may have SI budgets that far exceed 5 -10 percent. Activities supported by these resources have a more central or SI infrastructure focus, including for example, support to national or district health information systems, government monitoring and evaluation or statistical units, surveillance/survey implementation, university centers of excellence, etc.

### Program Budget Allocated for M&E

In addition to the overall support for SI activities in the country plan mentioned above, further deliberations are necessary to determine what percentage of program-level funding should be set aside for basic program monitoring and evaluation. International standards suggest approximately 5-10 percent of a program budget should be dedicated to monitoring and evaluation of the program. Regardless of the exact percentage, routine monitoring and evaluation should be integral to all PEPFAR programs. It is important to note that an outcome or impact evaluation may be considered in conjunction with a program, and these studies often require a higher level of funding. In these instances, additional resources above the 5-10 percent range may be necessary.

## 6.3 Single Partner Funding Limit

The single partner funding limit diversifies the PEPFAR partner portfolio, and expands partnerships with local partners, all with the goal of promoting the long-term sustainability of HIV/AIDS programs in our partner countries. For FY 2014, the limit on funding to a single partner is no more than 8 percent of a country's PEPFAR budget, excluding U.S. Government country team management and operations costs.

### 6.3.1 Exceptions to the Single Partner Funding Limit

The limit applies only to grants and cooperative agreements; contracts are exempted. In addition, there are three blanket exceptions to the limit (drug/commodity procurers, Government Ministries and parastatal organizations, and umbrella awards), which are defined as follows:

A. **Drug/Commodity Procurers:** The exception will apply to organizations that provide technical assistance and services but also purchase drugs and commodities, as well as to organizations that primarily purchase drugs and commodities. All commodity/drug costs will be subtracted from the partners' total country funding applicable against the cap. The remaining awards and all overhead/management costs will be subject to the cap.

   When a country team notifies OGAC that an awardee has been selected, it also should note whether the awardee purchases drugs and commodities and identify the amount spent on those drugs and commodities. The amount of funding for drug and commodity procurement should be included in the COP entry for the given partner.

B. **Government Ministries:** Awards to partner government ministries and parastatal organizations are excluded from the limit. A parastatal organization is defined as a fully or partially state-owned corporation or government agency. Such state-run enterprises may function through a board of directors, similar to private corporations, but ultimate control over the board rests with the government. Parastatal organizations are most often found in centrally planned economies.

C. **Umbrella Agreements**[18]**:** The grants officer will determine, in consultation with the country team, whether an award is an umbrella for purposes of exception from the cap on an award-by-award basis. This determination may be made at the time the announcement is written based on the statement of work or at the time of award based on the applicant's work plan. The following criteria apply to decisions about umbrella status:

- Awards made with the intent that the organization make sub-awards with at least 75 percent of the grant (with the remainder of the grant used for administrative expenses and technical assistance to sub-awardees) are umbrellas and exempted from the cap.
- Awards that include sub-awards as an activity under the grant but do not meet the above criteria are not exempt, and the full award will count against the cap.

Grantees may have multiple PEPFAR awards in a country, some of which qualify as umbrellas and are thus exempt from the limit, while others are not umbrellas and thus count against the limit. When country teams notify OGAC that the grants officer has selected an awardee, it also should note whether the award qualifies as an umbrella based on the above criteria and identify the amount of the award.

Where a grant has characteristics of an umbrella award but administrative and technical assistance expenses exceed 25 percent, the country team may consider requesting an exception to the cap on a case-by-case basis.

### 6.3.2 Umbrella Award Definition

An "**umbrella award"** is a grant or cooperative agreement that does not include direct implementation of program activities but rather acts as a grants-management partner to identify and mentor sub-recipients, which in turn carry out the assistance programs. Thus, an umbrella award functions primarily as a sub-grant-making instrument, although it may also operate a small administrative program attendant to its grant-making function. Typically, a relatively small percentage of the funds of the overall grant are appropriate for use for administrative purposes. In addition, it is feasible that in situations in which an umbrella award provides significant technical assistance and

[18] See definition of and additional guidance on umbrella awards below.

management support to its sub-recipients, it may reasonably devote a greater percentage of its overall funds to providing these services.

An umbrella award may be made to either a local or an international entity, although PEPFAR strongly encourages teams to use local, indigenous umbrella organizations wherever possible. A basic goal should be to use the umbrella award recipient to develop indigenous capabilities to create a more sustainable program. Umbrella awards are not subject to the eight percent cap on single-partner funding.

The following are "best practices" for umbrella awards:

- Where local organizations are strong, umbrella grant programs hire a strong local or international organization whose role is to run a grant making and administration program by using a relatively small percentage of the funds (usually around seven percent) in the overall grant for these purposes.
- Where local organizations are weak, umbrella grant programs include significant technical assistance, either as part of the responsibilities of the grant-making organization or of a separate organization. The best examples again spend a relatively small proportion of the overall grant (typically 20 to 30 percent) on these services and are quite specific as to the responsibilities of the prime grantee in strengthening local partners. Such awards must move to the seven percent level on a rapid timeframe as the technical capacity of local partners increases.
- To qualify for exemption from the single-partner funding cap, an umbrella award may not spend more than 25% of the overall grant for administrative expenses and technical assistance. Where a grant has characteristics of an umbrella award but administrative costs and technical assistance exceed 25 percent, the country team may consider requesting that OGAC authorize an exception to the cap on a case-by-case basis.
- An organization that receives umbrella awards may separately have other grants or contracts in which it engages in direct program implementation activities. However, awards containing such activities are not considered umbrella awards and are subject to the 8% single-partner cap. An award that includes both direct implementation and sub-grant-making activities will not normally count as an umbrella award for the purposes of that grant, but OGAC may permit exceptions on a case-by-case basis.

### 6.3.3 Single Partner Limit Justifications

You will be asked to submit a justification for any partner that exceeds the single-partner funding limit, after excluding organizations (host country government organizations, parastatals) and funding (umbrella awards, drug and commodity

purchases) exempted under the exceptions noted above. No justification is required for partners that would exceed the 8% limit only if procured commodities were included; however, the dollar amount of funding the partner will use for commodity procurement should be included with the implementing mechanism information. Teams can utilize the Single Partner Funding Limit report in the Budget Module of FACTS Info to help determine if a justification is required for any partners. Justifications should be uploaded to the FACTS Info document library as 'Budgetary Requirements Justification'.

## 6.4 Justifications

All justifications should be uploaded into the FACTS Info document library as 'Budgetary Requirements Justification'. Again, the Budgetary Requirements Worksheet and the Single Partner Funding Limit report will help teams to determine if justifications are required for the FY 2014 COP.

Justifications are required in the following instances:

- Former focus countries (except Vietnam and Guyana) not allocating 10% of their prevention, care and treatment budget to HKID/OVC activities
- Any country not allocating 50% of the prevention, care and treatment budget to the care and treatment of PLHIV
- Generalized epidemic countries not allocating 50% or more of their sexual prevention budget to Abstinence and Be Faithful programming
- Any country allocating more than 8% of their program budget to more than one partner if this partner does not fall within one of the exceptions.

## 6.5 Unallocated Funding

As in FY 2013, FY 2014 COPs/ROPs may not include **any** unallocated FY 2014 funding. All funds must be planned at the time of the COP.

**However, if funds are not needed or able to be spent in an efficient timeline teams are encouraged to submit a final COP requesting less new FY 2014 funding if they are able to fully fund their program under the funding amount listed in the FY 2014 official planning level letter, rather than creating TBDs and/or overfunding mechanisms.** Some examples of instances in which this scenario may occur are as follows**:** excess pipeline, transition, other available donor resources, etc**.**

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

**Teams that determine the existence of excess pipeline are advised to request fewer FY 2014 funds to support FY 2014 COP activities than recommended in their planning level letter.**

Countries may still utilize TBD mechanisms where necessary, being careful to ensure that the implementing mechanism template identifies the relevant program budget category/ies, cross-cutting issues, and the U.S. government agency expected to manage the TBD. However, country teams should take into consideration the increasingly rigorous scrutiny of pipeline, TBD balances and awarding track record, and that TBD submissions that are delayed in the procurement process limit the ability to sustain or scale-up vital services, and contribute to the scope of unobligated balances. Teams should be able to concretely discuss planned TBD procurements in the COP review process. TBD submissions that include a full year of funding for a TBD that will not be identified and awarded for several months will not be approved.

## 7. COP Elements

The COP, should be written in a business tone with consideration that this is an official document, that once approved is notified to Congress and will become a public document after redactions.

### Architecture of COP Narratives

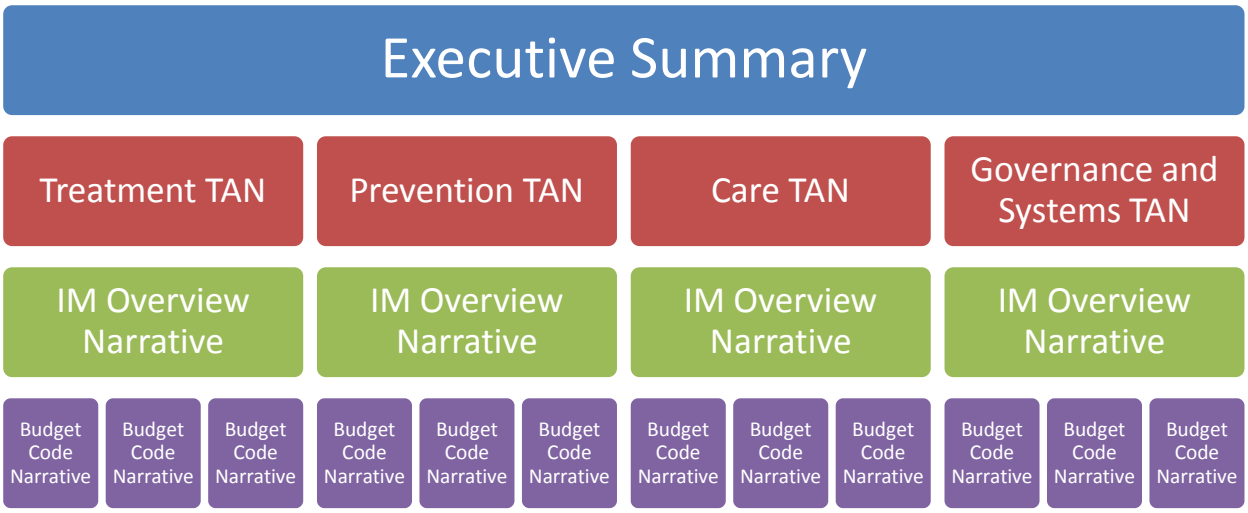
- Executive Summary is the overarching PEPFAR program strategy in country, highlight on key epidemiological data, key risk groups, and fit with host country government program.

- Technical Area Narratives (TAN) are the overarching strategic vision for each technical area.

- Implementing Mechanism (IM) Overview Narratives frame the overarching goals of the specific implementing mechanism or scope of work for a project. Each Implementing Mechanism has an Overview Narrative. that is updated in the Full COP year of the two year cycle. If a new IM is created in a COP lite year an overview narrative is required at the time of creating the IM.

- Budget Code Narratives fit under the Implementing Mechanism Overview Narrative and help illustrate the full picture of the activities planned with the funds budgeted. The Budget Code Narrative is the most detailed narrative about specific activities and should not be about the broader technical area strategy, accomplishments to

date, IM or broader targets or epidemiology. Each Implementing Mechanism has between 1 and 12 Budget Code Narratives.




## 7.1 Pre-COP Funding

Pre-COP funding is a business cycle in which all country teams doing FY 2014 COPs can request funding for critical **continuing** activities and management and operations expenses. Prior to submission to OGAC, pre-COP funding requests must be approved by agency HQs.

Pre-COP requests are completed and submitted via FACTS Info. Requested Pre-COP funding will be cleaned and reviewed by OGAC, reviewed and approved by DPs and The Global AIDS Coordinator. Funding is requested by IM, including budget code allocations. **Once approved, changes cannot be made to Pre-COP funding across mechanisms, M&O or budget codes.** The FACTS Info system locks the funding approved within pre-COP and all COP submissions must use the Pre-COP funding amount as a starting point or a base level of funding for that IM and the budget codes within the IM. The total funding requested during Pre-COP will be deducted from the total country planning level when the FY 2014 COP module opens. Thus, you should seek to allocate remaining funds in the COP module for the FY 2014 COP because the Pre-COP requested amounts are not able to be changed. Utilize the FACTS Info report called "2014 Standard Pre-COP Matrix Report" as a reference for how much additional COP funding should be added to Pre-COP mechanisms, accessing this report early in the COP planning process will be very helpful.

For example, if a country team submits a pre-COP funding request for IM # 1234 at a funding level of $500,000, with $250,000 in PMTCT and $250,000 in HLAB. At a minimum this mechanism will account for 500,000 of the new FY 2014 funding available for the country team and within the budget code allocations the $250,000 for PMTCT and $250,000 for HLAB cannot be reduced after the submission of the Pre-COP request. Additional FY 2014 funds can be added to this IM and these budget codes, but never reduced after the Pre-COP submission.

Teams should be aware that all FY 2014 Pre-COP funding requests will receive a high level of scrutiny from agency HQs and OGAC. This is due to the constraints on making funding available while under a Continuing Resolution (CR) and our commitment to maintaining the integrity of an interagency COP planning and review process as a time for a comprehensive review of country programming and funding decisions.

Finally, please note additional guidance will be provided in a separate document about how to enter Pre-COP cycle request before the cycle is open and available in FACTS Info.

## 7.2 Operating Unit Overview

### 7.2.1 Executive Summary

The Executive Summary gives a high level overview of the OU's program and its priorities for the coming year. The Executive Summary, as with all narratives in the COP, should be written in a business tone with consideration that this is an official document, that once approved is notified to Congress and will become a public document (after redactions).

Executive Summary Purpose:

- High Level OU Overview
- Priorities for Coming Year
- Significant Changes to the PEPFAR program strategy
- Plans for Future Years
- Address Funding Level Letter Priorities

This year, as in the FY 2013 COP, two processes are also being folded in that require a narrative in the Executive Summary. First, a narrative on the program trajectory in upcoming years needs to be included in the PEPFAR Congressional Budget Justification Supplement (CBJ Supplement). This section of the narrative will be used to help get funding to the field faster following COP approvals.

Countries that do not provide some or all HIV services (e.g., treatment, PMTCT or care) please use the Country Context section to explain who (e.g. Global Fund or Governments) fund these services, and what level of coverage they have achieved.

Second, in the FY 2014 funding level letters, a summary of country-specific priorities and guidance should be addressed with emphasis on how the country team is responding to these priorities in their COP.

The following outline, with suggested page lengths, should be appropriately adapted to your program's context, within the 10 page limit (a summary of character counts allowed can be found in section 2.4.3). Each country program is different, and different programs will need to spend more or less time on different topics. As a result, this outline includes different options for different types of programs. The teams are expected to adapt the outline to best describe their program.

In addition, below there is an optional alternative outline adapted for Regional PEPFAR platforms. PEPFAR teams developing Regional Operational Plans (ROPs) can elect to use this outline if it helps them better describe their program.

Countries that do not provide some or all HIV services (e.g., treatment, PMTCT or care) please use the Country Context section to explain who (e.g. Global Fund or Governments) fund these services, and what level of coverage they have achieved.

Country teams are strongly encouraged to write their Executive Summary first so it can be shared with program officers, host Government officials and partners early in the process, so that all partners are aligned on priorities for the coming year.

## Outline

**I. Country Context** (~½ -1 ½ pages)

a. Epidemiology of the HIV epidemic in the country
b. Status of the national response
c. How does U.S. government fit into the national response?
d. As appropriate:
    i. What do other donors and the private sector contribute to the national response? How does PEPFAR coordinate with these other stakeholders?
    ii. Other contextual factors (i.e., status of women, conflict, economic/population growth etc.)
    iii. How was pipeline and/or other HIV/AIDS funding sources taken into account when planning the FY 2014 COP?

**II. PEPFAR focus in FY 2014** (~1-1 ½ pages)

a. The U.S. government's 3-5 top priorities this year for the PEPFAR program
b. What, if anything, is PEPFAR changing from the FY 2012 or FY 2013 COP?

c. Respond as needed to the priorities outlined in the FY 2014 funding level letter, and explain how the team has responded in the COP.
d. Please describe the interagency approach used when assessing all available resources and determining budgets by program area, the distribution among current and prior year funds and the total planning level (new + applied pipeline) of the submitted FY 2014 COP program?

## III. Progress and Future (~1-1 ½ pages)

a. PF/PFIP/Country Strategy Monitoring – Update on the progress of your partnership framework PFIP, or country strategy, as appropriate. Explain how this year's COP furthers the objectives of the PF/PFIP or country strategy.
b. Please provide an update on Country Ownership, where the program has progressed since your assessment in the 2012/3 COP, and where you intend to focus in 2014, either through COP activities, or through U.S. government staff work.
c. Trajectory in FY 2015 and beyond – Provide any major changes, challenges or programmatic needs you foresee in FY 2015. This is not an opportunity to pitch a "wish list," but rather a place for the team to describe its plans within its understood funding trajectory. Consider reviewing the Country Ownership categories described in the Country Ownership section of this guidance section 5.2.1, and reflect on how your programming advances the country ownership policy for PEPFAR.

Example Program Areas for a large PEPFAR Service Delivery country:
- Treatment
- Care & Support
- Prevention
- SI
- Governance and Systems

## IV. Program Overview (~5-7 pages)

- Provide additional details on each of the major program areas of your COP. Choose major areas (4-5) relevant to your country's context.
- For each program area, discuss the following:
    i. Relevant data from population and behavioral surveys to define the fundamental country context for the program area (e.g., DHS, AIS, IBBS, etc.)
    ii. Major PEPFAR activities/targets or initiatives as appropriate.
    iii. Any significant changes since last year in this area, including plans for scale-up, new activities, transition, or significant changes in strategy.
    iv. Any new procurements planned for this area.

## V. GHI, Program Integration, Central Initiatives, and other considerations (~½ – 1 page)

a. If your country has completed a GHI strategy, please provide an update on how this COP will advance progress towards achieving the cross-cutting areas and targets defined in the GHI strategy. If your country has not done a GHI strategy, please describe how your PEPFAR program is implementing one or more of the GHI principles in this COP. *[For more information, please see the GHI section 5.1]*
b. PEPFAR teams should briefly describe their planned engagement strategies with the Global Fund Secretariat, UNAIDS Joint Program, and other partners to increase coordination, facilitate better joint planning, and achieve harmonized programs for this 2014 COP cycle. Teams should state the intended outcomes of enhanced collaboration with multilateral partners (e.g. better anticipation of TA needs or service interruptions, identification of duplication, adjustments to U.S. government programming to increase coverage, achieve efficiencies, etc.). PEPFAR teams will be asked to address more detailed aspects of their multilateral engagement in the separate Multilateral Engagement tab of the Operating Unit Overview.
c. As applicable, describe additional PEPFAR funds not reflected in the COP that the country is programming through Central Initiatives.
d. As applicable, please describe any other key program considerations relevant to your program's context that is not discussed elsewhere in the executive summary.

## Alternative Outline for Regional "ROP" PEPFAR Programs

## I. Regional Overview (~½ -1 ½ pages)

a. High-Level Overview of the HIV epidemic in the region
b. PEPFAR's Approach in the Region
    i. Partnership Framework
    ii. Key Multi-Country or Regional Partners (e.g. GF regional grant, or Regional HIV coordinating body)
    iii. What, if anything, is PEPFAR changing at a regional level from the 2012 or 2013 ROP?
c. Respond as needed to any regional/overarching priorities outlined in the FY 2014 funding level letter, and explain how the team has responded in the COP.
d. Any new multi-country/regional procurements planned.
e. As applicable, describe additional PEPFAR funds not reflected in the COP that the country is programming through Central Initiatives.

f. Trajectory in FY 2015 and beyond – Provide any major changes, challenges or programmatic needs you foresee in FY 2015. This is not an opportunity to pitch a "wish list," but rather a place for the team to describe its plans within its understood funding trajectory.

**II. Country-by-Country Summary** (~1 page per country, to vary based on size and complexity of country program.)

a. Country-specific epidemiological considerations (what data points, if any, stand out as markedly different from the region?)
b. Status of the national response
c. As appropriate:
    i. What do other donors and the private sector contribute to the national response? How does PEPFAR coordinate with these other stakeholders?
    ii. Other country-specific contextual factors (i.e., status of women, conflict, economic/population growth etc.), especially where this particular country stands out from the other countries in the region
d. How does USG fit into the national response?
    i. The USG's 1-2 top priorities this year for the PEPFAR program
    ii. Major PEPFAR activities/targets or initiatives as appropriate.
    iii. Any significant changes since last year in this area, including plans for scale-up, new activities, transition, or significant changes in strategy.
    iv. Government to Government agreement(s) if appropriate
e. Respond as needed to any country-specific priorities outlined in the FY 2014 funding level letter, and explain how the team has responded in the ROP.

## 7.2.2 Population and HIV Statistics

This section is populated by HQ with key UNAIDS, UNICEF, and WHO HIV prevalence, ANC, and other related statistics. Operating Units are encouraged to review the data. If country teams would like to supplement with additional data from other sources, use the additional fields to insert the information. Make sure to include year and source information for these data.

Country teams should use these figures to assess national service coverage and guide program planning during the COP process. HQ should also consider these background data during their COP review.

### 7.2.3 Partnership Framework/Strategy Goals and Objectives

OUs that have finalized Partnership Frameworks or Strategies that are still active will update PF/strategy goals and objectives for this section of the COP.

### 7.2.4 Global Fund and Multilateral Engagement

**Working with Multilateral Partners:**

Working together, PEPFAR, the Global Fund, and UNAIDS Joint Program have each made significant contributions to the global AIDS response. Each serves as an important pillar that underpins a host government's national program. Although the role each entity plays is quite different, if strong relationships exist among these key stakeholders, PEPFAR teams can access the unique strengths of each to support both U.S. government and the national HIV program goals.

The goals of collaboration with key multilateral partners are:

- *Improved investment*: more strategic investment of GF/PEPFAR funding and resources.
- *Improved management*: joint work towards better use of funds at country-level.
- *Improved technical and programmatic quality*: technical support and quality assurance to ensure high-quality service delivery, and to maximize outcomes.

Per section 7.2.1, please describe your overall engagement strategy with multilateral partners in the Executive Summary and use this section to answer more specific, detailed questions about key multilateral priorities and processes.

**UNAIDS Joint Program:**

At the country level, UNAIDS has a critical role to play in engaging government and key partners to make strategic and coordinated investments. PEPFAR country teams should engage with UNAIDS as a joint program and maximize the role of the UN as an "honest broker" and advocate for an effective AIDS response, particularly when moving government towards accountability and action.

The UCC is the entrance into the UN family in the same way that the PEPFAR Coordinator can be the entry point into the U.S. government HIV/AIDS response. UCCs are posted in over 80 countries. PEPFAR Coordinators should be in frequent contact with their country UCCs, ideally over a set of commonly identified program issues that require a political/diplomatic or technical intervention. Coordinators should allow UNAIDS to convene or lead when strategically appropriate.

The UN family is also actively engaged with the Global Fund at all levels: on the Board, on CCMs, and in direct work with Principal Recipients (PRs). Their relationships with government and their mandate to convene partners, including civil society, can be important tools as PEPFAR engages with the Global Fund. UNICEF and WHO are also important technical collaborators and program implementers to engage when present.

Lastly, in a few PEPFAR countries, UNDP serves as the Global Fund Principal Recipient. In these countries there are additional opportunities to engage with UNDP especially around their capacity development plans. UNDP recently published a Capacity Development Toolkit for Global Fund programs intended to support national partners and UNDP Country Offices in building capacity to manage Global Fund grants.

PEPFAR teams who have questions about opportunities to better engage UNAIDS, should contact your CSTL and the Multilateral Diplomacy team at OGAC.

### Global Fund stakeholders:

Close collaboration between the U.S. government and the Global Fund is actively happening on many levels in country and at headquarters, and further program integration and collaboration at the country level is critical to maintain and expand upon these gains. U.S. government staff engagement in these activities is necessary to ensure that PEPFAR, the President's Malaria Initiative (PMI), other U.S. government health resources, and Global Fund investments are utilized to the maximum gain of all stakeholders by ensuring increased efficiencies and greater health outcomes. **As such, PEPFAR teams are expected to demonstrate a high level of program planning, coordination, and integration between PEPFAR and Global Fund-financed HIV programs through COP activities and technical assistance (TA).**

In addition to engaging Global Fund stakeholders during COP planning (Section 2.2.2), PEPFAR teams should be in regular contact with the Geneva-based Global Fund counterparts, principally Fund Portfolio Managers (FPMs), and in-country Global Fund structures and partners; Country Coordinating Mechanisms (CCMs), Principal Recipients (PRs), and the Local Fund Agents (LFA). Together, PEPFAR teams and their Global Fund counterparts should review key program activities, performance of Global Fund grants, funding cycles/milestones (e.g. COPs, Global Fund Concept Notes), and calendar of other key events (e.g. high level or technical visits). Discussions may vary according to country context, but should include communication about host-country, PEPFAR, Global Fund, and sources of other funding for HIV/AIDS; identification of key implementing partners (especially partners receiving both Global Fund and PEPFAR support); an assessment of and engagement in in-country Global Fund governance/management

(through CCM participation, direct communication with Fund Portfolio Manager); support for high impact HIV/AIDS interventions; knowledge of epidemiologic, costing, program results and other data; and health commodities forecasting, procurement, and distribution. The goal of this targeted collaboration should be meaningful to the national health response, and may entail altering investments in a particular program area for greater alignment, holding a joint program review, and/or mapping jointly-financed sub-recipients and sites to reduce the possibility of duplication of efforts.

A number of PEPFAR teams are engaging successful collaborative activities and providing engagement in joint planning exercises. PEPFAR teams should work closely with FPMs to engage in some or all of the following specific programmatic activities:

- Mapping of HIV/AIDS services, and assessment of service and data quality to improve the delivery and quality of HIV/AIDS services and results reporting, identify current partner coverage areas, identify gaps in services, utilize both funding streams to implement a harmonized package of services provided through PEPFAR and Global Fund financing, and to inform development of the Global Fund Concept Note;
- Planning and alteration of investments as necessary to achieve greater coordination of health commodities procurement between PEPFAR and Global Fund, and support supply chain assessment and systems strengthening for health commodities funded by PEPFAR, Global Fund, and country resources;
- Promotion and participation in routine joint forecasting exercises and agree on reciprocal sharing of supply plans and data on orders;
- Risk assessment of joint/shared implementing partners in areas of program management and financial reporting;
- Joint monitoring and evaluation, quality-of-services, and facilities assessments of shared implementing partners, including data sharing, data reconciliation, and collaborative engagement in data quality and service assessment exercises where possible;
- Collaboration on the sustainable implementation of national monitoring and evaluation systems like DHIS2, review key data gaps and identify needed surveys, and encourage the use of high quality data for program management;
- Jointly working with the government to lead a sustainable national HIV/AIDS response by financing specific program areas or the transition of health workers from Global Fund and PEPFAR payrolls to government support; and
- Identification of funding cycles, and engaging in joint planning for GF and PEPFAR funding according to coordinated funding cycles.

PEPFAR teams who have questions about opportunities to engage in the Global Fund grant lifecycle, best practices or tools for coordination, or about central and field

mechanisms to support Global Fund grant performance, should contact your CSTL and the Multilateral Diplomacy team at OGAC.

**Technical Assistance:**

To support the goal of enhanced multilateral engagement, the U.S. government has various options for both providing and facilitating technical assistance to CCMs and PRs, and for increasing coordination between PEPFAR and Global Fund-financed programs. These options include:

- *Bilateral TA*: U.S. government projects can provide TA through bilateral and centrally-funded staff positions and mechanisms in order to build the capacity of CCMs and PRs, to resolve implementation bottlenecks, or to improve program quality. Possible areas of support include: CCM governance and oversight issues, PR programmatic and financial management issues, M&E, Health Management Information Systems (HMIS), procurement and supply chain management (PSM) planning, and provision of epidemiologic or costing data to inform proposal development, among others. Please see Appendix 9 of available mechanisms to support various activities.

- *Global Fund Liaisons:* An increasing number of country teams have added Global Fund Liaison positions to their staff in order to increase their capacity to coordinate and collaborate with the Global Fund. While every team may not need a dedicated FTE, all teams are strongly encouraged to designate one individual as a "Global Fund focal point" and ensure that some percentage of that person's level of effort (LOE) is specifically allocated for Global Fund work with associated performance objectives. The Multilateral Diplomacy team at OGAC can provide support in developing position descriptions and options for hiring mechanisms. Please be sure to include your Global Fund Liaison position in the staffing database per the guidance in Section 8.6.

- *Country Collaboration Initiative*: Under the centrally-funded Global Fund Country Collaboration Initiative, several PEPFAR field teams and partner governments received additional support to increase coordination and optimize Global Fund grant performance. This funding was intended to better integrate PEPFAR and Global Fund programs.

Identifying technical assistance needs through the COP review provides an ideal opportunity to understand existing and emerging challenges countries and PEPFAR teams are facing with Global Fund grant implementation. Your feedback helps to inform the allocation of central resources under the *Global Fund Technical Assistance*

*Strategic Framework*. Successes, challenges, and opportunities for technical assistance should be captured and flagged for the Multilateral Diplomacy team at OGAC.

### Multilateral Engagement FY 2014 COP Questions:

PEPFAR teams should describe their planning and engagement with multilateral partners by referencing Sections 2.2.2, Section 2.3.1, Section 5.2.4, and Section 7.2.4 and by responding directly in FACTS Info to the questions below:

1. Please describe how the U.S. government will leverage partnerships with the Global Fund, UNAIDS, and other partners to advance larger policy issues at the national level.
2. How is/will the U.S. government engaging with partners in Global Fund concept note development under the New Funding Model (NFM) and UNAIDS Investment Approach/Investment Case development?
3. How will these processes (Global Fund NFM and Investment Approach development) affect COP planning and U.S. government programming? How has the NFM and/or the Investment Approach created space for strategic discussions with stakeholders about the investment of Global Fund and donor resources? At which national entry point (i.e. NSP, Phase 2, GF concept note, national program evaluation)?
4. We recognize that procurement and supply chain management issues are regular challenges in Global Fund implementation and performance; please elaborate specifically if and how this is an obstacle in your country. In addition, what are 2-3 other primary challenges facing Global Fund grant implementation or Investment Case development? How are you planning to address these challenges through your COP, partners, or any other activities?
5. Are you a recipient of Country Collaboration Initiative funds and/or do you have a Global Fund liaison? If yes, please describe what has worked well and any lessons learned you may have. How have you tailored the placement and responsibilities of the Global Fund Liaison to your program needs? Do you have plans to incorporate any of these activities into your COP?

## 7.2.5 Public-Private Partnerships

PEPFAR defines Public-Private Partnerships (PPPs) as collaborative endeavors that combine resources from the public sector with resources from the private sector to accomplish HIV/AIDS prevention, care, and treatment goals. Private sector stakeholders include corporations, foundations, business and trade associations, and private health sector service delivery providers.

PPPs enable the USG and private sector entities to maximize their efforts through jointly defined objectives, program design and implementation, and the sharing of resources, skills, risks and results. The three hallmarks of PPPs are: 1) they help ensure sustainability of programs; 2) they facilitate scale-up of interventions; and 3) they leverage significant private-sector resources.

Matching resources can be financial resources, in-kind contributions, or intellectual property. For reporting purposes, a collaboration is considered a PPP if the ratio of private resources to PEPFAR funds is at least 1:1. In the event the private sector partner contributes resources in-kind, OU teams should monetize the contribution by estimating its market value, in coordination with the partner. While the definition of a PPP encourages a 1:1 match from the private sector, OU teams are strongly encouraged to engage with private sector entities regardless of resource inputs whenever it increases the effectiveness of programs.

**A private sector partner must contribute resources.** This is the key aspect of a public-private partnership.

A contract with a private company or private health provider to deliver services is not a PPP unless the partners is directly contributing matching resources to the collaboration. Additionally, a PPP is not an activity that builds off an existing investment with no new money or in-kind contributions from the private sector collaborator designated specifically for the newly proposed partnership.

The critical core elements that reviewers of the FY 2014 COPs will expect to see represented in the public-private partnerships operating unit summary are provided below:

- **Operating Unit:** Should be pre-populated
- **COP Planning Cycle:** Should be pre-populated
- **Name of Partnership: Required for submission**
- **Name of Partner(s):** Private sector partners, not implementing partners
- **Mechanism**: Required for submission
- **FY 2014 PEPFAR Planned Contribution:** Funding only
- **FY 2014 Private Planned Contribution:** Total of cash and in-kind
- **PEPFAR Life of Project Commitment**: Total funding level for life of the project
- **Private Sector Life of Project Commitment**: Total cash and in-kind value over the life of the project
- **PPP Description:** Brief description describing activity, reason for partnering with private sector, year in partnership (e.g. Year 2 of 4), and main indicators to

be tracked and related to core COP PEPFAR goals and objectives. Also a brief narrative on how the partnership activity is considered to be innovative and may lead to sustainable and scalable solution in country or regionally.

Each field should be filled in to the extent possible. However, if a piece of data is not known (e.g. FY 2014 partner name) then the field should be listed as TBD. If the funding amount is not known (for either PEPFAR or the Private Sector), please leave the field blank and indicate in the description that the funding amount is TBD. **During the COP Review Process, fields left completely blank will be tagged for follow-up by the TWG.**

Country teams should refer to the technical considerations as a basic resource and guidance as they consider the development, implementation, and scale-up of PPPs as appropriate to their country context and FY 2014 COP strategies. Country teams are encouraged to contact the OGAC's Private Sector Engagement (PSE) Office and PEPFAR's PPP TWG to assist during the FY 2014 COP process. Inquires can be sent to OGAC's PSE Office: Ms. Lauren Marks (MarksLA@state.gov), Ms. Whitney Ewing (EwingWF@state.gov), and Dr. Jeff Blander (BlanderJM@state.gov).

### 7.2.6 Surveillance and Surveys

The surveillance and surveys table is used to collect a summary of PEPFAR-supported surveillance and survey activities in PEPFAR OUs. Due to challenges in maintaining high quality data within the historical structure, a new version of this table will be implemented for the FY 2014 COP. The records entered into the FY 2014 COP table should reflect past, continuing and planned surveillance and surveys taking place between 2010 and 2016. Other SI activities including M&E and HIS related activities should NOT be included in this table. While completing the table, OUs should select the specific surveillance and survey activity that is being implemented using the pull-down menu, the time period of field work (actual, or projected, start and end dates), date of report publication and whether or not the specific activity collects information on HIV related risk behaviors, HIV prevalence, HIV incidence and size estimation of the target population.

## 7.3 Indicators and Setting Targets for the COP

Quality data are needed to inform the design of COP activities, to monitor partner performance, and to set reasonable and achievable targets. Good target setting and results reporting are inextricably linked. In order for targets to be meaningful and

realistic, the quality of the data on which they are based must meet minimum standards of acceptability.

PEPFAR considers targets and results from two perspectives:

1. National – all operating units (countries and regions) will report national level data on a small core subset of indicators, where applicable. See PEPFAR's Monitoring, Evaluation, and Reporting (MER) Guidance for additional information. National data represent the collective achievements of all contributors to a program area (i.e., host country government, donors, or civil society organizations).

2. PEPFAR Direct Support – The contributions to HIV programs directly attributable to PEPFAR programs. These targets represent expected achievements of the PEPFAR program through its funded efforts and activities. These figures are defined in the Technical Area Summary and Implementing-Mechanism Level indicators and targets.

Please refer to PEPFAR's *MER Operational Guidance and Indicator Reference Guide* for more guidance on required indicators and reporting, including detailed information on what constitutes PEPFAR direct support.

### 7.3.1 National-Level Indicators and Targets

National targets are the expected national achievements inclusive of all stakeholders in a country, and are based on a reporting timeframe defined by the partner national government. These are required for submission to headquarters for selected indicators. All Operating Unit teams must work with partner governments to set and review the annual targets for 2014 and 2015, at a minimum.

National level targets (and results) will be based on a reporting timeline defined by the partner national government. As in previous COP cycles, PEPFAR teams should identify the timeframe for which the national targets are set (e.g., Jan – Dec or Oct – Sept).

In light of recent legislation extending the authorities of the PEPFAR authorization, national targets will continue as a requirement of all COP submissions for selected program areas. These requirements are consistent with PEPFAR practices throughout the recent phase of the initiative. PEPFAR teams will report national targets for four national output indicators. For the FY 2014 COP, the required targets are in the areas of treatment, prevention of mother-to-child transmission (PMTCT), and voluntary medical male circumcision. The MER Guidance will outline the specific indicators that should be used for target setting and the reference sheets that will inform the target

setting process. Although these indicator labels and reference sheets primarily describe PEPFAR-supported programming, OUs are being asked to expand the utility of these indicators to the national context.

Operating units may also need to negotiate the use of additional national indicators associated with Framework and Strategy goals and objectives, and will need to provide targets and report on these indicators. These additional indicators may be submitted as custom indicators in the National Indicators section of the COP (please refer to FACTS Info training and data entry guidance for more information on custom indicators). All PEPFAR teams are encouraged to choose a full complement of indicators (output, outcome, and impact) to monitor major PEPFAR commitments and national program priorities supported by PEPFAR.

### 7.3.2 PEPFAR Technical Area Summary Indicators and Targets

The PEPFAR Technical Area Summary Targets are based on the collective work of all PEPFAR partners, and should represent PEPFAR's contributions to the national program. All teams are expected to report on targets for required indicators that are applicable to the program's funded activities. These targets reflect expected accomplishments that are directly supported by PEPFAR. PEPFAR recognizes that 'direct support' is provided within the context of partner country national programs, as a contribution to or a share of those programs, which may also receive financial and other support from the host country and other donors such as the Global Fund. As such, these targets should feed into the national program goals set through a strategic planning process led by the partner government and supported by key stakeholders.

PEPFAR teams are required to provide a minimum of two years of technical area summary targets for the FY 2014 and FY 2015 time periods (October 1st to September 30th of each fiscal year). While submitted FY 2015 targets are notional, they should reflect best estimates based on information currently available. Revision of out-year targets (FY 2015 and beyond) will be allowed during each following year's COP cycle. When setting targets, OUs should use expected funding levels, historical trends, portfolio reviews, year-end reports and program plans, and relevant program evaluations to inform target setting decisions. Technical area summary targets will need to be adjusted for double counting prior to submitting the COP to headquarters.

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

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

The FY 2014 targets should reflect the expected directly supported program achievements in the fiscal-year time period October 1, 2013 to September 30, 2014 regardless of the appropriation year of the funds used to support anticipated achievements.

**Target Justification Narratives (2250 characters)**

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

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

### 7.3.3 Implementing Mechanism-Level Indicators and Targets: Required for all IMs

Implementing Mechanism (IM) target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements. Country teams must provide a minimum of two years of implementing mechanism targets for the FY 2014 and FY 2015 time periods (October 1st to September 30th of each fiscal year). FY 2014 targets represent expected accomplishments by September 30, 2014. FY 2015 targets represent expected accomplishments by September 30, 2015.

Additionally, a *Planned Budget Target* is required for all CDC IMs only. Planned Budget Targets represent what you would expect to achieve with the planned fiscal year COP budget (i.e., with FY 2014 funds) for each applicable indicator. This is in addition to the FY targets described above.

Each Implementing Mechanism's indicator set should represent a comprehensive set of measurements that provide the information needed by the partner and the PEPFAR team to manage the program activities. Minimally, partners will be expected (by the

country team) to set targets for all required indicators that are applicable to the work they are doing (reference the MER Guidance for reporting requirements). If there are no applicable indicators, and none otherwise identified by the OU (such as a custom indicator), no IM target submission is necessary.

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

Please see section 7.5.9 for more information and where this same guidance is reissued.

### 7.3.4 Policy Tracking Table

The PTT continues to be an important means to monitor policy efforts for PEPFAR. One PTT must be completed for each specific policy targeted for reform by the PEPFAR country team and partner government. These policies are often listed in Partnership Frameworks or similar multi-year agreements between the U.S. government and partner governments. Priority policies selected for reporting should align closely with programmatic goals for HIV/AIDS prevention, care and treatment. It is recommended that PEPFAR country teams select 5-7 priority policies for regular and longer-term monitoring, and that these receive the necessary program support to advance required reforms. The PTT has been updated to allow for improved quality and consistency of reporting. Country teams can utilize the new format to streamline and prioritize what has been reported in past APRs, or as applicable, to include new or revised policy objectives.

The revised PTT utilizes a five-stage policy progress framework

1) Identify baseline policy issue/problem
2) Develop policy intervention/document
3) Official government endorsement of policy
4) Implementation of policy; and
5) Evaluation of policy implementation

The PTT facilitates monitoring of the development, adoption and implementation of key governmental policy reforms needed to achieve and sustain HIV prevention, care and treatment service scale-up, health systems strengthening, and country ownership. It is important to collect quality data that reflects the policy process to complement program monitoring data. Data collected about each stage of the policy process allows PEPFAR to understand the progress being made in strengthening the HIV and AIDS policy environment, and where there may be need for additional intervention or guidance to advance the policy development process or policy implementation. For the Country

Operational Plan, please complete only sections P1-P7 of the PTT. During the APR, all sections of the PTT will be completed for each specific policy targeted.

## 7.4 Technical Area Narratives

In FY 2014, technical area narratives capture a high level summary of the PEPFAR program in four technical areas, which in some cases include multiple budget codes. Information for each technical area is collected to ensure that headquarters has essential information about PEPFAR country and regional programs for approval and reporting while, as much as possible, organizing that information in a manner that is closest to the way programs are already implemented in the field. Technical area narratives and budget coding serve different but linked objectives. Technical area narratives describe an overview of your integrated programs, while budget codes describe details necessary for tracking program funds in response to legislative requirements and Congressional inquiries.

In FY 2012, the last year that included technical area narratives, there were four narratives required: Governance & Systems, Prevention, Care and Treatment. For each technical area, the country and regional teams will describe the strategic overview in narrative form. They narrative topics are the same for FY 2014. The technical area narrative should provide an overview of the country's strategy in the specific technical area, what role the U.S. government will play, and how these activities fit into the Partnership Framework, where applicable. The technical area narratives should not be more than ten pages. You are not required to use the entire space. If the PEPFAR program is not supporting activities in a particular technical area, please leave that Technical Area Narrative blank.

For each TAN there are suggested questions from each individual TWG. These are questions the TWGs wanted to highlight for COP preparation this year. As it is not possible to answer all the listed questions for each TAN, please use your discretion on which ones are most important for your country context. For the overall strategic direction of the technical area, please include reference to the strategy for the next two years.

Regional PEPFAR platforms may wish to take a different approach to writing the technical area narratives. Under each TAN, the team is encouraged to write a high-level 1-2 page regional overview of that technical area whether or not the PEPFAR program is invested in that program area. The team may then wish to highlight a few country-specific exceptions or differences. Following this regional introductory section, the team should then follow the generic TAN guidance as described below.

### 7.4.1 Care

In keeping with the principles of the PEPFAR Blueprint, PEPFAR programs should attempt to maximize access to HIV Care, while making every effort to ensure quality services are delivered in a sustainable fashion.

In planning for the FY 2014 COP, and developing the Care TAN, please review the technical priorities section of the COP Guidance, both for guidance specific to Care programs, and to understand overall program priorities; for example, some of the issues addressed as Treatment priorities may also have implications for Care programs. In addition, please be aware of a number of new strategy and guidance documents, including the soon to be released PEPFAR Quality Strategy, PEPFAR Linkage and Retention Strategy, the PEPFAR Monitoring, Evaluation and Reporting Strategy, and new guidance for Adult Care and Support programs (among others). PEPFAR teams should utilize these key documents to guide FY 2014 planning.

The Care TAN should encompass programs in Adult Care and Support (including Positive Health, Dignity and Prevention), Pediatric Care and Support, TB/HIV, Orphans and Vulnerable Children, and Food and Nutrition. The maximum length of the Care TAN is ten pages.

The initial section of the TAN should describe the overall programmatic strategy for Care across all these areas, following the outline below. Subsequent sections should describe strategies specific to the component technical areas (i.e., Adult Care and Support, TB/HIV, etc.), addressing the questions below. Where possible, the use of specific examples may be helpful to convey how strategies are made operational.

Following the outline below are questions related to each of the program areas within Care, as well as questions related to cross-cutting areas [Quality, Gender, Key Populations, Health Systems Strengthening (HRH, Lab, and SI), Private Sector Engagement]. **Teams need not feel compelled to address every question below; please focus particularly on areas of emphasis in your Care portfolio.** While it may not be possible to answer every question listed, please share the questions with your implementing partners as well for use in the design of activities.

- **Outline - Overall Programmatic Strategy in Care: (2-4 pages)**
    - Major Accomplishments in Last 1-2 Years
    - Key Priorities & Major Goals for Next 2 Years
    - Efforts to Build Evidence-Base – How Evidence Informs Strategy & Priorities
    - Alignment with Government Strategy and Priorities
    - Progress in Sustainability and Shared Responsibility

- o Contributions from or Collaboration with Other Development Partners
- o Efforts to Achieve Efficiencies

| AREA | QUESTIONS |
|---|---|
| **Adult Care and Support:** | • **Of the following Care and Support (C&S) interventions, please list all that PEPFAR supports in terms of <u>direct service delivery</u> in your OU.** Please also indicate which if any of these interventions are part of a "basic package" of services provided to most PLHIV receiving PEPFAR-supported C&S services.<br>a. Cotrimoxazole prophylaxis<br>b. Screening and prevention of TB<br>c. PHDP services<br>d. Malaria prevention (insecticide-treated nets)<br>e. Safe water, sanitation and hygiene (WASH)<br>f. Nutritional assessment, counseling and support (NACS)<br>g. Screening and treatment to prevent cervical cancer<br>h. Screening and treatment to prevent Cryptococcal meningitis<br>i. Screening and prevention of viral hepatitis<br>j. Social services (economic strengthening, legal services)<br>k. PLHIV support groups<br>l. Mental health services<br>m. Pain and symptom management and end of life care (palliative care)<br>• What HIV prevention services are delivered to HIV-infected persons as part of their routine care, through Positive Health, Dignity and Prevention programming? Specifically, how are risk reduction, condom promotion and distribution, partner/family testing, ARV adherence counseling, reduction in alcohol use, family planning/safer pregnancy counseling, and STI management integrated into their care?<br>• Which HIV-infected persons are eligible to receive community-based services? What services are provided to persons in community-based programs? What percent of HIV-infected persons in care receive them? How are patients linked from facility-based to community-based programs, and vice-versa? |

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| | • What efforts are underway to optimize quality of care?<br>• What strategies are in place to optimize linkage and entry into care following HIV diagnosis? (Such strategies should be developed and implemented in close collaboration with HTC programs.)<br>• What strategies are in place to ensure that "pre-ART" patients (HIV-infected persons who have not yet been staged, persons who have been staged and are not yet eligible for ART, and those who are eligible but have not yet started), are retained in care? How have facility- and community-based programs been modified to address retention of these "pre-ART" patients?<br>• What is the extent of coverage of HIV clinical care services (i.e., what percentage of persons who know they are HIV-infected are in care?)<br>• What efforts have been taken to ensure access to care in a non-stigmatizing environment? |
| | |
| **Pediatric Care and Support:** | • How many children (0-9), younger adolescents (10-14) and older adolescents/adults (15-19) are enrolled in care services (current, newly, ever)? What are targets for 2013 and 2014, and what is the retention rate over the past two years for children and adolescents enrolled in care? Are these numbers consistent with goals of reaching 90% coverage by 2015?<br>• What were your major pediatric and adolescent care and support accomplishments in the last two years, and what are your key priorities and goals for pediatric and adolescent care and support for next two years, within the context of the existing government strategy and scale up plan?<br>• How is the U.S. government working with government to implement new 2013 WHO Treatment Guidelines that include universal treatment under 5 years?<br>• How is access to EID and PITC for infants, children and adolescents being instituted to increase case finding within the context of broader MCH services, and what are existing measurement strategies and targets?<br>• What is the capacity at national level to collect and analyze disaggregated pediatric and adolescent care and support data (including costing data) for program use and |

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| | policy-making, and how will the U.S. government work with MoH and implementing partners to improve these data and their application?<br>• How will the U.S. government work to improve the capacity of all health care workers (facility and community), to provide quality pediatric and adolescent care and treatment services, including adherence, retention, and disclosure for children and adolescents, and transition to adult services for adolescents?<br>• How is the U.S. government working to ensure that community and facility-based services are developed and linked to ensure the provision of a continuum of care within a district, region or province, and to minimize loss to follow-up?<br>• What are the plans to expand capacity to prevent, diagnose and treat pediatric TB and other OIs, including procurement of drugs for OIs (e.g. cotrimoxazole), and management of pain? |
| | |
| **TB/HIV** | • Based on the tenets articulated for smart investments in TB/HIV in the PEPFAR Blueprint, what are your key priorities and major goals to strengthen and expand TB/HIV activities in the next two years?<br>• Early initiation of ART for all people with TB who test positive for HIV regardless of CD4 count contributes to a significant reduction in morbidity and mortality. Describe current coverage of ART for co-infected clients. How do you plan to scale-up this activity to rapidly increase coverage among co-infected individuals?<br>• Describe efforts to assure high coverage of HTC among TB suspects and patients.<br>• How do you plan to foster greater effective coordination across TB and HIV programs? What models of TB/HIV integration are implemented in your PEPFAR program/national strategy? Describe planned efforts to ensure linkage between services and across programs to achieve high levels of retention along the TB/HIV cascade.<br>• Describe plans to implement, track, and report on TB screening of PLHIV, follow-up for PLHIV that screen |

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| | positive, and provide isoniazid preventive therapy (IPT) for PLHIV who do not have active TB disease.<br>• How does the COP support TB infection control measures to prevent transmission of TB in healthcare and community settings?<br>• What is the status of efforts to expand interventions to improve early diagnosis and treatment of TB among PLHIV and support scale-up of Xpert MTB/RIF assay?<br>• What are your monitoring and evaluation strategies to measure progress in program implementation, assess the impact of TB/HIV activities and make program adjustments to improve outcomes?<br>• Describe efforts to ensure that children and other vulnerable populations (people in prisons, miners, people that use illicit drugs or abuse alcohol) are included in all TB/HIV program components. |
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| **Orphans and Vulnerable Children:** | • During the next two years, what are your primary goals for supporting children and their households affected by HIV/AIDS? (Please include supportive data and reference to host country priorities as well as relationship to other donor inputs)<br>• What are the program's priorities for strengthening systems to support and protect vulnerable children and their families, including workforce development? (Please reference role of civil and community capacity building as appropriate.)<br>• What are the program's priorities for family strengthening (e.g. economic strengthening, food security, building parenting/caregiver skills)?<br>• How are your programs supporting the needs of children across the age span from early childhood to transition to adulthood?<br>• How are your programs supporting linkages to the continuum of care, as outlined in the technical priorities section of the COP Guidance? (Please reference integration with other specific programs such as pediatric care and treatment, PMTCT or youth prevention as appropriate.)<br>• How have you planned to set aside 10% of the OVC earmark for monitoring and evaluation, especially in light |

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| | of the new MER guidance (see SI section below)? Do the plans include funding for the biennial special surveys for outcomes? Do they include any implementation science studies? |
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| **Food and Nutrition:** | ▪ Describe existing PEPFAR strategies or plans to integrate nutrition assessment, counseling and support (NACS) within HIV/AIDS care and treatment programs per PEPFAR guidelines, including the use of NACS indicators (e.g. Technical Considerations for Food and Nutrition). *Consider: how are these linked to national level food and nutrition coordination bodies, national strategies, and national M&E systems? How are quality improvement methods being employed to enhance data collection and analyses at the national, regional and program levels? What technical assistance partner (central or bilateral project) plays a leading role in food and nutrition work with the government and bilateral implementing partners at clinic and community levels?*<br>▪ Have the clinical and community partners been provided with funds specifically designated for NACS activities and included these within their budget and work plans? *Consider: how are therapeutic and supplementary foods being procured for provision within NACS? Is technical assistance being provided for food processing companies to meet quality and safety standards? Is there support for supply chain management for distribution of therapeutic and supplementary foods through NACS programs?*<br>▪ How are clinical and community partners linked, and/or how are bi-directional referral systems maintained to support a continuum of care that includes food and nutrition? *Consider: what assessments or programs exist that address household economic strengthening, livelihood and food security activities (ES/L/FS) linked to PEPFAR programs and are implementing partners linking PLHIV, their families and OVC to ES/L/FS support as a component of the continuum of care?* |
| **Cross Cutting Areas** | |
| **Quality** | The soon to be released **PEPFAR Quality Strategy (PQS**) describes an overarching approach to Quality, initially |

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| | addressing clinical programs. PEPFAR teams should consider implications for clinical care programs, including Adult Care and Support, Pediatric Care and Support and TB/HIV programs (and other programs as appropriate), focusing initially on a small number of high priority quality concerns in each program area. In the Care TAN, please address the following:<br>• Based on the principles and approaches outlined in the PQS, how will PEPFAR programs, in collaboration with national and local governments and implementing partners, address quality in clinical care programs? Please describe your overall approach, and specific areas of focus related to priority quality issues in each program area, addressing both quality assurance and quality improvement.<br>• What is the national plan to ensure and measure quality for clinical services, particularly in reference to clinical care programs? How will PEPFAR support further development and implementation of the national plan?<br>• What efforts are planned or underway in terms of standardized, periodic supportive site supervision and regular program reviews for PEPFAR-supported clinical care programs?<br>• What efforts are underway to harmonize quality management and quality improvement activities for clinical care with implementing partners and to align and institutionalize activities in accord with national, Ministry-led quality plans?<br>The forthcoming **PEPFAR Linkage and Retention Strategy (PLRS)** describes PEPFAR's approach to these critical issues, which are key elements contributing to quality care. In the Care TAN, please address the following:<br>• Based on the principles and approaches outlined in the PLRS, how will PEPFAR programs attempt to optimize linkage and entry into care following HIV diagnosis?<br>• Based on the principles and approaches outlined in the PLRS, how will PEPFAR programs attempt to optimize retention in clinical care programs? Please describe any specific areas of focus in different program areas (e.g. retention of children/adolescents in care; retention along |

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| | the PMTCT cascade; retention of TB/HIV patients; etc.). |
| **Gender:** | • Based on a review of the most recent APR results for males and females, are there gender disparities in delivery of care services? How will they be addressed?<br>• Please describe gender-specific approaches and programming goals related to care, and describe how these will be implemented and monitored. |
| **Key populations:** | • Based upon the best available data, what percentage of HIV-infected persons in the country are members of key populations (sex workers, people who inject drugs, transgender persons, and men who have sex with men)? What percent receive clinical care services?<br>• How is your country program addressing the care needs of key populations (KPs)? Does your country program provide a basic package of services for KPs? Please address the question specifically for the individual KPs – PWIDs, MSM/TG, and SWs.<br>• How are care programs for KPs linked to appropriate, accessible and friendly HIV prevention and support services for KPs? How is your country program advocating for supportive policies or addressing legal barriers to provide services to KPs and creating an enabling environment for KPs to access services? |
| **HRH** | • How does the country support health workforce development to sustainably expand HIV care and how does your work align with the overall PEPFAR HRH objectives (see the "Governance and Systems" TAN) and national HRH plan? As part of this discussion, please include a description of: Use of community health care workers, including training, mentorship and supervision, credentialing or other standardization, and compensation. Describe how CHWs are supported to assist in: 1) the early identification of HIV, TB and malaria, 2) the timely referrals of clients to health care sites for diagnosis and management, and 3) the support for client and family adherence and retention.<br>• Efforts to support the role of social workers in HIV care activities, such as in the area of OVC care and support. Please include discussion of the policy, training, mentorship and supervision, credentialing, and compensation of such workers. |

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| | • Use of "task-shifting/ task-sharing" efforts among HIV care staff, including work to change policy, training, and/or mentorship and supervision to support a task-shifted model of HIV care. Please include approaches to strengthen the use of multi-disciplinary teams and how task-sharing is implemented within these teams.<br>• Approaches to update the knowledge and skills of health workers through pre-service training and/or continuous professional development on new or emerging HIV care issues, including the implementation of WHO guidelines, and/or new national guidelines |
| **Laboratory** | • What laboratory services are available in the country to determine ART eligibility, diagnose TB and other HIV-related infections? How will access to these laboratory services be improved? Is there a tiered system of laboratory services? What quality assurance systems are in place to ensure accuracy of testing? |
| **Strategic Information** | • Describe the key challenges and strategic responses to strengthen the Care information base through integrated SI approaches, inclusive of surveillance and surveys, monitoring, evaluation, and health information systems.<br>• Describe the key challenges and strategic responses to expand and strengthen Care information use at all levels of implementation associated with national program strategies.<br>• Describe the key challenges and strategic responses to strengthening national systems for Care surveillance and surveys, monitoring, evaluation, and health information, while simultaneously integrating PEPFAR systems into these national developments. |
| **Private Sector Engagement:** | • What role will the private sector play in advancing key priorities in provision of care? Please highlight specific public-public private partnerships that will advance major care goals. PPPs may be specific to one element of the care technical area (such as OVC, food and nutrition, pediatric care and support, etc.) or may span multiple program areas. |

## 7.4.2 Governance and Systems

Health systems strengthening efforts are needed to ensure that U.S. government investments today result in sustainable, country-owned HIV responses into the future. Sustainable public health programs require an inclusive approach across public and private sectors – including civil society – to strengthen essential partner country capacities, institutions, infrastructures and systems. This comprehensive approach to sustainability supports Country Ownership and principles of the Global Health Initiative and allows activities supported by PEPFAR to facilitate a continuum of response across HIV programmatic areas.

In the Governance and Systems technical area narrative, country teams should demonstrate how HSS strategies within PEPFAR programs support the prevention, care and treatment components of their program – as well as promote sustainability and country ownership – through strengthening the host country health system and contributing to the partner country's capacity to lead, manage and sustain the national HIV/AIDS response over time. The Governance and Systems technical area narrative focuses on activities related to health system "building blocks" (see HSS section of Technical Considerations) and their linkages to the activities described within the Prevention, Care and Treatment TANs.

**Section 1: Introduction** (1-2 pages)

The introduction should describe the context in which the country team engages with the health system and strategically implements programs to improve both health system building blocks and interactions between them (refer to the HSS Technical Considerations for further guidance on health system building blocks). This section should include an overview of the health system, particularly the major actors and institutions that affect HIV/AIDS programming as well as health system constraints and bottlenecks that constrain delivery of HIV/AIDS services. This section should also describe how the PEPFAR program fits within other PEPFAR priorities, initiatives, and/or relates to other institutions that operate within the wider HIV and health space, such as Country Ownership, the Global Health Initiative, Partnership Framework, and other U.S. government or donor HSS activities (particularly those of the Global Fund).

Description of the context should be based on relevant health systems data as much as possible, drawing from global and country-specific sources as applicable. Data presented in the introduction are the foundation upon which the team's HSS strategy and program plan should be based. Teams should focus on presenting data most germane to PEPFAR HSS investment decisions, such as evidence of health systems and governance bottlenecks across the health system building blocks, aspects of HIV/health service coverage that inform the HSS strategy, features of the system that influence HSS programming (e.g., degree of functional decentralization, financing mechanisms in

use, etc.). Lack of necessary data revealed through health system assessments and/or other surveys that impact the country's HSS strategy, including capacity gaps should also be noted, and addressed, such.

**Section II: HSS Strategy and Program Plan (including Technical Area Descriptions)** (8-9 pages)

Based on the data analysis presented in the introduction, the HSS strategy and program plan for FY 2014 should describe which priority health system interventions (for example leadership gaps, HR gaps) are the focus for the FY 2014 COP, as well as the reasons why those priorities have been selected (e.g., focusing on the most pressing health system constraints to reducing the spread and impact of HIV/AIDS; filling in under-resourced components of existing national health sector plans and programs). **The HSS strategy and program plan should clearly demonstrate how its priority interventions flow from and support the prevention, care and treatment pillars of the overall PEPFAR program.** According to country context, key points to consider and convey across technical areas are:

- Relationships of priority HSS interventions to individual health system building blocks as well as how linkages between the building blocks leverage overall HSS efforts.
- Coordination and leveraging of other platforms, programs and resources (national, U.S. government, and other development partners, particularly the Global Fund)
- Which prevention, care and treatment goals and/or targets priority HSS interventions are supporting and expected to impact over the short- and medium terms
- The population focus(es) of priority HSS interventions
- The geographic focus(es) of priority HSS interventions
- How the priority HSS interventions address Health Systems Performance outcomes (see HSS section of the Technical Considerations), including equitable access to/coverage, efficiency, quality and safety of services
- How the priority HSS interventions contribute to integration of health services, such as integration of HIV services with Family Planning, TB, or MCH services
- How the priority HSS interventions and/or HSS strategy development relate to gender and the new PEPFAR Gender Strategy, including: any gender assessments (conducted or under planning) that highlight gender issues in the context of health systems and human resources; the development of a National HIV and Gender strategy and/or a PEPFAR Gender Strategy; those responsible for gender integration across the PEPFAR portfolio (e.g. Gender Focal Point? A TWG?)
- How the priority HSS interventions support sustainability and the four dimensions of Country Ownership (Political Ownership/Stewardship; Institutional Ownership; Capabilities; Mutual Accountability, including Finance)

- How the priority HSS interventions support decentralized delivery of HIV/AIDS services and/or functional decentralization of health sector authorities that affect delivery of HIV/AIDS services
- How the priority HSS interventions fit within broader national HIV/AIDS and health sector plans, as well as the roles and contributions of other stakeholders

When describing the HSS strategy and priority HSS interventions across various technical areas ("building blocks"), the team should refer to the questions listed in the table below (questions relating to Country Ownership and GHI should be addressed in the introductory section). In addressing those questions, responses should:

- address the technical areas that are relevant to the country program, and prioritize the selected technical areas according to the country context
- prioritize questions to address within each technical area that are most relevant to the country context
- address: (1) the current state of the activities in the technical area; (2) the key priorities in the technical area in the short- and longer-term; and (3) to which PEPFAR indicators do activities relate, with attention to prevention, care and treatment. To provide clarity and context to these sections, country teams are encouraged to employ specific examples in their responses.

| TECHNICAL AREA | QUESTIONS |
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| **Country Ownership** | • Describe how PEPFAR HSS activities support movement along the four dimensions of Country Ownership through systems efforts. In particular:<br>• in TA countries, what system strengthening efforts support transitioning of PEPFAR-supported HRH to country-level institutions?<br>• In LTS countries, how are health systems institutions being strengthened to take ownership over the HIV response, and which level(s) of the system are the focus (es) of the HSS strategy? |
| **Global Health Initiative** | • Describe how PEPFAR is supporting the GHI goals through systems efforts. If your country has developed a GHI strategy, please discuss the governance and systems inputs to the GHI strategy that will be jointly or solely funded through PEPFAR. For example - discuss engagement with the private sector; describe the approach to strategic integration of programs and leveraging of existing platforms (PMI, PEPFAR, MCH, FP/RH); discuss how HSS activities operationalize a focus |

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| | on women, girls and gender equality. |
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| **Leadership and Governance and Capacity Building** | • Describe how PEPFAR is supporting country-owned responses by strengthening the 1) government, 2) civil society (including the private sector) and 3) community capacity to design, manage, and monitor HIV programs at the national, regional, and local levels in order to advance country ownership and sustainability of the HIV/AIDS response. In particular:<br>a. How does the PEPFAR program assist the partner Government, civil society (including the private sector) and communities to take greater responsibility and accountability for decision-making and priority setting, policy making and regulation?<br>b. How does the PEPFAR program coordinate and leverage both existing and new programs of government, civil society (including the private sector) and communities to develop the capacity of relevant actors to manage operational and fiduciary functions, as well as the evaluation and monitoring (including quality improvement) for the HIV response at the community, facility, sub-national and national levels?<br>c. How does the PEPFAR program promote an enabling policy environment for an effective Continuum of Response?<br>d. How well does the PEPFAR team understand the partner country's legal and regulatory framework governing HIV services and health systems? |
| | |
| **Strategic Information** | How is the PEPFAR country program supporting the development and/or implementation of a National HIV SI Strategic Plan that integrates all aspects of SI and builds capacity (individuals, institutions, systems) and ultimately ensures the national government understands their epidemic and response?<br><br>Regardless of whether a National HIV SI Strategic Plan exists, please address following points in the narrative response:<br><br>• How does the PEPFAR country program work with the |

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| | Global Fund to support the National Government to strengthen data collection, management, and use to inform HIV prevention, care and treatment programs?<br><br>• Highlight key successes and challenges of the past year and describe your strategic priorities to support the long-term goal of sustainable, integrated, country-led SI systems.<br><br>In addition, how will the PEPFAR country team build country capacity to lead and implement an overarching SI strategy, ultimately to oversee, manage, and improve the HIV response? As elements of this effort, how will the PEPFAR country team build country capacity to monitor performance, and answer higher level questions of effectiveness, efficiency, and impacts of the program? In particular, how will SI activities:<br>• strengthen national M&E systems and country capacity for the management, interpretation, dissemination, and use of routinely collected information across programs for strategic planning and decision-making?<br>• reinforce country capacity to monitor clinical and community-based HIV programs, inclusive of HIV program inputs, costs, activities, outputs, and outcomes collected through routine monitoring?<br>• enhance the capacity of country governments and institutions to conduct evaluation and analyses to expand evidence to answer strategic questions about the outcome and impact of the response, and to build the necessary evidence base for HIV programs?<br>• build national capacity and leadership to improve data quality through the creation and use of standard practices and principles to ensure quality data ranging from the sources at health facilities and communities, and continuing to the district and national levels?<br>• support the development and implementation of a national strategic approach for health information systems; support development of a national health information architecture; support interoperability standards within the national health information systems; |

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| | and move away from parallel PEPFAR systems towards one national system (see the HIS priority narrative)?<br>• build in-country capacity for surveillance of HIV-related epidemiologic trends (e.g., prevalence, incidence, survival rate, mortality, etc.), and for design and implementation of surveys, including population surveys, IBBS, drug resistance surveys; support development of vital registration systems and additional special studies; support country partner use of results to inform HIV prevention, care and treatment programs? |
| | |
| **Service Delivery** | • In the context of the continuum of response (CoR) in the country (describe the CoR if not described elsewhere in the COP; refer to Appendix 2 for a description of the key features of a CoR approach), how the country will implement a process to:<br>• Use epidemiologic and population-based, behavioral, and other health and social services data to design CoR programs that target the prevention, care and treatment service needs of target populations, including for example: adolescent girls and women prior to pregnancy, pre- and post-natal periods and during infancy and early childhood mother-stages; at-risk and HIV infected adults with affected family members; and MARPs populations including MSM, PWIDs and CSWs?<br>• Establish sustainable, comprehensive CoR programs through the use of existing government service sites and programs at the facility and community level, with established mechanisms to link/integrate and leverage NGO/FBOs, civil society, and private services and providers?<br>• Demonstrate ability to link/integrate essential and evidence-based prevention, care/support and treatment services that address client needs through a lifespan approach and within the context of family units. Explain the integration of quality assurance/quality improvement activities within the CoR approach?<br>• Develop the capacity of partner country governments and institutions to plan, implement and monitor effective and efficient delivery of services? |
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| **Human Resources for Health** | • Describe how PEPFAR's HRH activities align PEPFAR's HRH objectives with country-level HRH priorities. In particular, how do HRH activities:<br>• Improve pre-service education and contribute to the 140,000 target in a way that is specific to your country needs, as well as advance in-service training and continuing education that is nationally standardized, coordinated at a national and local level, and relates synergistically to support for pre-service education?<br>• Strengthen MOH human resources management and planning, including efforts to develop a national human resource information system and the use of data in decision-making and policy change?<br>• Support capacity building of regulatory bodies and professional associations?<br>• Improve recruitment and retention of health workers, especially in rural or underserved areas?<br>• Transition any PEPFAR supported staff to local ownership, where appropriate?<br>• Support improved models of service delivery, including through task-shifting, introduction of new cadres, integration of community health workers in the continuum of response, engagement of the private sector, etc.? |
| | • |
| **Laboratory Strengthening** | • Describe current state of activities, your priorities and strategy to encourage and support the development of a national strategic laboratory plan for improving integration of laboratory services to meet the long-term goal of establishing a national integrated quality-assured network of tiered laboratory services. In particular, how do laboratory activities contribute to:<br>• The development of a comprehensive quality assurance program for HIV rapid testing, EIA-based testing and new POC assays?<br>• The development of governance units of medical lab services within ministries of health to promote policy & legislative frameworks, standards and monitoring, supportive of high quality & coverage lab services?<br>• The development of national laboratory policy, quality management systems and practical accreditation preparedness schemes, assurance programs, and |

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| | standardized training and testing across major disease programs?<br>• The establishment and on-going reinforcement of local referral networks both within and among implementing partners?<br>• Evidence-based planning to assure a competent laboratory work force that ensures quality laboratory services for HIV and other diseases of public health importance?<br>• The development and strengthening of local lab institutes (training, testing, referral, governance, etc.)? |
| | • |
| **Health Efficiency and Financing** | • Describe the current state of activities, your priorities and strategy for assuring efficient use of PEPFAR funds for maximum program impact and your strategy and priorities for contributing to the long-term sustainability of the national HIV programs. In particular, how do activities:<br>• Use economic analyses—such as cost and cost-effectiveness analyses, expenditure analyses and resource tracking—to guide program design, assure efficient program implementation and inform resource-allocation decisions?<br>• Develop country capacity to conduct cost and other economic analyses and use these data to guide program decisions? |
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| **Supply Chain and Logistics** | • Describe how PEPFAR is working to support and strengthen the national health supply chain system to ensure continued availability of key health commodities. In particular, how do approaches:<br>• Support/encourage the development and implementation of a national strategic plan for supply chain?<br>• Contribute to an adequately trained and well-performing supply chain workforce, including capacity building activities and transitioning roles and responsibilities to partner government counterparts?<br>• Improve the availability and use of information within the supply chain system for decision making? |

## 7.4.3 Prevention

The purpose of the prevention technical area narrative (TAN) is to articulate the team's strategy for averting new infections and to provide context for those reading the COP to better understand and assess the specific investments described in implementing mechanisms throughout the rest of the COP.
The Prevention TAN has the four basic parts listed below and subsequently described in further detail.

1. The "Four Knows"- This section describes information relevant to the prevention strategy and includes other important stakeholder roles and activities, e.g. The Global Fund to Fight TB, AIDS and Malaria (GF), ministries of health (MOH), other donors.
2. Strategy – This section is more specific and in-depth than the Executive Summary. It describes how the PEPFAR program's efforts fit into the broader national strategy, its goals for infections averted, how/to what extent each PEPFAR intervention contributes to averting infections, and the timeline for achieving those goals.
3. Priority populations –This section identifies specific priority populations, including by risk factors, vulnerability to HIV, geographic location, etc. Importantly, this section specifies the package of interventions for each identified priority population.
4. Foundational or systems strengthening activities – This section presents activities aimed at building or strengthening systems to support quality HIV prevention over the longer term.

In each section, it will be important to discuss how cross-cutting issues such as gender have been considered in the strategy. Where appropriate, include information on integration with or active linkage to other programs. For prevention of mother-to-child transmission (PMTCT), please describe how the program is integrated with adult and pediatric treatment programs along a continuum of response for pregnant or breastfeeding women, partners, and children.
Each section should present the information outlined below.

**Section 1: The 4 knows** (2 pages)

This data is the justification for your strategy and should be clearly linked to all that follows. It is important to focus on what is germane to PEPFAR investment decisions – 1) epidemiology, 2) context, 3) current response, and 4) costs. Teams should highlight existing data gaps that must be addressed for prevention programming and reference Section 3 or 4 for how those gaps are being addressed (e.g. through PEPFAR strategic information activities, by other donors, at a later date due to competing priorities).This section should reference but NOT repeat epidemiology that has already been presented in the Executive Summary or other parts of the COP; and it should include any recently started and/or ongoing assessments. A brief summary of the team's gender-sensitive

analysis of both the epidemiology and the context must be provided. This analysis should look at gender norms and inequalities, including norms around decision making and control, access to resources, laws and policies, knowledge and beliefs and overall power dynamics - and their role fostering HIV vulnerability and risk.
Include the following:

- Population size estimates, where available, of priority populations, including pregnant women, as defined by your epidemiology, and contributions of those populations to overall HIV incidence.
- Data on key populations (sex workers (SW), men who have sex with men including transgendered individuals (MSM/TG), and people who inject drugs (PWID), their geographic location, incidence and prevalence, disaggregated by age, sex where appropriate and available.
- Coverage of PMTCT services, including quality indicators (e.g.: % HIV positive pregnant women receiving lifelong antiretroviral treatment (ART) as part of a PMTCT program, any cascade and retention data, etc.).
- The prevalence of male circumcision among countries scaling up voluntary medical male circumcision (VMMC).
- The percentage of women and men reporting condom use at last higher-risk sex.
- Salient findings from the most recent DHS, AIS, BSS, etc. including relevant differences by sex and data from the domestic violence module if available.
- Salient findings from any gender or other special assessments conducted by U.S. government or other in-country source.

**Section 2: Strategy** (3-4 pages)

The strategy described in this section should flow from the data presented in Section 1. This section expands upon the overarching strategy presented in the Executive Summary to explain the following:

- National or regional goals for averting infections (including new pediatric infections)
- The PEPFAR program's committed contribution to the national or regional goals. In the absence of national goals, describe the PEPFAR program's goals. When there are gaps between national goals and PEPFAR's committed contributions, describe the contributions of other donors or national strategies for addressing shortfalls.
- How the US Government prevention strategy relates to national or regional care and treatment strategies.

- Other goals of the strategy, such as building capacity or strengthening health systems.
- The approach to achieving these goals with a clear explanation of how cross-cutting issues such as gender and stigma are being taken into account
- The overall approach to linking community services to the clinical platform and back.
- For countries scaling up voluntary medical male circumcision (VMMC), PEPFAR OUs should describe engagement with MOH and other stakeholders on planning for an early infant male circumcision (EIMC) program. EIMC programs must be sustained once implemented and thus financed with long-term funding sources. If EIMC is not part of current agreements or program plans, OUs should outline a plan for incorporating EIMC into documents that describe transition of long-term programs from PEPFAR to the partner country government.
- For countries scaling up VMMC, please also describe your planned request for TA from the MC TWG related to program quality and safety in FY 2014. Indicate whether the program will request an interagency external quality assurance (EQA) assessment. OUs that have previously participated in one or more EQA assessments should also provide that information. Not all countries will require an EQA in FY 2014, as some have recently participated in assessments. If you will not be requesting an EQA assessment in FY 2014, but will instead request TA around other quality-related activities (e.g., development or implementation of continuous quality improvement programs for sites), please describe your planned request here.
- The roles and contributions of other stakeholders. If there are priority populations or needs that emerge in the first section of the TAN, but are not addressed through PEPFAR programming, it is crucial that the team explain the reason. Common reasons may include: other donors are doing this work; the team is working to build political buy-in around sensitive issues and hopes to address the gaps in programming at a later time, etc.
- This section is also the place to describe specific activities undertaken by the PEPFAR team to set program targets and plan activities on the basis of data analysis. PEPFAR teams who provide technical assistance, rather than direct services, use this space to describe activities undertaken to build capacity and support quality in areas where data has identified weaknesses.

**Section 3: Priority Populations** (1 – 2 pages)

Every PEPFAR strategy for averting new infections should be built largely around a set of priority populations. These populations should emerge clearly from the available data described in Section 1, and should be specifically delineated, including by risk factor, vulnerability to HIV, age, sex, and geographical location. For example, "adolescent girls" is too broad; "out of school adolescent girls and young women ages 15-24 in the urban areas of region X" is appropriate. An example for key populations may be MSM in the capital city. Pregnant women should be a priority population for all countries with a PMTCT portfolio. Budget code narratives should also include a finer level of detail about populations where appropriate.

Sex workers (SW) and people living with HIV (PLHIV) should be priority populations in <u>every program</u> unless government or other donors are already providing prevention activities for them. All PEPFAR programs should periodically collect data on MSM/TG populations. Where warranted by data or context (e.g. existing or growing drug trade route), data should be collected on PWID. All studies of key populations (MSM/TG, SW, and PWID) should be conducted in a way that minimizes risk to members of those populations. PEPFAR teams should ensure programs for these key populations when warranted by the data.

For each priority population, please indicate the package of interventions to be provided. *The following examples are only meant to be illustrative of the level of detail expected:*

| Priority Population | Package of interventions |
|---|---|
| MSM in capital city | • Peer education on HIV prevention;<br>• condom and lubrication promotion and distribution;<br>• HIV testing and counseling;<br>• Referrals to friendly clinical services, including STI diagnosis and treatment and HIV care and treatment |
| Adolescent girls and women aged 15-24 in district X | • Programs to promote school attendance;<br>• Peer education on HIV prevention;<br>• Condom promotion and distribution in appropriate settings;<br>• HIV testing and counseling;<br>• Referrals to friendly clinical services, and HIV care and treatment |

These packages should be consistent with the 2011 PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections, the PEPFAR Technical Guidance for Men who Have Sex with Men, the PEPFAR Technical Guidance for People Who Inject Drugs, or WHO Guidance on Prevention and Treatment of HIV and STIs for Sex Workers in LMIC. The updated PEPFAR Gender Strategy also provides important information on ensuring programs address critical gender issues. These prevention packages should typically include condom (and lubricant for SW and MSM) promotion and demand creation for clinical services.

PMTCT interventions should be consistent with PEPFAR Technical Guidance for PMTCT, Adult Treatment, and Pediatrics. For PMTCT programming, include activities supported in each of the 4 prongs, and describe the service delivery model for PMTCT in your country. Indicate whether task shifting policies have been implemented and how this has impacted services.

Teams should indicate the size of the population, and the time-specific coverage goal for the intervention package or parts of the package at the programmatic level and, where possible, at the population level. In addition, teams should articulate how intervention packages will address any cross-cutting issues such as gender and stigma to ensure good uptake and, where appropriate, retention. Teams should indicate where these activities might be integrated within other budget codes or programs such as prevention for adolescent girls on the orphans and vulnerable children platform, early infant diagnosis for exposed infants, or for PLHIV on the care and treatment platforms.

### Section 4: Foundational, systems strengthening and capacity building of national stakeholders (1-2 pages)

Activities described in this section should include support for strengthening or harmonizing monitoring and evaluation systems, ensuring blood safety and availability, ensuring injection safety, providing technical assistance to government ministries or lower level government bodies, strengthening prevention commodity procurement and distribution systems, establishing or improving efforts to ensure quality as well as support to civil society for both advocacy and service-delivery capacity, as well as monitoring and quality assurance. Some of these activities might contribute directly and or immediately to reductions in new infections, others might be aimed at longer term impact.

This is also the place to describe planned activities related to surveillance, surveys or evaluation that address gaps identified in Section 1, if they have not already been clearly described in Section 2. Countries transitioning to PMTCT Options B/B+ should

describe support for enhanced monitoring and evaluation during and after the transition. Describe additional health systems strengthening activities here if they are a large component of the prevention portfolio. Teams should ensure that systems strengthening activities are consistent with the overall health systems strengthening strategy in the Governance/Systems TAN and refer to that section of their COP if they do not describe those activities here.

### 7.4.4 Treatment

Rapidly and strategically increasing coverage of HIV treatment for all eligible PLHIV, both to *reduce AIDS-related mortality* and to *enhance HIV prevention,* is a cornerstone of the PEPFAR strategy to achieve an AIDS-free generation, as outlined in the PEPFAR Blueprint. PEPFAR treatment programs should maximize access to antiretroviral care and treatment programs and work to expand coverage for all eligible PLHIV, while ensuring that quality services are delivered in a sustainable fashion. The Adult and Pediatric Treatment TAN should describe past year accomplishments, major challenges, and planned activities to address challenges and attain goals for the upcoming year.

In developing this TAN for FY 2014, country teams should consider the following issues and provide an overview in the narrative provided:

**Adult Treatment Section** (no more than 4 pages)
Please address the questions below on the OU adult treatment program.

- **Getting Ahead of the Epidemic: Increasing Treatment Coverage for all eligible PLHIV & Reaching the Tipping Point**

  - What are the goals and expected outcomes national treatment program? What is the targeted coverage? How many net new persons will be added to the treatment program over the next funding cycle? What is the targeted tipping point? Over what period of time is the scale-up planned? How is the PEPFAR team engaging with the national government to accelerate and support scale-up?
  - Given the new WHO guidelines, what is the status of national treatment guideline revisions, and what is the anticipated impact on the national program (in terms of access, expanded coverage, prioritization of the sickest patients, ARV regimens, and laboratory monitoring protocols)? What is the timeframe for guideline implementation and how is progress being monitored?
  - Given available prior year resources and anticipated budgets for treatment and external donor support, what is the plan for financing scale-up, both nationally and with PEPFAR support?

- Key Populations: How is your country program addressing the treatment needs of key populations (commercial sex workers, people who inject drugs and men who have sex with men)?
- What efforts are being done to integrate treatment services with care, prevention, MCH (e.g., PMTCT, family planning), and primary care services (e.g., family-centered approach, provision of pediatric ART)?
- HIV/TB Integration: Describe planned efforts to increase ART coverage for persons co-infected with TB and HIV. Are TB screening and infection control practices in place at ART sites, and is IPT available? Are TB patients tested for HIV and offered ART? What models of integrated TB/HIV programming are being supported by MOH policy and PEPFAR?

- **Quality & Oversight [THIS SECTION REFERENCES TWO IMPORTANT PROGRAM STRATEGIES, THE PEPFAR QUALITY STRATEGY AND PEPFAR LINKAGE AND RETENTION STRATEGY THAT WILL BE RELEASED SHORTLY]:**

  - This year, PEPFAR will launch a PEPFAR Quality Strategy (PQS), focusing on HIV Clinical Services. The PQS provides country teams with guidance and tools to develop implement and/or strengthen quality in HIV clinical services with partner governments through a Quality Management, Quality Assurance, and Quality Improvement approach. This year PEPFAR will also launch the PEPFAR Linkage, engagement & retention, complementing the model and the principles outlined in the PQS. The strategy sets expectations for retention outcomes in PEPFAR supported programs and provides guidance, best practices and specific tools for implementation.
  - How is PEPFAR implementing these new strategies?
  - Does PEPFAR support the following activities?
    - National plans to ensure and measure quality for clinical services as governments and local partners take on increasing financial and clinical management of the HIV response?
    - National framework for support and supervision of ART programs under the umbrella of the national HIV and/or health quality strategy?
    - Harmonized quality management (QM) and quality improvement (QI) activities among country teams and implementing partners, which are in alignment with national, Ministry-led, quality plans and initiatives?
    - Performance measurement data used for quality improvement at the site level?

- Standardized, periodic supportive site supervision and regular program reviews as an integral part of U.S. government-supported ART programs?
- Geographic alignment processes to focus service provision in areas with highest concentration of HIV transmission, prevalence, and numbers of people in need of services?
- Efficient and effective algorithms for treatment failure monitoring?
- Surveys for HIV drug resistance?
- National pharmacovigilance systems?

- How is the PEPFAR team ensuring the quality of treatment programs? What elements of supportive supervision and oversight are planned at the site, district, and national levels? How do training, mentorship, and quality improvement activities fit together to support the quality of treatment programs? How is treatment failure being handled, and what impacts are anticipated on 2nd line use and HIV drug resistance?
- How is the PEPFAR team monitoring patients for adherence and treatment failure within treatment programs?
- Is there an existing national or regional system for pharmacovigilance (monitoring and reporting of clinical events related to pharmaceutical use), and if so, to what extent is it currently able to track ARV-related events? Is there a role for PEPFAR or others in strengthening or building such a system?
- Are contingency plans available or in development to determine how ART programs will be supported in the event of unforeseen emergencies?

- **Sustainability & Efficiency:**
  - How are expenditure data and cost modeling activities being used to encourage long-term sustainability of treatment activities and forecast the impact of changes in national treatment guidelines (e.g., change in CD4 threshold for ART initiation to ≤500 cells/mm3, Option B or B+ for pregnant women, treatment of serodiscordant partners, change in ARV regimens, and changes in lab protocols)?
  - What efforts are being done to leverage/coordinate with GFATM and other funders?
  - What activities are planned to improve forecasting (for ARVs, rapid test kits, etc.) and supply planning, streamline procurement efficiency, and simplify treatment regimens?
  - What other activities are planned to identify opportunities for cost-savings and greater efficiency of treatment services?
  - For countries where PEPFAR provides technical assistance for treatment, and not direct treatment service delivery, what plans are in place to improve treatment coverage and reach the tipping point?

**Pediatric Treatment Section** (no more than 3 pages)
PEDIATRIC HIV TREATMENT SECTION (no more than 3 pages)
Areas of focus for the FY 2014-15 COP are: a) Improving pediatric HIV data collection (with disaggregation, if possible), analysis and use at national levels and in USG-supported programs for program and policy improvement; b) continuing collaborative scale-up efforts to increase the number of children and adolescents accessing treatment and achieving 90% coverage by 2015 while improving AIDS-free survival in this population; c) increasing efforts to address the needs of the growing population of adolescents on treatment and linking them to adult services.

- **Background:**

Please describe:
  - What were your major pediatric HIV treatment accomplishments in last 1-2 years in case finding, HTC, treatment and retention in care and treatment?
  - How many children ( Children: <1, 1-4, 5-9; adolescents: 10-14, and 15-19 years of age) are currently, were newly and ever enrolled on ART?
  - What percent of all persons on ART is represented by children 0-<19 years?
  - What are the pediatric treatment targets for FY 2014 - 215 COP?
  - What percent of USG supported treatment sites offer services for children and adolescents (please be specific for both)?

- **Key Priorities & Major Goals for Next Two Years:**
  - How will the USG evaluate the impact of pediatric and adolescent HIV care and treatment programs in the context of the national goal/targets?
  - What are the plans to conduct a comprehensive pediatric/adolescent ART program evaluation?
  - What pediatric and adolescent HIV surveillance activities are planned in your country?
  - What are the plans to better document outcomes of children and adolescents enrolled in care or on treatment (retention rates, morbidity, mortality, HIV drug resistance, growth, nutrition, OI (especially TB)?
  - What are your key priorities and goals for pediatric and adolescent HIV treatment for next two years to meet the goal of 90% coverage by 2015?
  - What approaches and strategies will be used to improve early treatment initiation in young infants and universal treatment of all children less than 5 years of age?
  - What strategies and approaches will be used to expand quality treatment services inclusive of adolescents?

- **Alignment with Government Strategy and Priorities:**
  - Does the country have specific pediatric/adolescent HIV scale-up plans, targets and operational plans?

- How is the USG supporting the government's pediatric/adolescent HIV strategy and scale-up plan?
- How does the USG team work with the MOH to support pediatric /adolescent HIV scale-up?
- What are the contributions to pediatric HIV treatment from other donors?
- What is the current capacity of the MOH to implement pediatric HIV treatment and how is the USG supporting capacity development at this level?

- **Policy Advances or Challenges (Some may have been identified in PF/PFIP):**
  - Have the country guidelines been updated using WHO 2013 recommendations for treatment of children and adolescents?
  - What approaches are being used to decentralize pediatric HIV treatment services?
  - What are the main challenges faced by the country and USG partners to expand pediatric and adolescent HIV treatment services and what are the plans to address these challenges?

- **Efforts to Achieve Efficiencies:**
  - What is USG supported pediatric and adolescent HIV treatment doing to achieve efficiencies?
  - How is the pediatric HIV program being integrated into the broader MCH and community-based program?
  - What are the challenges faced in linking OVC and GBV programs with pediatric and adolescent HIV treatment.

- **Health Systems Strengthening efforts to improve pediatric HIV programs:**
  - What is the capacity at national level to collect, analyze and use (disaggregated) pediatric HIV program data? How is the USG contributing to develop this capacity? How will the USG work with implementing partners to analyze and use pediatric HIV data to further improve the program and national policies?
  - How will the USG work to improve health care worker capacity to provide quality pediatric treatment services? (pre and in-service)What are the plans to expand the capacity to monitor HIV-infected children on treatment, and specifically to identify treatment failure and drug resistance?

- **Key Priorities & Major Goals for Next Two Years:**
  - What are the projected ARV drug needs for the pediatric population for the next two years?

- What are your key priorities and goals to assure country government rationalizes its pediatric ARV drug list, and to secure procurement or quality drugs and improve forecasting of pediatric ARVs next two years?

- **Alignment with Government Strategy and Priorities:**
  - What are the contributions to the pediatric ARV drug supply by the country government, the USG, the Global Fund, CHAI and other relevant donors?
  - How is the USG involved in planning for pediatric ARV procurement with the government and relevant donors?
  - What are the plans for future procurement of pediatric ARVs?

- **Policy Advances or Challenges (may have been identified in PF/PFIP):**
  - How will WHO 2013 pediatric treatment guidelines influence the procurement of pediatric ARVs in the next two years (estimates of number of children eligible for treatment; impact on ARV budget)?
  - What proportions of children are receiving FDCs? With AZT? With d4T?
  - What are the expected needs for lopinavir/ritonavir in the next two years, based on WHO 2013 guidelines for newly diagnosed children?

- **Efforts to Achieve Efficiencies:**
  - Are there plans to work with the country government and relevant partners to develop a rational list of pediatric ARVs in order to simplify ARV drug forecasting, facilitate procurement, increase the use of FDCs, and minimize unnecessary and costly redundancies?

In no more than 3 pages, please address the following cross-cutting priorities:

| AREA | QUESTIONS |
|---|---|

| | |
|---|---|
| **Supply Chain** | • Who are the international procurement and supply chain stakeholders in your country and how are they contributing to either procurement or technical assistance?<br>• How often are pharmaceutical and laboratory commodity product quantifications and forecasting done? Is the forecasting based on consumption data or eligibility criteria? How is the USG contributing to this effort?<br>• Does the country have a "risk mitigation" strategy to prevent stockouts? Please describe.<br>• What are the most important supply chain management information systems strategies that are required in the next few years for pharmaceutical and laboratory commodities? How is the USG team contributing to this effort? Please describe.<br>• What are the main human resources challenges with supply chain issues, and where should the USG put capacity building efforts during the next two years?<br>• Do you have a strategy for promoting sustainability and country ownership specifically related to supply chain issues?<br>• If non-ARV pharmaceuticals are procured in-country, is there an appropriate mechanism to assess drug quality? Briefly describe. |
| | |
| **ARV Drugs: Pediatric section** | Overall Programmatic Strategy in ARV Drugs –Describe the following:<br>• How many children and adolescents have received HIV treatment over the past year with USG support?<br>• Is there a specific working group at the national level that works on pediatric ARV drug selection, forecasting, procurement and distribution?<br>• Who are the principal USG-supported partners working on pediatric ARV drug forecasting, procurement and distribution?<br>• Have there been over-stocks or stock-outs of pediatric ARVs over the past two years? If so, what measures are being taken to avoid these in the next two years?<br>• What are some of the challenges faced in the area of pediatric ARV drug procurement? |

| | |
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| **Laboratory** | • Quality Management and Biosafety Systems: Is there a national strategic laboratory plan that addresses Quality Management System (QMS) across a tiered laboratory network and laboratory safety? What is the progress on laboratory accreditation in the country?<br>• Policies: Are there national policies standardizing and linking laboratory practices across various disease control programs (including HIV/AIDS, TB and malaria, etc.), and assuring quality and resources? Do these support a quality network of tiered laboratories? Are there clear laboratory work force development policies, plans and resources? What progress has been made towards country ownership and sustainability of the laboratory system?<br>• Access: How is the national program working to improve access and quality of rapid HIV testing, CD4 testing, and HIV viral load testing?<br>• Supply Chain Management Systems: Is there a nationally managed SCMS where logistics data are used for action? What was the number of stock outs in the past fiscal year and what are the priorities for next year? Has there been progress in the harmonization of equipment procurement? |
| **Gender:** This section should highlight the priority gender issues affecting HIV treatment in the country and describe PEPFAR's overall approach to addressing them. | Know your Epidemic<br>• Please review the most recent APR results for males and females and describe any disparities in accessing and receiving treatment. Please comment on the extent to which the program results demonstrate gender equity in services relative to men's and women's, and boys' and girls' burden of disease.<br>Know your Response<br>• Please describe gender-specific approaches and programming goals related to treatment, including for each of the 5 gender strategies, and describe how the combination of approaches will be implemented. (Please see technical considerations section for illustrative activities for each strategy and for treatment programs). |
| | |
| **Strategic Information** | • Describe the key challenges and strategic responses to strengthen the Treatment information base through integrated SI approaches, inclusive of surveillance and surveys, monitoring, evaluation, and |

| | |
|---|---|
| | health information systems.<br>• Describe the key challenges and strategic responses to expand and strengthen Treatment information use at all levels of implementation associated with national program strategies.<br>• Describe the key challenges and strategic responses to strengthening nationals systems for Treatment surveillance and surveys, monitoring, evaluation, and health information, while simultaneously integrating PEPFAR systems into these national developments. |
| | |
| **Capacity Building** | • What are the priority capacity building objectives for government, private sector, and civil society players in this technical area?<br>• Are priorities determined by their potential effect on expected HIV/AIDS outcomes and impact?<br>• What components of capacity building (individual, system, organization) are currently being addressed by in country activities?<br>• What current or new partnerships with national government, civil society, and/or other stakeholders will support the strategy?<br>• How are capacity building activities aligned with other stakeholder efforts in the technical area?<br>• What are the capacity development activities, outputs and outcomes and how will these be measured? Does the strategy integrate individual/workforce, organizational, and systems/policy approaches?<br>• What measures are in place or will be developed to assure that quality standards remain as host countries take a greater role in leading and managing the response. What capacities will need to be enhanced to take on these roles? |
| | |
| **Public Private Partnerships** | • What role will the private sector play in advancing key priorities in provision of treatment? Please highlight specific public-public private partnerships (PPPs) that will advance major treatment goals. PPPs may be specific to one element of the treatment technical area (such as pediatric treatment, lab, etc.) or may span multiple program areas. |
| | |
| **Key Populations** | • Based upon the best available data, what percentage of new HIV infections in your country takes place in key populations (sex workers, people who inject drugs, and men who have sex with |

| | |
|---|---|
| | men)? What percentage of key Populations with advanced HIV infection is receiving ART?<br>• How is your country program addressing the treatment needs of key populations? Does your country program provide the minimum package of services for key populations? Please address the question specifically for the individual Key Populations – PWIDs, MSM, and SWs.<br>• How are your treatment programs for key populations linked to appropriate, accessible and friendly HIV prevention, care and support services for Key Populations? How is your country program advocating for supportive policies or addressing legal barriers to provide services to Key Populations and creating an enabling environment for Key Populations accessing services? |
| | |
| **HRH** | Equipping and motivating the clinical and non-clinical workforce to provide quality services and programs is the foundation for expanding and decentralizing HIV treatment. Please summarize your work in the HIV treatment program area to address key HRH issues, and how this work aligns with your PEPFAR country team strategy for HRH, as described in the Governance and Systems TAN. Specifically, please describe your program's efforts to:<br>• support improved staffing models for HIV treatment (such as through task-shifting, expanding the role of community health workers in the continuum of response, introduction of new cadres, and/or the formation of multi-disciplinary teams) and how these models have been adopted / owned by the national health system<br>• promote a country–owned system of continuous professional development (including how it complies with national regulatory bodies) and quality improvement for health workers<br>• strengthen the non-clinical, public health workforce to manage the country's HIV treatment program at national and sub-national levels |
| | |

## 7.5 Implementing Mechanisms

An implementing mechanism (IM) is a grant, cooperative agreement, or contract in which a discrete dollar amount is passed through a prime partner entity and for which the prime partner is held fiscally accountable for a specific scope of work. Examples of

implementing mechanisms are bilateral contracts, bilateral grants, field support (USAID) to a HQ-managed project/entity, cooperative agreements, etc.

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

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

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

**Note: Pipeline information submitted as a part of each mechanism will be reviewed in conjunction with past performance as provided by Agency HQ to determine how FY 2014 COP funds will impact partner pipelines.**

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

### 7.5.1 Mechanism Details

The following pieces of information regarding an implementing mechanism will be submitted on the "Mechanism Details" tab of the Implementing Mechanisms section of the COP.

In general, these implementing mechanism details should not change from one cycle to the next (i.e., the data remains static over time):

- Prime Partner Name
- G2G ( and Managing Agency)
- Funding Agency
- Procurement Type
- Implementing Mechanism Name
- HQ Mechanism ID (system assigned)
- Legacy Mechanism ID
- Field Tracking Number (optional)
- Agreement Timeframe (may change if there are no-cost extensions)
- Benefitting Country(ies) (only required for Regional OU programs)

The following implementing mechanism details must be reviewed and if necessary updated by country teams for the current FY 2014 COP. While some

items may stay the same from cycle to cycle, others must be updated for the current submission in order respond to revised guidance and/or reflect current data.

- TBD mechanism (a mechanism that was TBD in prior cycles may be named in COP14)
- New Mechanism (A mechanism can only be listed as "new" during its first COP cycle)
- Global Fund/Multilateral Engagement
- Total Mechanism Pipeline as of December 31, 2013
- FY 2013 Outlay Rate
- Construction/Renovation Projects
- Motor Vehicle data
- Implementing Mechanism Outlay Plan (for both TBD or Non-TBD IMs)

**PRIME PARTNER NAME**

The prime partner name for a mechanism, regardless of prime partner type, will be selected from a list of pre-existing partner names that currently exist within the FACTS Info – PEPFAR Module system. If the partner is new, and does not already appear as a prime partner within the FACTS Info system, you will select "New Partner" as the partner name. In order to request the addition of a new partner, country teams will need to submit a "New Partner Form" to your CSTL. The New Partner form is posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles.

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

## Partnership for Supply Chain Management

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

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

## GOVERNMENT TO GOVERNMENT PARTNERSHIPS

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

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

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

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

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

Upon submission of a G2G request, OGAC will conduct a review process to approve all newly planned G2G agreements under PEPFAR. This includes activities using FY 2014 PEPFAR planned funds, prior-year funds and anticipated out year funds for the life of

the project. To fully evaluate the proposed G2G mechanism, country teams need to provide supporting documentation on the government entity that will hold the agreement and execute the activities, the agency-specific risk assessments conducted or planned, as well as the intended fund transfer mechanism (i.e. Fixed Amount Reimbursement Agreement (FARA), direct transfer, cooperative agreement, etc…).

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

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

The merit of a G2G request will be evaluated during the technical and programmatic FY 2014 COP reviews. OGAC will conduct a final review and approve which proposals can advance through a G2G agreement.

## FUNDING AGENCY

It is critical that you identify the correct U.S. government agency in the Funding Agency field because the U.S. government Agency / Operating Division selected will be the one that receives funding from OGAC (see table on next page).

| Agencies | |
|---|---|
| • DoD (Department of Defense)<br>• DOL (Department of Labor)<br>• Department of State<br>  o AF (African Affairs)<br>  o EAP (East Asian and Pacific Affairs)<br>  o EUR (European and Eurasian Affairs)<br>  o INR (Intelligence and Research)<br>  o NEA (Near Eastern Affairs)<br>  o OGAC (Office of the U.S. Global AIDS Coordinator)<br>  o PM (Political-Military Affairs)<br>  o PRM (Population, Refugees, and Migration)<br>  o SCA (South and Central Asian Affairs)<br>  o WHA (Western Hemisphere Affairs) | • HHS (Health and Human Services)<br>  o CDC (Centers for Disease Control and Prevention)<br>  o HRSA (Health Resources and Services Administration)<br>  o NIH (National Institutes of Health)<br>  o OGA (Office of Global Affairs)<br>  o SAMHSA (Substance Abuse and Mental Health Services Administration)<br>• Peace Corps<br>• USAID (United States Agency for International Development)<br>• U.S. Treasury |

- HHS/NIH – Field teams should ensure that they are familiar with the scope of HIV-related clinical or other research that NIH (and potentially other U.S. government agencies) currently fund in country to determine whether or not there are non-research activities appropriate for inclusion in the COP that may be logically "appended" to these research efforts. If there are opportunities to provide country/regional PEPFAR funding to add a service component to an NIH study, country funding for the additional service component *only* would be put into the COP. The NIH study would NOT be included. You can also include support for training through NIH via Fogarty International Center (FIC) research training grants that support the strengthening of human capacity in strategic information: surveillance, HIS, targeted and public health evaluations, program monitoring and evaluation, modeling, and bioethics. Operating Unit teams should be in contact with the FIC research training program officer or directly with the grantee and their in-country collaborators to discuss capacity building needs (see research training websites at www.fic.nih.gov for contact info for AIDS International Training and Research Program, International Clinical, Operations and Health Services Research Training Award for AIDS and TB, and International Research Ethics Education And Curriculum Development

Award). To expedite the distribution of funds, please identify the grant name (e.g. Vanderbilt AITRP) or number (D43TW001035) in the narrative. As with all agencies, NIH should be listed as the Funding Agency, and the Prime Partner who will eventually receive the funding should be listed as the Prime Partner.

- HHS/HRSA - Please note that although CDC locally manages HRSA partners such as ITECH (the University of Washington), the Twinning Center (American International Health Alliance (AIHA)), New York AIDS Institute (HIVQUAL), Harvard University, Catholic Relief Services, and Columbia University (Nursing Capacity Building), HRSA should be listed as the Funding Agency, as they hold the grants/contracts for these partners and must receive the funds.

- Peace Corps – Funding going to the Peace Corps should be identified with Peace Corps as the Funding Agency. Peace Corps should never appear as another U.S. government Agency's prime partner. The Implementing Mechanism section of the COP should only be used to capture Peace Corps programming outside of Peace Corps Volunteer costs. For more information on how to capture Peace Corps Volunteer costs, please see Section 8.7.

- Department of Labor – Funding going to the Department of Labor should be identified with Department of Labor as the Funding Agency. Department of Labor should never appear as another U.S. government Agency's prime partner.

- State **–** Please identify the State Department Bureau for all mechanisms where the Department of State is the Funding Agency. Any project using State's Regional Procurement Support Offices (RPSO) for construction or renovation, must list the relevant State regional bureau as the Funding Agency. For more information on construction or renovation as an implementing mechanism, see Section 7.5.10.

- Treasury – GHI and the second phase of PEPFAR place an increased focus on country ownership and increased multilateral engagement. In this context, it will be important to develop public financial management capacity within partner governments. Treasury's Office of Technical Assistance (OTA), which provides advisors with expertise in public financial management to government ministries, was included in PEPFAR's most recent authorization for this purpose. Depending on country context, Operating Unit teams may wish to incorporate this element into their broader health systems strengthening portfolio. For these mechanisms, please identify Treasury as the Funding Agency and as the Prime Partner.

## PROCUREMENT TYPE

The types of procurement types 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 partner government agency that is a principal signatory party to the instrument. Note: IQCs should be listed as contracts.

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

- Umbrella Award – An umbrella award is a grant or cooperative agreement in which the prime partner does not focus on direct implementation of program activities, but rather acts as a grants-management partner to identify and mentor sub-recipients, which in turn carry out the assistance programs. See Appendix 3 for additional criteria.

Inter-agency Agreement (IAA) **-** An Inter-Agency Agreement is a mechanism to transfer funding between agencies. This mechanism should only be used in **very rare** occasions and is never permitted for use with GHP-State funding. If the U.S. government team decides that one agency has a comparative advantage and is better placed to implement an activity with either GHP-USAID or CDC GAP funding, the U.S. government team has the option of requesting to transfer money from one agency to another through an IAA. This is not the most efficient way of providing funds from one agency to another. However, one example of an appropriate use of an IAA is agency buy-in for census bureau (BUCEN) services

## IMPLEMENTING MECHANISM NAME

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

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

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

Examples of Implementing Mechanism and Prime Partner names are below:

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

## HQ MECHANISM ID, LEGACY MECHANISM ID, AND FIELD TRACKING NUMBER

The **HQ Mechanism ID** will be assigned by the FACTS Info – PEPFAR Module system when the mechanism is saved in the system (either through a template upload or on-screen). New FY 2014 mechanisms will be assigned HQ Mechanism IDs by the FACTS Info – PEPFAR Module system when they are saved to the system.

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

- For mechanisms that existed in the FY 2009 COP in the COPRS I system, Operating Unit teams should use the COPRS I "mechanism system ID."

- For mechanisms that were created in the FY 2010 or 2011 COP or using the "Plan B" system, country teams should use the mechanism ID from that system. For example, if the file name included "new017" in the name, the mechanism ID would be "17."

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

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

## AGREEMENT TIMEFRAME

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

## TBD MECHANISMS

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

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

## IMPLEMENTING MECHANISM OUTLAY PLANS

For the FY 2014 COP, an outlay plan will be required for all Implementing Mechanisms (TBD, new and continuing IMs). The outlay plan will be submitted in FACTSinfo on the "outlay" tab in the Implementing Mechanism data entry screens. This is the same manner in which the COP 2013 TBD outlay information was collected. With this requirement, supplemental agency outlay plans, as required in the FY 2012 COP and FY 2013 COP, are no longer required in the document library of FACTS Info.

For all IMs, outlays will be projected on a quarterly schedule. The outlay plan should account for and include only the new FY 2014 resources and the applied pipeline

resources allocated to this mechanism (applied pipeline resources as defined in section 7.5.4). Not all funding allocated to a mechanism (both applied and new funding) will necessarily be outlayed over the time span indicated in the form. The supplied narrative space should be utilized to discuss the overall outlay schedule and include information that would assist an HQ reviewer.

All **TBDs, both continuing and new**, must also complete the outlay tab in FACTS Info. Questions specific to TBDs will be enabled on the Outlay Plan after properly indicating an IM has a TBD prime partner.

Programmatic and financial points of contact should work in coordination to complete the mechanism outlay projections and narratives. Country teams should contact their CSTL with any additional questions.

### NEW MECHANISM

Upon the creation of a new mechanism, the "New Mechanism" tickbox will be checked automatically.

### GLOBAL FUND / PROGRAMMATIC ENGAGEMENT

This tickbox is used to identify mechanisms where the PEPFAR prime partner is jointly funded by the Global Fund or provides technical assistance to support Global Fund grant implementation. Once you check the box, please select from the dropdown options.

1. Please select PR/SR if the Prime Partner of this IM is also a Global Fund Principal Recipient or Sub-Recipient (PR or SR).
2. Please select TA if the Prime Partner of this IM provides technical support to Global Fund grant recipients.

### CONSTRUCTION / RENOVATION

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

A Construction/Renovation tab will appear requesting the user to enter each proposed project. All fields on the Construction/Renovation Project Plan form must be completed. There is no cap or minimum/maximum limit on the amount of funds allocated to a construction/renovation project for it to be subject to inclusion in the COP submission

i.e., all projects, regardless of amount, need to be submitted for approval. The construction and renovation cross-cutting attributions for each IM should match the total of all IM project plans. Please see section 7.5.10 for more information.

**MOTOR VEHICLES**

This tickbox is used to identify mechanisms that have purchased and/or leased motor vehicles over the timeframe of the IM/agreement. This tickbox must be used in order to report on the FY 2014 request for the purchase and/or lease of motor vehicles as well as to report on the number of previously PEPFAR purchased or leased that are in use at the time of COP submission. A Motor Vehicle tab is where country teams should enter the data on new FY 2014 funding and provide the current size of the PEPFAR fleet under this mechanism.

- At the top of the tab, enter the total number of motor vehicles previously PEPFAR purchased or leased under this mechanism that are currently in use (i.e. from the start of the mechanism through COP submission.)).

- The main section of the tab requires OUs to provide specific information on each motor vehicle request. Upon clicking the "add" button, you will be required to provide:

    - The type of vehicle requested (boat, truck, car, ambulance, etc.)
    - The acquisition method for the requested vehicle (leased or purchased)
    - The total number/amount of this particular type of vehicle being requested
    - The new FY 2014 funding being requested for the group of vehicles that are batched in this entry.
        - NOTE: Any vehicles that are being funded out of the applied pipeline should be listed as zero-funded.
    - A brief (500 character max.) narrative explaining the purpose of the vehicle(s), how they contribute to furthering the stated objectives of this mechanism, and justifying/explaining the associated cost.

As with all cross-cutting attributions, only new FY 2014 funding requested for motor vehicles should be entered in the appropriate cross cutting attributions ("Motor Vehicle: Purchased" and "Motor Vehicle: Leased.") The cross-cutting totals for these attributions must equal the new funding requested in the motor vehicles tab. Teams are encouraged to utilize the Motor Vehicles IM Summary Report, found in the Budget Section of FACTS Info to check their planned allocations and requests to ensure accuracy.

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

### TOTAL MECHANISM PIPELINE

This data field entry requests the total existing pipeline for this mechanism as of the end of FY 14 Q1 (December 31, 2013). This field must be filled out for all continuing mechanisms.

In-country and headquarters-based accounting reports and financial staff should be relied upon and consulted in order to complete this data field accurately.

### FY 2013 OUTLAY RATE

This data field requests the total dollar amount that was disbursed for this mechanism during Fiscal Year 2013 (October 1, 2012 to September 30, 2013). This field should be filled out for all continuing mechanisms.

In country and headquarters-based accounting reports and financial staff should be relied upon and consulted in order to complete this data field accurately.

For central buy-in mechanisms, teams must be in contact with agency headquarters and work to estimate a country-specific outlay rate for that project.

## 7.5.2 Prime Partners

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

There can be only one prime partner per implementing mechanism. When implementing mechanisms are awarded to a joint venture/consortium, the lead partner is the prime, and any other partners in the consortium should be identified as sub-partners. With the exception of the prime partner, you will only need to enter those members of the joint venture/consortium that are active in your country. See additional guidance on local joint ventures in Appendix 3.

As noted above, the prime partner name for a mechanism, regardless of prime partner type, will be selected from a list of pre-existing partner names that currently exist within

the FACTS Info – PEPFAR Module system. If the partner is new, and does not already appear as a prime partner within the FACTS Info system, you will select "New Partner" as the partner name. In order to request the addition of a new partner, country teams will need to submit a "New Partner Form" to your CSTL. The New Partner form can be found at: PEPFARii.com Once the partner form is received, the new partner name validated, and the partner information loaded into FACTS Info, you will be notified that the "New Partner" prime partner entry can be changed in the system to the actual partner name (note, this update will not be possible via templates).

**Maximizing Efficiencies:**

1) **In order to maximize efficiencies in administrative costs, countries should have no shared prime implementing partners with multiple agency agreements, including with partner governments** (see cable entitled: MESSAGE FROM SECRETARY CLINTON ON GOVERNMENT-TO-GOVERNMENT MECHANISMS FOR PEPFAR). If you feel that this is necessary in your country's context, you will be expected to submit a request for a waiver of this requirement.

2) In order to avoid duplication in program implementation by partner, agency, program area and geography, country teams are not allowed to fund different partners that are working in the same program area in the same facilities or geographic locale – independent of whether or not they are currently funded by one agency or different agencies. The following is allowed however:
    - Different partners; same program area; same agency; distinct geographic locales
    - Different partners; same program area; different agency; different locale
    - Different partners; different program area; different agency
    - Partners working in multiple geographic areas on technical assistance only

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

**Do not** name a partner as a prime or sub under an implementing mechanism until it has been formally selected through normal Acquisition & Assistance processes, such as Annual Program Statements, Requests for Application, Funding Opportunity Announcement, or Requests for Proposals. If a partner has not been formally selected, list the prime partner for the implementing mechanism as "To Be Determined" (TBD). See Appendix 3 for guidance on notifying OGAC once you have identified a prime partner.

For all direct programming to be implemented by a U.S. government Agency, the agency should have an implementing mechanism with itself named as the prime partner. Note that all of the costs associated with a U.S. government agency's footprint in country, i.e., costs of doing PEPFAR business or "Management and Operations" costs (including staffing to support technical assistance), will be entered in the M&O section. Technical staff salaries will be attributed to the applicable budget code through the M&O section, **not** through implementing mechanisms.

For more information on partner definitions, please see Appendix 3.

### 7.5.3 Sub-Partners

For FY 2014, sub-partner names need to be provided for each implementing mechanism proposed in the COP. If sub-partners are unknown for an implementing mechanism, nothing need be entered in the mechanism at this time; however, sub-partner lists must be updated throughout the year during the COP/ROP update process. If the sub-partner is known you should choose it from the pre-existing list of partner names.

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

## Definitions

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

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

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

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

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

## 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 U.S. government 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 (MOH) in your country, you should only list the district level health ministries as sub-partners if they are receiving funds directly from a prime partner without going first through a national level headquarters.

## 7.5.4 Funding Sources / Accounts

The funding sources tab is the space for OUs to indicate the total funding that will be used for the implementation of FY 2014 COP, and provide details of the breakdown across funding accounts and new vs. prior FY year funds. Country teams are encouraged to think about new planned FY 2014 resources and available pipeline funding as one funding envelope for the mechanism. A strong COP submission will reflect a strategic application of pipeline and allocation of new funds.

FY 2014 Resources

For new FY 2014 funds, there are as many as three accounts (GHP-State, GHP-USAID and GAP) available to country teams for programming. FACTS Info will be programmed with the available budgets for these three accounts, and not all OUs will have all accounts available to them.

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

| U.S. government Agency | FY 2014 COP Funding Source Categories for New Planned Funding |
|---|---|
| USAID | GHP (State)<br>GHP (USAID)* |
| HHS/CDC | GAP**<br>GHP (State) |
| HHS/HRSA | GHP (State) |
| HHS/OGA | GHP (State) |
| DoD | GHP (State) |
| DoL | GHP (State) |
| State | GHP (State) |
| Peace Corps | GHP (State) |
| ALL OTHERS | GHP (State) |

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

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

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

At the top of the Funding Source tab, country teams have the opportunity to enter an amount of "**Applied Pipeline Funding**," which the system will auto-sum with the new FY 2014 funding requested, by funding account. This applied pipeline data will reflect the amount of PEPFAR pipeline funding, from all accounts, that will be applied to the mechanism for the FY 2014 COP implementation. The applied pipeline is the amount of money you project will not be expended by September 30th, 2014 and can be used in the FY 2014 COP (i.e. FY 2015). This total pipeline funding amount may be less than, equal to, or more than the Total Mechanism Pipeline indicated on the mechanism detail tab.

PLEASE NOTE: If the applied pipeline funding amount is greater than the total mechanism pipeline amount, the country team must indicate in the IM Overview narrative where the funding is being reprogrammed from, and whether or not this action was approved in an official Operational Plan Update (OPU) cycle.

### 7.5.5 Implementing Mechanism Overview Narratives

Narratives for both the overall Implementing Mechanism (IM) and the budget codes are required for **ALL mechanisms** in the FY 2014 COP.

Each new IM should have an overall narrative and at least one budget code narrative completed. Please be concise and follow the guidance. Each overall IM narrative is limited to ½ a page (find an overview of all character counts in section 2.4.3), while each budget code narrative is limited to 1 page. The table below summarizes the information to be included in the new implementing mechanism summary narrative, along with an illustrative example of information that may be required for the budget code narratives. Do not repeat information in both sections.

| **Implementing Mechanism Narrative**<br>Please address the following: | **Budget Code Narrative**<br>Please address the following: |
|---|---|

| | |
|---|---|
| • The implementing mechanism's goals and objectives and if applicable, how it links to the country's PF/strategy and/or the country's approved GHI strategy.<br><br>• The implementing mechanism's geographic coverage and target population(s).<br><br>• The implementing mechanism's strategy to become more cost efficient over time.<br><br>• The implementing mechanism's strategy to transition over time to the partner government, local organization or other donor.<br><br>• Monitoring and evaluation plans for included activities.<br><br>• If applicable, explain the projected change in outlay rate that has informed your total IM planning level.<br><br>• If applicable, please describe the proposed shift of pipeline funds to this IM if your applied pipeline is larger than the stated total mechanism pipeline. | Each budget code narrative must address the 10 Required Elements for Budget Code Narratives along with the Budget Code Specific questions/issues for each budget code.<br><br>All of these elements are listed in section 7.5.6.1 of the FY 2014 COP Guidance. |
| Page Limit: ½ page per IM | Page limit: 1 page per BC (character counts summarized in section 2.4.3) |

## 7.5.6 Budget Code Narrative: Required Elements for ALL BCs and Additional BC Specific Instructions

### 7.5.6.1 Required Elements for All Budget Code Narratives

In FY 2014 COP there has been a concerted effort to improve the Budget Code use and narratives by streamlining and clarifying the guidance. In previous years much of the guidance on budget code narratives asked for the similar information under each

budget code but it was asked in several slightly different ways. Therefore, for COP 14 consult the 10 required elements that should be addressed in every budget code narrative.

In addition to the required elements each budget code has a shortened list of BC specific narrative guidance. When drafting budget code narratives ensure that both the required elements and BC specific questions/topics are addressed.

**Required Elements for All Budget Code Narratives:**

1. Geographic coverage
2. Populations targeted
3. The specific interventions to be implemented
4. Describe the type, mix and dosage of interventions for each target population
5. Relevant financial information
    - Pipeline
    - Unit costs
    - Expenditure Analysis data - basic rationale for partner/geographic allocations based on fiscal and economic data
6. Quality improvement activities
7. Describe program evaluation and monitoring plan
8. Integration and/or important linkages with other relevant areas/services/platforms
9. Coordination with other USG central work streams or activities
10. For capacity-building activities
    - specify different levels of intervention such as providers, supervisors/mentors, facilities, national-regional-district structures
    - list the specific outcomes of the activity and timelines

**Budget Code Narratives should NOT cover:**

- IM Level Targets- Because in FY 2014 COP each IM is required to have associated Indicators and Targets this information should not be listed in the BC Narratives. Instead this information will be captured in the Indicators section of each IM.
- Describe the epidemic- Instead this should be done in the Executive Summary, TANs and/or Population and HIV Statistics sections of the COP.
- Justifications for addressing specific populations- Instead this should be covered in the TANs as part of the strategy for that program area.
- Accomplishments to date – This should be covered in the TANs and S/APR.

### 7.5.6.2 BUDGET CODE SPECIFIC REQUIREMENTS

In FY 2014 COP the budget code narrative specific guidance serves as a place where HQ TWGs have prioritized a short list of budget code specific topics that teams should address within the budget code narrative. Each Budget Code specific section that follows will outline for country teams both:

- Definition of the Budget Code:
  - Including types of activities to include and not include under the budget code.
- Budget Code Specific Narrative Guidance: Topics that need to be included in the narrative that are very specific to this budget code and beyond what is covered in the 10 Required Elements for all budget code narratives.

## Prevention Budget Codes

### 7.5.6.3 MTCT- Prevention of Mother to Child Transmission

**MTCT** – Includes activities aimed at preventing mother-to-child HIV transmission, such as HIV testing for pregnant women, antiretroviral treatment (ART) for HIV-infected pregnant women and ARV prophylaxis for newborns, counseling and support for maternal nutrition and exclusive breastfeeding, and related training for clinical and other personnel. **Funding and targets for provision of ART for prophylaxis and/or lifelong therapy for HIV-infected pregnant women, breastfeeding (BF) women, and newborns should be coded in the ARV Drugs and PMTCT budget codes (for first year of therapy for pregnant/BF women) and in Adult Treatment budget code in subsequent years.** Budget & targets for pregnant & BF women should be cross-referenced in Adult treatment and PMTCT budget codes – please be sure to fill out the supplemental document, "PEPFAR Clinical Cascade Worksheet for Target-Setting and Budgeting" to clearly show where cohorts of pregnant and BF women on ART are captured in year1 and the out-years for target and budgeting purposes. Funding for HIV counseling and testing in the context of preventing mother-to-child transmission should be coded under PMTCT. Targets set for this funding should be set under both NGI P1.1.D (Number of pregnant women with known HIV status) and P11.1.D (Number of Individuals who received Testing and Counseling services for HIV and received their status). Early infant diagnosis should be included under Pediatric Care.

#### MTCT Specific Narrative Guidance

Please concisely describe each implementing mechanism's activities in PMTCT. In particular, please address (in non-hierarchical order):

- Contribution to scaling-up PMTCT programs, including current geographic PMTCT coverage, accomplishments, targets for next two years, and a detailed plan for achieving the targets and periodically measuring progress.
- Provide available information on unit cost per mother-infant pair reached with PMTCT, and plans to decrease the unit cost and increase coverage and/or quality by improving program efficiencies.
- Activities and strategies aimed at building the capacity of health care providers and facilities to provide PMTCT services at various health care levels (decentralizing PMTCT services, integration of PMTCT and ART services, etc.).
- Activities and strategies to build capacity at national, regional, district and health facility level to supervise the program, routinely collect data and monitor the quality of data and services.
- Activities to ensure initiation of ART for eligible HIV+ pregnant women, program retention, and ART adherence among mothers and infants in care and treatment programs.
- Activities to scale-up additional quality PMTCT interventions to increase HTC, including PITC of pregnant women at ANC, ANC attendance and facility deliveries, use of more effective ARV regimens, access to CD4 testing, and evidence-based interventions to reduce incident HIV infections during pregnancy, and improve care and support services at health facilities and in communities.
- Activities to support PMTCT program evaluation: 1) in real time using innovative approaches and tools (e.g., dashboards and mobile technology); and 2) through measurement of population transmission rates at national and/or subnational levels.
- Activities that promote demand creation such as community mobilization, action-oriented male involvement, couples CT services, including identification of discordant couples, in order to increase PMTCT uptake and improve PMTCT and health outcomes for women and their families.
- Activities supporting integration of PMTCT with ART and routine maternal child health/reproductive health services, especially family planning services, adult and pediatric treatment services, and broader prevention programs

### 7.5.6.4 HVAB- ABSTINENCE/BE FAITHFUL

**Sexual Prevention — Abstinence/be faithful:** Activities (including training) to promote abstinence (including delay of sexual activity or secondary abstinence), fidelity, reducing multiple and concurrent partners, and related social and community norms that influence these behaviors. Activities should address programming for both youth and adults.

**HVAB Specific Narrative Guidance**

In addition to the required elements for all budget code narratives please address the following in the HVAB budget code narrative:

- Explain how the intervention(s) target(s) the key drivers in the specific epidemic context, including relevant gender dynamics

### 7.5.6.5 HVOP – OTHER SEXUAL PREVENTION

**Sexual Prevention — Other sexual prevention:** Activities (including training) aimed at preventing HIV transmission through means other than promoting abstinence and fidelity. All sexual prevention programs for key populations fall within this budget code and should be consistent with existing guidance. Other activities funded within HVOP may include: procurement, promotion, distribution and social marketing of male and female condoms and lubricants beyond key populations; STI management for PLHIV outside of care settings (STI treatment for PLHIV within care settings should be coded under adult care: HBHC); comprehensive care for survivors of sexual violence including provision of post-exposure prophylaxis (PEP); and activities to reduce alcohol-related sexual disinhibition.

**HVOP Specific Narrative Guidance**

In addition to the required elements for all budget code narratives please address the following in the HVOP budget code narrative:

- Clearly define the population(s) that will be targeted by age, sex, risk behavior or other relevant parameters. Refer to the estimated size of the population if known.
- Provide a concise description of the type, mix and dosage of intervention(s) for each specific target population.
- Describe the geographic and/or population coverage of the program, refer to the estimated size of the population if known.
- Specify mechanisms included as part of the intervention(s) to promote quality assurance and supportive supervision
- Describe how activities are integrated with other services/platforms.
- Describe how beneficiaries are linked to appropriate services, including community and clinical services, and how these linkages will be measured.

### 7.5.6.5 HMBL- BLOOD SAFETY

**Blood safety** – activities supporting a nationally-coordinated blood program to ensure an accessible, safe and adequate blood supply including: infrastructure and policies; donor-recruitment activities; blood collection; testing (transfusion-transmissible infections, group, and compatibility); 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.

## HMBL Specific Narrative Guidance

In addition to the required elements for all budget code narratives please address the following in the HMBL budget code narrative:

- The basic objectives and approaches being applied in policy development, blood collection (donor recruitment, donor clubs, mobilization), processing (including component preparation), testing, M&E, quality assurance (quality systems/control), training, infrastructure development (procurement system etc.), blood utilization, and distribution (including expansion to rural areas).

### 7.5.6.6 HMIN- INJECTION SAFETY

Injection safety includes the programs, policies, training, advocacy, and other activities to reduce medical transmission of HIV and other bloodborne pathogens, reduce unnecessary injections and promote the safety of necessary medical injections and related procedures. Injection safety also encompasses infection prevention and control, standard precautions, supply chain management, health care waste management, needle stick management/occupational post-exposure prophylaxis (PEP) and safe phlebotomy.

## HMIN Specific Narrative Guidance

In addition to the required elements for all budget code narratives please address the following in the HMIN budget code narrative:

- Partnerships/collaboration
- Commodity security, i.e., ensuring sustained availability of single-use syringes and needles, lancets and blood drawing equipment, safety boxes, gloves, etc.

### 7.5.6.7 IDUP- INJECTING AND NON INJECTING DRUG USE

**Prevention among people who inject drugs –** activities including policy reform, training, capacity building, community mobilization and comprehensive approaches including needle and syringe access programs and medication assistance therapy to reduce injecting drug use. Comprehensive programs for PWID that also address non-injection drug use (e.g. methamphetamine) should be included under this budget code. Do not include non-injection drug use interventions (e.g. alcohol) that are not part of a larger and comprehensive PWID program; such interventions should be coded using HVOP. Procurement of methadone and other medical-assisted therapy drugs as well as programs for prevention of sexual transmission among People who Inject Drugs (PWIDs) should be included in this category.

## IDUP Specific Narrative Guidance

In addition to the required elements for all budget code narratives please address the following in the IDUP budget code narrative:

- Describe the number of PWID program sites to be supported and the number of beneficiaries to receive services at each site.
- Describe efforts to scale up and, as appropriate, transition PWID programs to host country, including an estimated timeline and any civil society engagement.

### 7.5.6.8 CIRC- VOLUNTARY MEDICAL MALE CIRCUMCISION

**Voluntary Medical Male Circumcision (VMMC)** – UNAIDS/WHO issued normative guidance in March 2007, stating that VMMC should be implemented in specified countries as an important intervention to reduce the risk of male heterosexually acquired HIV infection. In response to the normative guidance and under the leadership of partner country governments, PEPFAR funds can be utilized to support the implementation of VMMC, in accordance with national standards and international guidance. All VMMC services must include a minimum package of clinical and prevention services which includes: offer (and availability) of HIV testing and counseling for all men and, where possible, their partners attending MC services; active referral of clients determined to be HIV-positive to HIV care and treatment programs; age-appropriate sexual risk reduction counseling and counseling on the need for abstinence from any sexual activity during wound healing; pre-procedure clinical screening (focused physical examination and medical history) to detect STIs and contraindications to circumcision; treatment of STIs that are detected; circumcision by a medical method recognized by WHO (surgery or device); post-procedure follow-up, including systematic assessment of adverse events; and, promotion of correct and consistent use of condoms. Though clients cannot be forced to return for follow-up care, programs must recommend that all clients return post-MC for clinical assessment

and care and allocate resources to provide such follow-up services. VMMC programs must provide active linkages with other HIV prevention, treatment, care and support services. VMMC programs may encompass monitoring, evaluation, and reporting, policy efforts, training (task shifting/sharing), outreach, development of tools for communications, quality assurance, and equipment /commodities related to male circumcision, which focus on safe, efficient service delivery.

Policy Guidance Reminder for VMMC programming:

1. PEPFAR funds may not be used to provide VMMCs that require sedation or general anesthesia.

2. PEPFAR-funded VMMC service locations must have emergency equipment and supplies on site to manage the very unlikely life-threatening complications that may occur. Staff trained in the use of the emergency equipment and supplies must be on site at all times VMMC surgeries are being provided.

3. PEPFAR-funded VMMC service providers must document (through written records or electronic source documents) the minimum package of clinical and prevention services provided to each client.

4. PEPFAR-funded VMMC service providers must obtain written informed consent from all clients (or parental/guardian consent for minor clients) before performing VMMC. Informed consent documentation must be maintained on file and available as needed.

5. PEPFAR-funded implementing partners supporting VMMC service delivery must report any VMMC client's death, even if the relatedness to the VMMC procedure is uncertain, to the PEPFAR agency country lead (mission chief, country director, health team lead, etc.), or his or her designee, and the country PEPFAR Coordinator within the same day that the implementing partner becomes aware of the client death.

6. PEPFAR funds **may not be used to** support VMMC for clients between **61 days of age and 10 years of age.** Boys 10 years of age and above may be candidates for VMMC supported by PEPFAR funding, if the clinician determines that the client is mature enough to cooperate with the VMMC under local anesthesia and has the agency to provide assent.

For more information, please see the VMMC Technical Considerations. Each IM's BC narrative must explicitly confirm the IM's awareness and compliance with the Policy Guidance directives above, and indicate that all service sites that they support meet these requirements.

## CIRC Specific Narrative Guidance

In addition to the required elements for all budget code narratives please address the following in the CIRC budget code narrative:

1) **Communication:** Each IM should list communication activities planned using the funds requested, including community engagement and sensitization, demand creation, and in-service communication, and indicate any communication resources not funded under the IM but expected to complement those efforts. Each IM should describe whether their communication activities target women as an audience to increase demand for VMMC among men and also support men post-MC. As applicable, specific communication strategies for reaching women should be described, as well as the goals, preferably measurable, of such strategies. Finally, as stated in the Technical Priorities section 3.5.1 of the 2014 COP Guidance, the VMMC TWG is encouraging focused demand creation efforts toward males 10-29 years of age, and HIV negative men at particularly high risk of heterosexual HIV acquisition, such as men in discordant heterosexual relationships. Strategies that will be used to reach prioritized groups with demand creation efforts should be described.

2) **Training:** Each IM that supports training should include in their BC narrative details about the training program/curriculum, the target number of personnel trained on surgery vs. device-based VMMC, and efforts to ensure that staff trained actually provides VMMC services post-training.

## 7.5.6.9 HVCT- HIV TESTING AND COUNSELING

**HIV Testing and Counseling (HTC)** – this budget code covers the provision of HIV testing and counseling across the range of community and facility-based settings including client- and provider-initiated approaches. Mobilization to support HTC as well as activities linking HTC-users to appropriate follow-on services and tracking linkages are also covered under this budget code.

Funding for HIV counseling and testing in the context of preventing mother-to-child transmission should be coded under PMTCT. Targets set for this funding should be set under both NGI P1.1.D (Number of pregnant women with known HIV status) and P11.1.D (Number of Individuals who received Testing and Counseling services for HIV and received their status). Funding for HTC in the context of TB services should be included under the TB budget code; targets should be set under P11.1.D. Funding for HTC in the context of VMMC services should be included under the CIRC budget code;

targets should be set under P11.1.D. For other technical areas where HTC is part of the minimum package including: PHDP; services for key populations; adult treatment, care and support; early infant diagnosis; and pediatric treatment; funding should come from HVCT and targets should be set under P11.1D.

## HVCT Specific Narrative Guidance

In addition to the required elements for all budget code narratives please address the following in the HVCT budget code narrative:

- The approach used for setting the HVCT budget and how the current situation in country shapes HVCT budgeting decision (e.g. other funders/donors).
- For the specified target population(s): HIV prevalence (if known), coverage (% tested in past 12 months) either in the geographic area or among the target population, and strategic prioritization of services.
- Target for number of people trained or receiving refresher trainings and results achieved in the past year, including the areas in which they were trained (e.g., PITC, couples HTC, quality assurance or improvement, rapid testing)
- Excluding HTC within PMTCT and TB, describe the proportional allocation of HVCT funding to each of the technical areas (VMMC, MARPs, PWP, Tx, Care/Support) and how HTC links with these other services. For example, testing client and/or partners, strengthening linkage interventions/systems.

## Care Budget Codes

### 7.5.6.10 HBHC- Adult Care and Support

The Care and Support Technical Working Group is currently reviewing activities within the Care and Support portfolio to examine existing evidence on public health impact of these activities and re-assess priorities. Following review of the literature and consultation with stakeholders, new guidance will be drafted to assist countries in determining priority care and support activities. Guidance is anticipated in late 2013. Countries should be aware of this guidance and use it in planning for the FY 2014 COP.

**Adult Care and Support –** All facility-based and home/community-based activities for HIV-infected adults 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. To assure access to the continuum of care and to support timely initiation and maintenance on ART, programs should attempt to optimize linkage and entry into care following HIV testing, and retention in pre-ART and ART care; a) clinical care to reduce HIV-related

morbidity and mortality should include evaluation for ART eligibility so that ART can be initiated at the appropriate time; b) prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria, diarrhea, and Cryptococcal disease (including provision of commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services); c) nutrition assessment, counseling and support (NACS); d) pain and symptom relief; and screening and treatment to prevent cervical cancer in HIV-infected women *(given specific funding considerations, please refer to FY 2014 Technical Considerations for further information regarding cervical cancer)*. 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 include partner/couples HIV testing and counseling, risk reduction counseling, adherence counseling and support, STI diagnosis and treatment, family planning counseling, and condom provision. The purchase of OI drugs (excluding TB drugs) should be included under Adult Care and Support. ARV drugs should be coded under Adult Treatment and ARV Drugs.

## Instructions for writing HBHC budget code narrative

Please describe the implementing mechanism's activities in care and support thoroughly yet concisely. In addition to the required elements for all budget code narratives in the HBHC budget code narrative please address:

- Approaches to optimize quality, including quality assurance and quality improvement *(please refer to new PEPFAR Quality Strategy when released*)
- Approaches to optimize linkage and entry into care following HIV diagnosis, and retention in pre-ART and ART care *(please refer to new PEPFAR Linkage and Retention Strategy when released)*
- Methods of program monitoring and evaluation to assess and improve quality and outcomes, including standardized, periodic supportive supervision to assure compliance with guidelines, protocols and standards, and regular program reviews and evaluations to assess and optimize program results

### 7.5.6.11 HKID- Orphans and Vulnerable Children

**Orphans and Vulnerable Children** – are defined as children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects—as stated in the Hyde-Lantos Act that reauthorized PEPFAR in 2008.

Support for orphans and vulnerable children and their households, is integral to the efforts of the President's Emergency Plan for AIDS Relief (PEPFAR). To support vulnerable children, programs should prioritize family strengthening approaches that reinforce families 'long-term caring capacities as the basis of a sustainable response to children affected by HIV/AIDS. Included under the rubric of "family strengthening" are interventions that boost household economic and food security, improve child/family access to health care and schooling, and encourage healthy parent-child relationships.

Families in turn rely on safe and supportive communities to thrive. Therefore HKID funds also support building the capacity of local community structures to respond to children and families in need. Such interventions include, for example, mobilizing multi-sectoral child protection committees at district and sub-district level and sharing and modeling best practices for local communities in working with vulnerable children and families. HKID funds also play an important role in strengthening social services systems. Social service systems (also referred to as social development or welfare) are chiefly responsibility for coordinating the multi-sectoral response to children and families and for providing a vital safety net for those who are most vulnerable.

Examples of such interventions include helping governments to assess and expand the number and quality of social service workers, to enact regulation for the protection of children including those living in alternative care, and to improve capacity to monitor and evaluate the national OVC response. In addition to the above, programs should ensure that HKID funds are invested in the evaluation of OVC program impact and in building an evidence base of best practice. The 10% budgetary requirement is for OVC programming only and is not to be used for pediatric treatment and care. In reports submitted by OGAC to Congress, persons may be counted only once under each of the three global program areas of prevention, treatment and care. Thus, in reports to OGAC, children may be counted only once under care but may <u>also</u> be counted under Pediatric treatment (treatment) and PMTCT (prevention).

As per the OVC programming guidance, country teams should **allocate Sufficient Funds (10% of the 10% recommended) for monitoring and evaluation of OVC programs.** OVC programs have often lacked robust program evaluations and, at times, adequate monitoring and data tracking systems, in part due to a lack of funds committed to this area. To combat this deficit, programs are advised to allocate at least 10 percent of their program budgets to ensure adequate funds for M&E activities. This rule is primarily directed at the Mission portfolio level, not at the project level. This means that at the country level there can be a pot of a minimum of 10% of the total HKID funds at country level which can be directed at M&E.

**An appropriate portion of this allocation of funds for M&E should be planned and used for the biennial surveys that will be required under the new MER strategy from Strategic information and OVC.** In addition, it is highly recommended that some portion of this pot should go to rigorous intervention research (wherever appropriate into implementation science using experimental design) using a proven research partner. For these biennial special studies as well as for ongoing intervention linked implementation science, missions should pull in expertise from beyond the NGO/CBO community as necessary. That is, missions should plan to use institutions for external evaluation and not internal, project level evaluations using one partner. The OVC TWG is happy to help with planning such research and evaluation.

### Instructions for Writing HKID Budget Code Narrative

In addition to the required elements for all budget code narratives please address the following in the HKID budget code narrative:

- Describe the strategies/activities this mechanism is using to achieve their goals and if these strategies are evidence-based. If not, outline how they are contributing to building evidence through their program.

- What successes and challenges has this partner had in their past performance? What efforts are being made to strengthen this partner's performance, if needed, and how are their strengths being used to build other partner capacity?

## 7.5.6.12 HVTB- TB/HIV

**TB/HIV** – includes exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis (including isoniazid and drugs for treating active TB), 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. Pediatric TB/HIV services should be included in this budget code. Laboratory investments for TB/HIV should be included under the TB/HIV budget code.

### Instructions for writing HVTB budget code narrative

In addition to the required elements for all budget code narratives please answer the following questions in the HVTB budget code narrative:

- Alignment of Partner Activities with Country Policy: Is the partner able to show that activities are aligned with host country national policies and strategic plans for TB and HIV?
- Coordination across Partners: Does the partner activity clearly demonstrate added value relative to other related partner activities that target similar technical and geographic areas?
- Human Resource Capacity and Sustainability: How does the partner activity ensure that there are sufficient trained personnel to carry out the proposed activities and sustain the program over time?
- Monitoring and Evaluation: Does the partner regularly review and report high-quality data using the national TB and HIV M&E framework and tools to track progress toward stated objectives/targets? To what degree is the partner prepared to report on the revised TB/HIV indicators?
- Accomplishments: What were the key accomplishments and lessons learned since last year's COP and how do proposed activities take these into consideration?

### 7.5.6.13 PDCS- PEDIATRIC CARE AND SUPPORT

**Pediatric Care and Support** –Includes all health facility-based care aimed at extending and optimizing quality of life for HIV-infected children, adolescents, and their families throughout the care continuum through provision of clinical, psychological, spiritual, social, and prevention services. Clinical care should include early infant diagnosis, prevention and treatment of OIs 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), pain and symptom relief, and nutritional assessment and support including food. Other services – psychological, social, and spiritual and prevention services – should also be provided as appropriate. Pediatric care and support services should be counted if they are provided at a facility, while community-based care and support services should be included within programs for orphans and vulnerable children (OVC). It is important that funding for pediatric care activities is not double-counted in OVC. Pediatric TB is an important contributor to morbidity and mortality in HIV affected and infected populations. Please include all pediatric TB activities and efforts under the TB/HIV section. Infrastructural and construction activities should not be included under PDCS, but rather under HSS. Key retention activities that address girls, YMSM, LGBT, substance users and youth involved in sexual exploitation are to be budgeted under Key pops.

## Instructions for Writing PDCS Budget Code Narrative

In addition to the required elements for all budget code narratives please address the following in the PDCS budget code narrative:

- Activities that provide drugs, food and other commodities for pediatric clients (HIV exposed infants, HIV infected children and adolescents)
- Activities to support the needs of adolescents with HIV (ALHIV) (PwP, support groups, support for transitioning into adult services, adherence support, reproductive health services, educational support for in and out of school youth)
- Activities promoting integration with routine pediatric care, nutrition services and maternal health services, malaria prevention and treatment.
- Activities to strengthen laboratory support and diagnostics for pediatric clients.
- Activities to ensure appropriate dispensation of CTX and INH, prophylaxis in infants, children and adolescents.
- Activities to address nutritional evaluation and care of malnutrition in HIV+ and exposed infants, children and youth.
- Activities to address psychosocial support of children and adolescents, including disclosure, adherence counseling, and support groups.
- Activities that will increase direct linkages to the community to improve communication between facilities and community services for HIV+ children and youth.
- Activities that support HTC to widen the access, utilization and uptake by families and adolescents, but MTCT budget code captures all MTCT data
- Activities that strengthen retention in care from infant to transition from adolescent to adult services
- Follow cohorts of infants prospectively with suggested age disaggregation

## Treatment Budget Codes

### 7.5.6.14 HTXD- ARV DRUGS

**ARV Drugs** – including procurement, delivery, and in-freight of ARV drugs. Funding for all ARVs should be reflected under HTXD, including ART costs for adult and pediatric treatment and PMTCT. All antiretroviral Post-Exposure Prophylaxis procurement for rape victims and needlestick injuries should be included within this program area. Distribution/supply chain/logistics, pharmaceutical management and related systems strengthening inputs are to be included in the Health Systems Strengthening section. Country teams are expected to forecast, cost and fully budget for the PEPFAR supported cost of antiretroviral treatment and buffer stock.

**Instructions for writing HTXD budget code narrative**

In addition to the required elements for all budget code narratives please answer the following questions in the HTXD budget code narrative:

- What drugs will this partner procure?
- Does the partner support the national program in procurement strategic planning by participating in national quantification exercises and by providing estimates of the costs of proposed ART guideline changes?
- Has this partner experienced any stockouts in the last year? What is the partner doing to ensure that there will be no stockouts in FY 2014?

### 7.5.6.15 HTXS- ADULT TREATMENT

**Adult Treatment -** including infrastructure, training for clinicians and other providers, clinical monitoring, related laboratory services, and community-adherence activities. Clinical monitoring and management of opportunistic infections is classified under Adult Care and Support.

Country teams are expected to budget appropriately to meet treatment targets. In addition, regardless of their entry point (PMTCT or Treatment program) treatment for eligible pregnant women should be forecasted, costed and fully and adequately budgeted for in PEPFAR supported programs. Funding and targets for provision of ART for prophylaxis and/or lifelong therapy for HIV-infected pregnant women, breastfeeding (BF) women, and newborns should be coded in the ARV Drugs and PMTCT budget codes (for first year of therapy for pregnant/BF women) and in Adult Treatment budget code in subsequent years. Budget & targets for pregnant & BF women should be cross-referenced in Adult treatment and PMTCT budget codes – please be sure to fill out the supplemental document, "PEPFAR Clinical Cascade Worksheet for Target-Setting and Budgeting" to clearly show where cohorts of pregnant and BF women on ART are captured in year1 and the out-years for target and budgeting purposes.

The total cost of treatment supported by PEPFAR should be reflected as locally appropriate across PEPFAR budget codes including MTCT, HTXS, OHSS and others as needed. HIV drug resistance surveillance activities are classified under Strategic Information (HVSI).

#### Instructions for writing HTXS budget code narrative

In addition to the required elements for all budget code narratives please answer the following questions in the HTXS budget code narrative:

- What type of training does the implementing partner provide? Training activities may include pre-service and in-service training, mentorship, and preceptor programs.
- What type and frequency of on-site supervision does the partner provide?
- How does the partner track and evaluate clinical outcomes and other performance data? What are their current clinical outcomes?
- How is performance measurement data used for quality improvement at the site and district level?
- What activities does the partner support to improve retention and/or adherence of patients initiated on ART? What are the outcomes of these activities?
- What is the partner's target population(s) and coverage with a comprehensive care and treatment package, including ART provision, cotrimoxazole prophylaxis, and TB screening? In what ways has the partner improved programmatic efficiencies to allow for continued expansion of services while continuing to prioritize the sickest patients?
- How is the partner working to expand treatment coverage to key populations (commercial sex workers, people who inject drugs, transgender persons, and men who have sex with men)?
- What activities of the partner promote transition to local ownership and sustainability of ART service delivery?
- Activities not to include: cost of ARV drugs; laboratory services for counseling and testing, TB screening, pediatric care and treatment, and HIV drug resistance surveillance activities.

### 7.5.6.16 PDTX- PEDIATRIC TREATMENT

**Pediatric Treatment** – Includes support to the government to roll out updated pediatric treatment guidelines; infrastructure development; training clinicians and other providers; clinical and laboratory monitoring of children and adolescents on treatment; adherence support and strategies to improve retention in the pediatric and adolescent population; development of capacity to provide laboratory services that escalate case finding for children/adolescents and detect treatment failure; building capacity to monitor, supervise and implement uninterrupted HIV treatment services from infancy to adolescents (including transition to adult services); and promoting integrated approaches to improve outcomes. Infrastructural and construction activities should not be included under PDCS, but rather under HSS. HIV drug resistance surveillance activities are classified under Strategic Information (HVSI).

## Instructions for Writing PDTX Budget Code Narrative

In addition to the required elements for all budget code narratives please address the following in the PDTX budget code narrative:

- Contribution to scaling up treatment for HIV infected pediatric and adolescent populations using age disaggregation, if possible, to include 0-<1, 1-4, 5-9, 10-14, 15-19, and 20-24 years of age, including numbers of current, newly and ever enrolled on treatment and targets for the next two years. Ensure the contribution of scale up is consistent with national targets to be reached in 2015.
- Activities related to specialized curriculum modification for in-service training should be budgeted in OHSS.
- Activities to support adherence in pediatric and adolescent populations, improve overall retention on treatment and establish functional linkages between programs and with the community to reduce losses to follow up and improve long-term outcomes.
- Activities promoting case finding and integration of pediatric HIV treatment services into MCH platforms of service delivery and linkages with nutrition support programs, linkages with community-based activities, programs and services.
- Activities to expand capacity to provide early infant diagnostic services, rolling out PITC HIV testing in infants, children and adolescents (include proportion and number needed to improve access). Describe efforts to extend CD4 % availability and viral load monitoring of children in pre-ART or on ART.
- Describe activities to provide specific services for adolescents in treatment, including support to facilitate transitioning to adult services, family planning, educational and psychosocial support.
- Describe activities to improve capacity to disaggregate, collect, analyze and use pediatric HIV data in collaboration with the U.S. government and national program.
- Activities to address increased access to treatment to pediatric-aged PLHIV and retention activities appropriate for ALHIV
- Activities to evaluate treatment failure in pediatric HIV+ patients and access to second and third line ARVs for these children and youth.
- Activities to address procurement and maintenance of adequate supply and efficacious, easy to use formulations of pediatric ARVs
- Activities to address simplification of national pediatric formularies
- Activities to address the issues of disclosure to PLHIV and ALHIV

## Other Budget Codes

### 7.5.6.17 OHSS- Health Systems Strengthening

OHSS definition: The Health Systems Strengthening budget code includes activities that contribute to improvements in national-, regional- or district-level health systems.

Activities may be focused on health systems building blocks themselves as well as on institutions and processes that strengthen the building blocks and their interactions (see below for examples). Consistent with PEPFAR's Expenditure Analysis methodology, activities that fall into this budget code are generally those that are implemented above the service delivery point (site) level and/or are not directly tied to patients, beneficiaries, facilities or communities.

Examples of activities that fall into the OHSS budget code:

- Development and implementation of policy, advocacy, guidelines and tools (e.g., broad-based, such as development of Human Resources for Health Strategic Plan; related to specific technical areas, such as circular/guidelines/protocol development on rapid HTC testing)
- Technical assistance to improve system-level financial management systems
- Building capacities of pre-service training institutions or curriculum development support for in-service trainings at regional training centers
- An integrated package of activities focused on a range of health systems strengthening building blocks with a SI or lab component that does not constitute the majority of those activities
- Supporting supply chain systems through training and development of cadres with supply chain competencies, or to expand access to family planning commodities as part of HIV care, such as PEP and contraceptives
- Capacity building of civil society institutions that interact with the health system, such as local non-governmental, faith-based, and community-based organizations
- Support to Global Fund programs and activities, and donor coordination

Examples of activities that do not fall into the OHSS budget code:

- In-service training for health workers and program staff at the site level (e.g., training in PMTCT)
- Laboratory and Strategic Information activities that fall under the HLAB and HVSI budget codes, respectively

- All activities not considered Health Systems Strengthening referenced in the HSS section of the Technical Considerations

## Instructions for Writing OHSS Budget Code Narrative

In addition to the required elements for all budget code narratives please answer the following questions in the OHSS budget code narrative should address, where relevant, the following areas concisely within the OHSS budget code narrative: governance/ leadership, health finance, human resources for health, strategic information, medical products/ technologies and procurement systems, and health delivery services.

The following questions should be addressed:

- What is the systems barrier/s that this mechanism/activity addresses?
- How does mechanism/activity address this barrier?
- What funding does this mechanism/activity leverage, if any, and how?

### 7.5.6.17 HLAB- LABORATORY INFRASTRUCTURE

**Laboratory infrastructure** – development and strengthening of laboratory networks and facilities to support HIV/AIDS-related activities including purchase of equipment (including Point-Of-Care) and commodities and provision of quality assurance, staff training and other technical assistance.

## Instructions for writing HLAB budget code narrative

In addition to the required elements for all budget code narratives please address the following in the HLAB budget code narrative. Please describe the activities in laboratory infrastructure development thoroughly yet concisely using very clear goals and targets. In particular, please address:

- Coverage of laboratory testing and product placement strategies either in the geographic area or among target populations.
- Development of training activities focused on laboratory management and quality assurance of laboratory testing. Description should include specific information on who will be trained and at which level of the laboratory system or cadre (i.e., regional, district, health center) at which the training is targeted. Laboratory testing sites may include: testing sites or facilities that perform routine clinical laboratory testing, point-of-care (POC) testing, or testing in a non-traditional laboratory setting (i.e., community outreach center).
- Mechanisms to accelerate use of private sector approaches to expand access to country health systems, such as private-public partnerships (PPPs).
- Plans and activities that will result in sustainable quality laboratory programs during the transition of laboratory services to local in-country partners.
- Describe planned laboratory systems strengthening programs and how these plans will improve the laboratory network, such as quality management systems improvement programs (SLIPTA) and accreditation, laboratory safety and equipment maintenance programs, laboratory workforce development, laboratory information systems, supply chain management, national plans and policies, country ownership and institution strengthening, sample referral systems. Detailed information about the specific outcomes of the activity, timeline for

implementation, linkages to other program areas (i.e., human resource development, care and treatment, other HSS), how the program improves access to laboratory testing (i.e., POC diagnostics, rapid HIV testing and community centers), and any monitoring or evaluation plan should be included where relevant.
- Activities not to include: An integrated package of activities focused on a range of health systems strengthening "building blocks" that has a lab component, but where laboratory activities does not constitute the majority of those activities.

It is important to stress that when laboratory activities such as testing, services, and renovations are described in COP sections other than Laboratory Infrastructure the funding supporting these activities should be cross referenced, especially when assigned to implementing partners not specifically identified in the Laboratory Infrastructure section. This is especially important for procurements, technical assistance, M&E, and training related to Point-of-Care (POC) technology.

### 7.5.6.18 HVSI- STRATEGIC INFORMATION

**Strategic Information** – Activities in this budget area aim to establish and/or strengthen national systems and to build in-country individual, institutional, and organizational capacity for HIV/AIDS behavioral and biological surveillance, facility surveys, monitoring program results, reporting results, health information systems, and related data analytic and data dissemination activities. HIV drug resistance surveillance activities also fall under strategic information. Program area-specific monitoring and routine evaluation should be incorporated under the specific program area.

## Instructions for writing HVSI budget code narrative

How to describe SI activities in the HVSI Budget Code Narrative:

If working in more than one SI area, describe the SI-specific activity or activities to be supported through this mechanism. Discuss in general terms the type and extent of work to be implemented within each SI area and how this work supports the national SI strategy. Review the SI Technical Considerations and the MER Operational Guidance for potential activities within HIS, M&E, and Surveillance and Surveys. Notation also should be made with respect to the Partnership Framework, if applicable.

- Describe how activities will provide support to national capacity building to collect, manage, analyze and utilize data.

- Describe how the proposed activities will support the broader technical program areas for monitoring, evaluation, surveillance, survey, or information systems.

- If more than one implementing mechanism is being used for the same SI activity, please explain how the activities relate to each other.

Deciding whether activities should be included in the SI budget code:

Country teams need to determine if an SI activity best fits in the SI (HVSI) budget code or within another budget code. Large scale SI activities that support multiple technical areas or national systems might best fit under the SI budget code. This would include the following types of activities:

1) Activities that build capacity for and ensure the implementation of the collection, analysis and dissemination of HIV/AIDS behavioral and biological surveillance and monitoring information;

2) Supporting capacity building efforts and the implementation of facility and other surveys;

3) Build the capacity for the development of national program monitoring systems;

4) Support the development of country-led processes to establish standard data collection methods; and

5) Support for the national health information system planning and development.

Conversely, these types of activities might be more appropriate reflected in another budget code:

- Activities directly supporting one specific program area;

- Activities that are integral components of a prevention, care, or treatment funding mechanism; and

- An integrated package of activities focused on a range of health systems strengthening “building blocks” that have a SI component that does not constitute the majority of those activities.

For example, suppose you are supporting PMTCT service delivery in 20 sites. A component of this program is to provide TA to set up facility-based health information

system (HIS) in the 20 PMTCT sites. This activity should be included in the PMTCT budget code, where the funding mechanism is entered and described within the narrative. If an HIS is being installed to support all programs in the facility and is part of a national rollout, it might best fit in the SI budget code. Conversely, if support is provided to build capacities of District Health Offices and one component of the training is on data quality (along with training in leadership, management, workforce planning, etc.), this would fit better into the health systems strengthening budget code.

### 7.5.7 Cross-Cutting Budget Attributions

For more information please see Appendix 4.

#### Overview

The importance of cross-cutting budget attributions cannot be over-emphasized. Each represent areas of PEPFAR programming with great potential to contribute to PEPFAR and GHI by more consciously seeking opportunities for integration and synergy across program areas. Cross-cutting attributions also reflect areas in which there is continuing stakeholder interest, including recommended ("soft") Congressional earmarks for food and nutrition activities. Similar to other earmarks and budgetary considerations, only new FY 2014 planned funding can be reflected in cross-cutting attributions (i.e. applied pipeline does not get reflected).

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

All mechanisms that are applying new FY 2014 planned funding for work in any of the cross-cutting attributions (Human Resources for Health (HRH), Construction/Renovation, Motor Vehicles, Food and Nutrition, Economic Strengthening, Education, Water, Condoms, Gender-based Violence, or Gender Equality) **must** have the cross-cutting budget attributions identified and accurately quantified; if you need assistance in developing standard approaches to quantifying cross-cutting attributions, please contact your CSTL. For definitions of cross-cutting attributions, please see Appendix 4.

In FY 2014, we will be capturing FY 2014 funding information for fourteen cross-cutting areas, which are listed below and defined in Appendix 4. Individual attributions should not total more than the FY 2014 mechanism planned funding (new FY 2014 funds only), but the sum of all cross-cutting attributions may exceed the FY 2014 mechanism total planned funding. For example, if a partner is being funded at $1,000,000 for Pediatric Treatment, the planned funding for each cross-cutting attribution cannot be more than $1,000,000. A single activity can often have more than one cross-cutting attribution

(e.g., service training on safe water would be split between both HRH and Water), and together these attributions could exceed $1,000,000 in funding. Cross-cutting attributions should be identified for all relevant mechanisms, even in the case of "To Be Determined" (TBD) mechanisms. In these cases, country teams should estimate the amount of funding for each of the cross-cutting budget categories. The cross-cutting budget information can be updated during subsequent COP update cycles (OPU) if necessary.

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

**New Requirement:** For the Gender: GBV, Gender: Gender Equality, Key Populations: SW ,cross-cutting budget attributions, there will be a new required check list of activities that teams must complete. Teams should check all activities that apply. See COP Appendix 4 for further information.

While they do not require budget attributions, accurately identifying the key area/s in which a given activity contributes to priorities associated with integrated health programming or other priorities associated with the second phase of PEPFAR or GHI is also important.

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

### 7.5.8 Key Issues

The Key Issues tab presents the below issues as with a tick box next to each, please tick all that are applicable to the IM. Please see Appendix 5 for further information and definitions.

| Key Issues |
|---|
| **Health-Related Wraparounds**<br>• Child Survival Activities<br>• Family Planning<br>• Malaria (PMI)<br>• Safe Motherhood<br>• TB |
| **End-of-Program Evaluation** |
| **Mobile Population** |
| **Military Population** |
| **Workplace Programs** |

### 7.5.9 IM Level Indicators and Targets: REQUIRED FOR ALL IMs

Implementing Mechanism (IM) target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements. Country teams must provide a minimum of two years of implementing mechanism targets for the FY 2014 and FY 2015 time periods (October 1st to September 30th of each fiscal year). FY 2014 targets represent expected accomplishments by September 30, 2014. FY 2015 targets represent expected accomplishments by September 30, 2015.

Additionally, a *Planned Budget Target* is required for all CDC IMs only. Planned Budget Targets represent what you would expect to achieve with the planned fiscal year COP budget (i.e., with FY 2014 funds) for each applicable indicator. This is in contrast to the FY targets described above.

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

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

For more information on Indicators and Target Setting in the COP see section 7.3.

### 7.5.10 Construction and Renovation Tab: For HIV/AIDS Assistance Projects Only

The guidance in this section is not for U.S. government-Occupied Projects. Please see section 8.5 for information on this topic.

The primary purpose of PEPFAR funds is to provide vital services to those infected and affected by HIV/AIDS and to prevent new HIV infections. As a general rule, teams should only use PEPFAR funds for construction or renovation of facilities where the intent is to provide the completed facility as a form of foreign assistance (e.g., to the Ministry of Health), and when the construction activities are considered a "necessary expense" that is essential to the ability to provide HIV/AIDS services. PEPFAR funds may be used to construct or renovate medical and public health facilities, such as inpatient and outpatient hospitals or clinics, laboratories, and counseling and testing centers that reach critical populations and/or provide sustainable community-based services. In particular, PEPFAR funds may be used to construct or renovate host government medical or public health facilities, including Ministry of Health infrastructure, provided these facilities will be used to support HIV/AIDS services. The Construction or Renovation cross-cutting attributions should be identified for all relevant mechanisms that support the purposes outlined above. Please refer to the following considerations in programming FY 2014 funds to support these aims. Please note: For the FY 2014 COP submission, only IMs receiving new FY 2014 funds should provide a project plan. Projects that will utilize prior year/pipeline resources only and are not yet approved for construction or renovation must be requested during Operational Plan Update (OPU) cycles, at which point a project plan will be required.

*PEPFAR Funding for U.S. government-Direct Contracting/In-Kind Transfer for Construction/Renovation:* PEPFAR teams have several U.S. government options for undertaking construction and renovation projects in support of PEPFAR programs in foreign countries. These include providing assistance through grants and cooperative agreements to partners who have the capacity to manage construction contracts, as well as direct U.S. government contracting, where the U.S. government implementing agency will transfer the facility in-kind to the HIV/AIDS partner (usually the Ministry of Health or other host government agency) upon completion.

The appropriateness of using U.S. government direct/in-kind mechanisms (e.g., RPSO) should be carefully evaluated against other available options before proceeding. Given the bureaucratic procedures inherent in government procurement, constructing or renovating through the U.S. government can take upwards of two years from start to finish. Teams should first consider whether such projects could be funded and managed by the host government, an international organization, or another implementing partner, or whether such entities could manage construction efficiently with grant funding from the U.S. government. Country teams should also carefully consider individual agency policies on construction when identifying the U.S. government implementing agency before requesting COP funding for construction to be managed by a U.S. government agency, and ensure that the identified U.S. government agency HQ is aware of and approve the new requests.

If the team would like to construct or renovate using U.S. government direct/in-kind mechanisms, teams have the option of using the U.S. Agency for International Development (USAID), the Department of Defense (DOD), or the Department of State (DOS). At this time HHS/CDC does not engage in direct contracting for construction services abroad and thus should not be identified as the U.S. government implementing agency for construction. The Department of State should generally be the implementing agency for PEPFAR construction, unless USAID or DOD indicates a wish to manage construction on a particular project.

*Host Country MOU (and MOU Amendment) on Construction and Facility Handover:* All OUs with construction/renovation funding in their COP that use direct contracting/in-kind mechanisms must conclude with the host government a Memorandum of Understanding (MOU) on PEPFAR construction and renovation. The goal of the MOU is to improve coordination with host government officials on construction needs in-country, to facilitate the planning and tracking of projects, and to establish appropriate host country responsibilities for facilities following transfer. PEPFAR countries must also sign a MOU Amendment when adding projects after the original MOU (that includes the original list of projects) is signed. The MOU Amendment document template references the originally signed MOU and includes the new list of approved projects. The MOU provides a simplified form for transfer of completed projects. A model MOU, MOU Amendment and related template forms are posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles.

It is a requirement that all PEPFAR countries use the above mentioned documents for direct contracting/in-kind transfers. Substantive departure from the templates should be cleared by OGAC and the Office of the Legal Adviser.

Any OU that requests funding for direct contracting/in-kind construction/renovation in its FY 2014 COP must conclude a host country MOU on construction substantially in the provided template. Because the MOU establishes essential host country responsibilities for facilities, a signed MOU is required before beginning project activities (i.e., before requisitioning construction services). Construction projects may be proposed in the COP in anticipation of an MOU, and may be conditionally approved by OGAC subject to conclusion of the MOU.

Once completed projects have been transferred to the host government, post keeps legal documentation (MOU and Transfer documents) on file and sends signed copies to the OGAC Management & Budget, Javon Williams (WilliamsJL@state.gov).

In cases where teams are entering into contracts, grants or cooperative agreements with partners who will undertake construction activities under the terms of the award, but the intent is not to provide the completed facility to the host country government as a form of in-kind assistance, a host country MOU is not required. In such cases, the assistance instrument governs the terms of the project.

*PEPFAR Construction/Renovation Project Plan:* Operating Units (OUs) will submit their FY 2014 project plans via the FACTS Info system. A project plan is a formal, approved by host country, document used to guide both project execution and project control. At a minimum, a project plan should answer the basic questions of Who, What, When, Where, Why and How about the project. Prior to being included in the COP, all construction or renovation projects and project plans must have been approved by the appropriate parties at agency headquarters.

*Construction* refers to projects which build new facilities or expand the footprint of an already existing facility (i.e. adds on a new structure or expands the outside walls). In order to maintain a full account of all PEPFAR construction projects, comply with Congressional and White House inquiries regarding PEPFAR construction investments, and support the other business cycles collecting construction data (i.e. APR for EUM Reporting and SAPR for status updates), each individual construction project must have a corresponding and completed project plan within FACTS Info. Construction projects cannot be bundled together, and each individual project must have its own plan even if there are multiple under one Implementing Partner. Should you have further questions during the COP planning process, contact your CSTL directly.

*Renovation* refers to projects with existing facilities intended to accommodate a change in use, technical capacity, or other infrastructure improvements. For FY 2014, OUs must report all planned renovation projects, but may bundle like renovation projects into

larger more manageable project plans under one implementing partner, given the following factors:

(1) The "Who, What, When, Why and How" for each individual renovation project is the same;
(2) all information for project leads and contacts is the same for each individual renovation;
(3) the same scope and type of work is being done at all sites (i.e. one implementing partner is providing the same types of renovation work to a number of facilities, such as painting and electrical work, etc.);
(4) the timeline for all projects is the same or within a reasonable timeframe;
(5) the requested renovation at all sites can be encompassed under a single narrative;
(6) the location of each project is clearly identifiable and stated within the project plan.

The intent is to minimize the number of renovation projects you have to input and staff has to review while ensuring that the work being done at each individual worksite is clearly stated, justified, and includes all necessary tracking information. Should you have further questions regarding your ability to bundle renovation plans, contact your CSTL directly.

*Reporting on Construction/Renovation Investments within FACTS Info*

If an OU is requesting FY 2014 PEPFAR funds for new or continuing construction or renovation of facilities under an implementing mechanism (non-U.S. government) where the intent is to provide the completed facility as a form of foreign assistance, a team must include mechanism level details (i.e. identification of cross-cutting attribution investment, project plan) of their proposed projects with their COP submission. A team's ability to provide all of the required information with COP submission will allow for a more streamlined review and approval process.

Please follow the below steps for submission of non-U.S. government construction and renovation requests (incl. project plan):

1. From within the COP module and the implementing mechanism sub-section, visit the "mechanism details" tab.
2. Select the tick box for "Construction/Renovation within this IM."
3. Scroll across the bottom of the screen, to the "cross-cutting attribution" tab.
4. Indicate the level of investment with new FY 2014 resources ONLY in the Construction or Renovation cross-cutting attributions (cross-cutting attributions may not include any applied pipeline).
5. Enter the dollar amount for FY 2014 planned resources within the implementing mechanism details tab as done with all IMs (i.e. funding sources, budget codes)

6. Scroll over to the “project plan” tab.
7. Complete all required fields.

Please note: For all laboratory construction/renovation projects the biosafety level (BSL) of the proposed laboratory will need to be specified. For higher containment laboratories (BSL-2 enhanced or BSL-3) additional information is required. BSL-4 laboratories are not permitted. Please see the construction in Appendix 8 for additional details and details on the required supplemental document in section 10.8 of the COP guidance.

### 7.5.11 Global Fund Engagement Tab

This tickbox is used to identify mechanisms where the PEPFAR prime partner is jointly funded by the Global Fund or provides technical assistance to support Global Fund grant implementation. Once you check the box, please select from the dropdown options and fill in the respective narrative box to elaborate on the nature of activities or assistance.

1. Please select PR/SR if the Prime Partner of this IM is also a Global Fund Principal Recipient or Sub-Recipient (PR or SR). In the narrative box below please describe what technical program area this partner engages in.
2. Please select TA if the Prime Partner of this IM provides technical support to Global Fund grant recipients. In the narrative box below please describe what type of assistance/support the partner is providing to support Global Fund grant implementation.

## 8. U.S. government Management and Operations (M&O)

This section captures information about the U.S. government PEPFAR footprint in country – how the team is organized; each agency’s roles and responsibilities on the interagency team; staffing requests and vacancies; and the costs of doing business (CODB) in country, by agency, for PEPFAR. Collecting this information under the M&O heading centrally organizes data in one location and allows for easier itemization of individual costs; reduces the burden for country teams by centralizing data entry; and provides more transparency to Congress, OMB, as well as in-country and other stakeholders, on the costs for each U.S. government agency of managing and implementing the PEPFAR program. The funds captured in M&O reflect the costs of the field-based personnel who provide oversight, technical assistance, management, and leadership of the PEPFAR programs in country.

**Activities in which the PEPFAR Operating Unit (OU) team purchases services from a U.S. government agency acting in the capacity of an implementing partner should be captured in the "Managing Implementing Mechanism" section.** For example, costs associated with Peace Corps volunteers should be reflected in M&O, but a Peace Corps grants program should be included as an implementing mechanism in the Managing Partners section; similarly, State Department personnel and CODB are reflected in M&O, but support for an Ambassadors' small grants, Public Affairs/Public Diplomacy (PA/PD) outreach, and self-help activities should be entered as implementing mechanisms. State RPSO construction should be entered as an implementing mechanism to capture the construction contracting services provided on behalf of the country team.

Only U.S. government agencies that have staff in-country and receive funding for in-country staff should be reflected in this section. U.S. government agencies that do not have a presence in country should be captured as implementing mechanisms (e.g. Department of Labor or Department of Treasury).

### Budgetary Requirements

The headquarters M&O COP review team will consider the country team's responses to the guiding questions included in the COP. Country teams should evaluate the appropriate alignment of M&O costs, availability of pipeline within M&O, interagency organization and structure, and staffing data to the program in evaluating M&O investments.

## 8.1 Background

Each country team is expected to manage the in-country program and deliberate strategic changes to the PEPFAR-funded U.S. government staffing footprint as a cohesive interagency unit. Teams should review the staffing and organizational structure of the in-country U.S. government team regularly throughout the year and especially during the COP planning process. While planning for the FY 2014 COP, country teams should reevaluate their U.S. government staffing footprint and organizational structure to ensure that it continues to maximize interagency planning, implementation, and evaluation – especially in consideration of any programmatic and/or budgetary changes. As part of their staffing analysis, country teams should consider staffing needs for program technical and management demands for the next two years.

For the FY 2014 COP, country teams will be required to provide pipeline for M&O with their COP submission. Specifically, teams will report the total available M&O pipeline by agency and CODB cost category as of December 31, 2013. In addition, teams will enter

the total amount of pipeline that will be applied to the FY 2014 COP implementation cycle (applied pipeline) by agency and CODB cost category. As with implementing mechanisms, the total and applied pipeline fields will be a priority area for review by HQ, and should be a key area of focus as teams formulate M&O requests in the FY 2014 COP.

PEPFAR continues to be committed to addressing issues hindering our ability to recruit and retain LE Staff working for PEPFAR around the world. LE Staff may be host country nationals, locally resident Americans, or locally recruited Third Country Nationals (TCNs). Providing a work environment that fosters collaboration, respect, and professional development is an essential element in supporting the long-term retention of these staff who maintain critical relationships with the host government and partners and are essentially the institutional knowledge for our programs. These staff members, especially the host country nationals, build capacity within the country, ideally leading to greater sustainability of the program and improving the likelihood of achieving both national and PEPFAR goals. The PEPFAR Interagency Working Group on Issues Affecting LE Staff (LE Staff WG) is available to assist teams in improving recruitment, retention, and empowerment of LE Staff.

### M&O Review

As an ongoing process and especially during COP planning, country teams should evaluate the appropriate alignment of M&O costs across technical areas, interagency organization and structure, and staffing footprint, M&O pipeline funding, as well as M&O investments over the next two years.

The headquarters M&O review team will consider the allocation of funding and staffing data submitted in the COP, the application of pipeline to fund FY 2014 COP M&O costs, historical data and vacancies, repurposed vacancies, prioritization of proposed new positions (as appropriate), and the country team's responses to the guiding questions included in the COP. The reviewers will bear in mind PEPFAR rightsizing principles, unique country/regional contexts, and field planning processes. They emphasize country teams' careful consideration of the appropriate mix of technical, professional and administrative staff; ratio of LE Staff to U.S. citizen direct hires/appointees and Personal Services Contractors (PSCs); growth in CODB annually and over time; and changes in staff in relation to programmatic and funding level shifts.

## 8.2 Coordination with Embassy and Agency Management Teams

According to State Department policy, all Chiefs of Missions (COM) must ensure that all elements under their authority establish and maintain consolidated support platforms

under the International Cooperative Administrative Support Services (ICASS) program. No Executive Branch agencies or sub-agencies with staffs operating under COM authority, including State elements, should plan to establish new administrative systems or expand existing support operations outside of the ICASS framework. PEPFAR programmatic staff should consult with non-program offices, such as human resources, management, and general services/procurement, to ensure sufficient support to facilitate PEPFAR activities. Teams should ensure the accuracy of agency workload counts when provided to the ICASS Council in April each year and consult with financial management staff to project ICASS charges for each fiscal year based on the previous year's workload. Country teams should look for creative solutions to challenging management burden issues without creating duplicative positions or processes.

In addition, country teams should work in concert with agency acquisition and assistance (A&A) staff, as appropriate, when considering any changes to existing contracts or awards and in the planning of new procurements for the upcoming fiscal year. The agency A&A staff can advise on legal, policy, and procedures that must be followed. It is also important to consult with A&A staff from a workload perspective. Consulting with A&A teams early in the process allows them to plan for workload burden during the fiscal year. The same is true for Human Resources and other management support staff.

## 8.3 Interagency M&O Narratives

For the FY 2014 COP, country teams are asked to respond to three narratives that concretely address team structure, management, interagency planning processes, staffing skill sets, and construction/renovation. The narratives should *directly* respond to the questions with a view toward strategic staffing and planning over the next two years.

Each narrative should be no more than 2250 characters (less than one page); teams should use as much or as little of the available space as needed to convey their answers.

### 8.3.1 Narrative 1: Interagency M&O Strategy Narrative

A single supporting narrative is required to describe the PEPFAR program's management strategy in country. The narrative should be inclusive of all U.S. government agencies present in country and how the team manages the program collaboratively. Highlight each agency's staffing, unique roles and core strengths; address the strategic direction of the interagency team for the next two years. In conjunction with the second five-year strategy, PEPFAR's role in GHI, and with your

Partnership Framework or other guiding country-specific strategy document, as appropriate, describe the country team's staffing and management strategy for the next two years.

The narrative should also address issues affecting recruitment or retention across your team. What is the team's approach to addressing these issues? Can headquarters provide any assistance with recruitment and retention issues?

### 8.3.2 Narrative 2: Assessment of Current and Future Staffing

This narrative should assess whether the country team's staff footprint is appropriate to manage the program based on the trajectory outlined in the COP. The narrative should also specifically describe any adjustments to the staff footprint to adapt to changes in the program and/or budget (please indicate specific changes to overall staffing numbers, including vacancies).

*Country teams Should Address the Following Questions:*

- Does the country team have the appropriate mix of technical, management, and administrative staff required to implement the program, during and beyond Partnership Framework or Strategy implementation (where relevant)?
- Did the country team conduct a staffing review during the year to determine any changes in size or mix or staff in the program and/or budget? If yes, please describe what changes have been implemented or are planned.
- Are current management resources (staff, space, etc.) sufficient to manage the program?
- What specific adjustments have been made to adapt to the current budget climate (e.g. repurposing existing long-term vacancies)?
- To what extent are pipeline resources being applied to meet FY 2014 COP costs?
- What changes were made in the previous year or will be made in the upcoming year to increase the number of host country national and other LE Staff in the context of your overall staffing strategy, namely increasing the number of leadership positions and responsibilities across the interagency team?

In addition to responding to this narrative prompt regarding current staffing, country teams are required to upload an overall organizational chart as well as agency specific organizational charts with their FY 2014 COP submission. These organization charts should be uploaded to the Document Library in FACTS Info as "Org Chart Team or Agency X".

For any proposed new positions, describe: (1) the interagency process by which additions to the overall US staffing footprint were prioritized and approved; (2) technical assistance (e.g., Framework Job Descriptions) or other support that may be needed from headquarters to fill proposed new positions; (3) how the new positions are explicitly linked to one or more of the following overarching priorities in the second five-year strategy and/or PEPFAR's role in the Global Health Initiative; and (4) why this position could not be created through a current vacancy. Specific comments should be included in the staffing data (see below).

### 8.3.3 Narrative 3: U.S. government Office Space and Housing Renovation

As noted in Section 8.4, country teams may request, in exceptional circumstances, the use of PEPFAR funds to renovate U.S. government-occupied facilities, which provide office space or housing for U.S. government PEPFAR personnel. Please provide a narrative for each proposed renovation project.

In addition to the narrative, country teams must provide the total costs associated with renovation of buildings owned/occupied by U.S. government PEPFAR personnel under the **Agency Cost of Doing Business (CODB)** section (Section 8.3 of the COP Guidance). Costs for projects built on behalf of or by the partner government or other partners should be budgeted for and described as Implementing Mechanisms (see Section 7.5.1 of the COP Guidance).

The narrative should provide the dollar amount, describe the project in detail, and provide a breakout of costs associated with the renovation of buildings occupied by U.S. government PEPFAR personnel. Please list the owner of the property in the narrative. Significant renovation of properties **not** owned by the U.S. government may be an ineffective use of PEPFAR resources, and costs for such projects will be closely scrutinized. Additional information required in this section includes:

- The number of U.S. government PEPFAR personnel that will occupy the facility, the purpose for which the personnel will use the facility, and the duration of time the personnel are expected to occupy the facility.
- The expected timeline for the U.S. government renovation activities (start/end date)
- A detailed description of the renovation project and the associated cost.
- The mechanism for carrying out the renovation project, e.g. Regional Procurement Support Office (RPSO).
- Name of the city/town where the building is located.

- The U.S. government Agency which will implement the project, and to which the funds should be programmed upon approval. If the project will be implemented by DOS through RPSO, the funding agency should be the State Bureau (e.g., State/AF).
- The appropriate funding source (e.g., GHP (State)).
- Brief description why alternatives – facilities that could be leased and occupied without renovation – are unavailable or inadequate to personnel needs.

## 8.3.4 Staffing Narratives: Justify Vacant and Proposed New Positions

For all vacant (as of March 1, 2014) and/or planned (newly requested) positions, country teams are asked to provide additional details in the Comments field within the Staffing section of the PEPFAR module. Position narratives should be no more than 500 characters and should be entered directly into the Staffing section of the PEPFAR module. There should be one justification per each staffing record marked as vacant or planned.

Updating staffing data prior to or simultaneous to responding is advised (see Section 8.6 of the COP Guidance).

### EXPLAIN VACANT POSITIONS

For each approved but vacant position, the country team must explain the reasons it is vacant and describe the plan and timeline for filling the vacant position within the Comments section of the staffing data. If the position has been previously encumbered, please provide the date the position became vacant and whether the position has been recruited yet. If recruitment has occurred but the team has been unable to fill it, please indicate why (e.g. lack of candidates, salary too low, etc.). Submitting this information will inform understanding of program wide recruitment and retention issues and assist in identifying specific remedies where possible.

### JUSTIFY PROPOSED NEW POSITIONS

For each proposed new position, describe how it fits into the overall and individual agency staffing footprint (e.g. meets changes in the program, addresses gaps, complements the existing staff composition) within the Comments section of the staffing data. Indicate why a new position is necessary instead of repurposing an existing filled or vacant position. For positions that the team plans to fill with a U.S. citizen direct hire, appointee, or PSC, indicate why this position cannot be hired locally. There should be one explanation for each staffing record marked as planned in the staffing data.

Please note that country/regional programs with significant vacancies among previously approved positions and/or proposing new positions not aligned to programmatic priorities, should anticipate that any proposed new positions will be rigorously evaluated for relevance.

Teams should strongly justify why they are proposing new positions given their vacancies and are encouraged to address this directly in the narratives and staffing data fields. Wherever possible, country teams are advised to repurpose existing vacancies to fill new staffing priorities (particularly long-standing vacancies, i.e. having been vacant for 2 or more COP cycles). In the FY 2014 COP review process, all proposed new positions will be heavily scrutinized and may not be approved.

Note that any proposed new positions should spend at least 50% of their time on PEPFAR activities.

## 8.4 Planned Funding of U.S. government Costs of Doing PEPFAR Business

U.S. government Cost of Doing Business (CODB) includes all costs inherent in having the U.S. government footprint in country, i.e. the cost to have personnel in-country providing the technical assistance and collaboration, management oversight, administrative support, and other program support to implement PEPFAR and to meet PEPFAR goals.

By capturing all CODB funding information in the M&O section, data are organized in one location, allowing for clear itemization and analysis of individual costs. In addition to providing greater detail to headquarters review teams and parity in the data requirements for field and headquarters management costs, the data provides greater transparency to Congress, OMB, in-country and other stakeholders on each U.S. government agency's costs for managing and implementing the PEPFAR program.
If there is any funding requested for the following CODB categories, then you must complete the "Item Description" field associated with the category and planned amount. The narratives should be no more than 500 characters.

- **Non-ICASS Administrative Costs:** Please provide a detailed cost breakout of the items included in this category and their associated planned funding (e.g. $1,000 for printing, $1,000 for supplies).

- **Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) and will be used solely for that purpose, purchase or lease information needs to be justified and dollar amount specified.

- **Institutional Contractors:** Describe the institutational contractor (IC) activities and why these activities will be conducted by an IC rather than a U.S. Direct Hire or PSC/PSA. Where possible, please provide the contracting company name and the technical area(s) which the IC(s) will support.

Once you have completed the steps for one agency, please repeat for all other agencies working in country.

There are eleven U.S. government CODB categories. The following list of CODB categories provides definitions and supporting guidance:

1. **U.S. Government Staff (Direct Hire, Personal Services Contractor [PSC], Personal Services Agreement [PSA]) Salaries and Benefits:** The required costs of having a person in country, including housing costs not covered by ICASS, rest and relaxation (R&R) travel, relocation travel, home leave, and shipping household goods. This category includes the costs associated with technical, administrative, and other staff.
    a. PEPFAR program funds should be used to support the percentage of a staff person's salary and benefits associated with the percentage of time they work on PEPFAR. The direct costs of PEPFAR, specifically the costs of staff time spent on PEPFAR, need to be paid for by PEPFAR funding (e.g. GHCS, GAP). For example, if a staff person works 70% on PEPFAR, PEPFAR program funds should fund 70% of that person's salary and benefits. If the percentage worked on PEPFAR is 10%, then PEPFAR funds should fund 10% of the person's salary and benefits.
    b. For agencies that cannot split-fund staff with their agency appropriations (such as USAID's OE funds), multiple staff may be combined to form one FTE and one of the staff's full salary and benefits will be funded by PEPFAR. For example, if two staff each work 50% on PEPFAR, PEPFAR funds should be used to fund the salary and benefits of one of the positions. If three staff each work a third of their time on PEPFAR (33% + 33% + 33%), PEPFAR funds should be used to fund the salary and benefits of one of the positions. If multiple staff work on PEPFAR but not equally (such as 10% + 20% + 70% or 25% + 75%), the full salary and benefits of the person who works the most on PEPFAR (in the examples,

either 70% or 75%) should be funded by PEPFAR. This split should be reflected in the staffing data.

c. If the agency is paying for host country citizen fellowships and is going to only train the fellows, then the funding can remain in an implementing mechanism. If the agency is going to be getting a work product from the fellows, then this cost should be counted in M&O. Similarly, if agencies are paying for trainers who are U.S. government staff, then the costs associated with these staff should be reflected within M&O. If the mechanism is paying for the materials and costs of hosting training, then the funding should be reflected in an implementing mechanism.

*2.* **Staff Program Support Travel:** The discretionary costs of staff travel to support PEPFAR implementation and management does NOT include required relocation and R&R travel (those are included in U.S. government Salaries and Benefits).

This category includes the costs associated with technical staff travel and travel costs associated with the provision of technical assistance. All costs associated with technical staff time should be reflect within M&O; other TA funding (e.g. materials) should be reflecteded in an implementing mechanism.

In FY 2014, technical assistance-related travel costs of HHS/CDC HQ staff for trips of less than 3 weeks will be included in the PEPFAR Headquarters Operational Plan (HOP) and funded centrally. Under this model, costs for short-duration technical assistance travel by HHS/CDC staff should not be included in the countries' COPs.

*3.* **ICASS (International Cooperative Administrative Support Services):**

a. ICASS is the system used in Embassies to:
   *i.* Provide <u>shared common</u> administrative support services; and
   *ii.* <u>Equitably distribute</u> the cost of services to agencies.

b. ICASS charges represent the cost to supply common administrative services such as human resources, financial management, general services, and other support, supplies, equipment, and vehicles. It is a generally a required cost for all agencies operating in country.

c. Each year, customer agencies and the service providers present in country update and sign the ICASS service "contract." The service contract reflects the projected workload burden of the customer agency on the service provision for the upcoming fiscal year. The workload assessment is generally done in April of each year. PEPFAR country teams should ensure that every agency's workload includes all approved PEPFAR positions.

*i.* ICASS services are comprised of required cost centers and optional cost centers. Each agency must sign up for the required cost centers and has the option to sign up for any of the optional cost centers.

*ii.* More information is available at http://www.state.gov/m/a/dir/regs/fah/c23257.htm.

d. ICASS charges must be planned and funded within the country/regional budget (COP). However, ICASS costs are typically paid by agency headquarters on behalf of the country team from their budgeted funding. Each implementing agency, including State, should request funding for PEPFAR-related ICASS costs within its M&O budget.

*i.* It is important to coordinate this budget request with the Embassy Financial Management Officer, who can estimate FY 2014 anticipated ICASS costs. This FY 2014 ICASS cost estimate, by agency, should then be included as the planned ICASS funding.

*ii.* It is important to request all funding for State ICASS costs in the original COP submission, as it is difficult to shift funds at a later date.

*iii.* The Peace Corps subscribes to minimal ICASS services at post. Most GSO and all financial management work (except FSC disbursing) are carried out by Peace Corps field and HQ staff. In order to capture the associated expenses, Peace Corps will capture these costs within the indirect cost rate.

*4.* **Non-ICASS Administrative Costs:** These are the direct charges to agencies for agency-specific items and services that are easy to price, mutually agreed to, and outside of the ICASS MOU for services. Such costs include rent/leases of U.S. government-occupied office space, vehicles, shipping, printing, telephone, driver overtime, security, supplies, and mission-levied head taxes.

In addition to completing the budget data field, teams are expected to explain the costs that compose the Non-ICASS Administrative costs request, including a dollar amount breakout by each cost category (e.g. $1,000 for printing, $1,000 for supplies) in the "Item Description" field.

*5.* **Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) and will be used solely for that purpose, purchase or lease information needs to be justified. For new requests in **FY 2014** please provide a brief narrative (few words) explaining the purpose of each vehicle (s) and associated cost (s) in the "Item Description" field. It is also a requirement that the total number of vehicles purchased and/or

leased under Non-ICASS (Motor Vehicles) costs to date **(cumulative through FY 2014 COP)** are provided in this category.

6. **CSCS (Capital Security Cost Sharing):** Non-State Department agencies should include funding for CSCS, except where this is paid by the headquarters agency (e.g. USAID).
    a. The CSCS program requires all agencies with personnel overseas subject to Chief of Mission authority to provide funding in advance for their share of the cost of providing new, safe, secure diplomatic facilities (1) on the basis of the total overseas presence of each agency and (2) as determined annually by the Secretary of State in consultation with such agency.
    b. The State Department uses a portion of the CSCS amount for the Major Rehabilitation Program (MRP).
    c. It provides steady funding annually for multiple years to fund 150 secure New Embassy Compounds in the Capital Security Construction Program.
    d. More information is available at http://www.state.gov/obo/c30683.htm.
    e. Country teams should consult with agency headquarters for the appropriate amount to budget in the COP.

7. **Computers/IT Services:** Funding attributed to this category includes USAID's IRM tax and other agency computer fees not included in ICASS payments. If IT support is calculated as a head tax by agencies, the calculation should transparently reflect the number of FTEs multiplied by the amount of the head tax.
    a. CDC should include the IT support (ITSO) charges on HIV-program-funded positions; these costs will be calculated at CDC HQ and communicated to country teams for inclusion in the CODB.
    b. USAID should include the IRM tax on HIV-program-funded positions.

8. **Management Meetings/Professional Development:** Discretionary costs of country team meetings to support PEPFAR management and of providing training and professional development opportunities to staff. Please note that costs of technical meetings should be included in the relevant technical program area.

9. **U.S. Government Renovation:**
    a. Country teams should budget for and include costs associated with renovation of buildings owned/occupied by U.S. government PEPFAR personnel.

b. In addition to the budget information, country teams must provide a M&O narrative (see COP Guidance Section 8.3) to describe the requested project, timeline, and justification.
c. Costs for projects built on behalf of or by the partner government or other partners should be budgeted for and described as Implementing Mechanisms (see Sections 7.5 of the COP Guidance).

### *10.* Institutional Contractors (non-PSC/non-PSA):

a. Institutional and non-personal services contractors/agreements (non-PSC/non-PSA) includes organizations such as IAP Worldwide Services, COMFORCE, and all other contractors that do NOT have an employee-employer relationship with the U.S. government.
b. All institutional contractors providing M&O support to the country team should be entered in M&O, not as an Implementing Mechanism template.
c. In addition to the budget information, country teams must provide a narrative to describe institutional contractor activities in the "Item Description" field..
d. Costs associated with this category will be attributed to the appropriate technical program area within the FACTS Info PEPFAR Module.

### *11.* Peace Corps Volunteer Costs (including training and support):

a. Includes costs associated with Peace Corps Volunteers (PCV), **Volunteer Extensions,** and Peace Corps Response Volunteers **(PCRVs)** arriving at post between **October 1, 2014** and **September 30, 2015**.
    i. The costs included in this category are direct PCV costs, pre-service training, **Volunteer-focused** in-service training, medical support and safety and security support.
    ii. The costs <u>excluded</u> from this category are: U.S. government staff salaries and benefits, staff travel, and other office costs such as non-ICASS administrative and computer costs, which are entered as separate CODB categories. Also excluded are activities that benefit the community directly, such as Volunteer Activities Support and Training (VAST) grants or **selected** training events where the number of host country nationals is greater than the number of PCVs participating. These types of activities should be entered directly into the appropriate program area budget code in an Implementing Mechanism template.
b. Funding for PCVs must cover the full 27-month period of service. For example:
    iii. Volunteers arriving in June **2015** will have expenses in **2015, FY 2016, and FY 2017**.

iv. Volunteers arriving in September **2015** will have expenses in FY **2015, FY 2016, FY 2017, and FY 2018**.

c. PCV services are not contracted or outsourced. Costs are incurred before and throughout the Volunteer's 27-month period of service. Starting in FY 2010, costs incurred by Peace Corps Washington and domestic offices, such as recruitment, placement and medical screening of Volunteers, will be included in the Headquarters Operational Plan (HOP). Costs such as living allowance, training, and support will continue to be included in the COP.

*Inclusion of Global Fund Liaison Costs (where applicable):* For Global Fund Liaison positions that remain centrally-funded at this time, the funding should not be included in the CODB. As Missions pick up the funding of the Liaison position (full or cost share), the percentage of the position which is PEPFAR funded should be reflected in the COP and allocated to the above CODB categories. Please contact your CSTL with any questions about funding stream for this position.

## 8.5 U.S. government Office Space and Housing Renovation

Country teams may include support for U.S. government Renovation in their CODB submission. All other construction and/or renovation should be included in the Implementing Mechanism section of the COP. The notes below outline how U.S. government renovation funds may be used.

*PEPFAR Funding May Not Be Used for New Construction of U.S. government Office Space or Living Quarters*

Consistent with the foreign assistance purposes of PEPFAR appropriations, PEPFAR GHAI, GHCS and GHP-State funding should not be used for the construction of office space or living quarters to be occupied by U.S. government staff. The Embassy Security, Construction and Maintenance (ESCM) account in the State Operations budget provides funding for construction of buildings to be owned by the Department of State, and the Capital Investment Fund (CIF) is a similar account appropriating funds for USAID construction. Other agencies such as HHS/CDC and DOD have accounts that provide funding to construct U.S. government buildings, and implementing mechanisms may contribute to the ESCM account through the Capital Security Cost Sharing program.

*PEPFAR Funding May be Used to Lease U.S. government-Use Facilities*

Where essential office space or living quarters cannot be obtained through the Embassy or USAID Mission, a request to use PEPFAR funds may be made in the context of a Country or Regional Operational Plan (COP/ROP) to rent or lease such space for a term not to exceed 10 years, if necessary to implement PEPFAR programs.

*PEPFAR Funding for Renovation of U.S. government-Owned and Occupied Properties*

Country teams may request the use of PEPFAR funds to renovate U.S. government-occupied facilities in exceptional circumstances. The justification for using PEPFAR funds to renovate U.S. government-occupied facilities must demonstrate that the renovation is a "necessary expense" that is essential to carrying out the foreign assistance purposes of the PEPFAR appropriation, and should show that the cost of renovation represents the best use of program funds. The justification should also explain why appropriate alternative sources of funding for renovation are not available. The country team must submit a comprehensive plan that includes an explanation of the unique circumstances around the request to renovate U.S. government-occupied facilities. The plan must have support from the Ambassador that justifies the renovation project. In addition to the narrative, country teams must provide the total costs associated with renovation of buildings owned/occupied by U.S. government PEPFAR personnel under the **CODB** section. Note, renovation of facilities owned by the U.S. government may require coordination with the State Department's Office of Overseas Buildings Operations (OBO) and other State Department bureaus, and may require the clearance of the State/Office of the Legal Advisor.

## 8.6 Staffing Data

As a part of the COP, country teams are asked to update their staffing data annually within the FACTS Info PEPFAR Module (pre-populated with the latest available staffing data).

The purpose of the staffing tool is to assist each country team with strategic staffing – during the COP planning process and throughout the year – by organizing and managing the demographic information and breakdown of time dedicated to each budget code of each team member working at least part of his/her time on PEPFAR. The information should assist each country team in assessing their current and proposed PEPFAR staff, from interagency and functional perspectives, and for the purposes of program design and oversight.

The annual revision of staffing data should support each U.S. government agency in ensuring that sufficient staff is in place for effective fiscal management and ensure that better information on staffing composition and needs is communicated to headquarters

as part of the COP. Staffing data should be integral to COP planning and reporting, staff planning, and position and program management. In both management and technical areas, review of staffing data by each U.S. government agency may help to identify gaps and areas of overlap, as well as support Chiefs of Mission in managing the PEPFAR team while engaging in agency headquarters-driven management exercises such as "rightsizing" and "managing to budget."

### 8.6.1 Who to Include in the Database

Staffing data should be entered for:

- All PEPFAR or partially-PEPFAR funded current, vacant (as of March 1, 2014), and proposed positions that will spend at least 10% of their time working on PEPFAR planning, management, procurement, administrative support, technical and/or programmatic oversight activities.
- Any non-PEPFAR funded current, vacant (As of March 1, 2014), and proposed positions that will spend at least 30% of their time working on PEPFAR planning, management, procurement, administrative support, technical and/or programmatic oversight activities.

**Hiring Mechanism**

The database should include all:

- LE Staff (locally hired host country nationals, Americans, and TCNs),
- Internationally recruited TCNs,
- US Direct Hire (USDH) (includes CDC appointed staff, military, and public health commissioned corps),
- Personal Services Contractors (PSCs),
- Personal Services Agreements (PSAs) (includes locally-recruited Eligible Family Members and Foreign Service Nationals)
- Non-personal Contractors (also known as commercial, third party, or institutional contractors) /Fellows, and
- Other employment mechanisms (for which there should be very few entries)

As in past years, U.S. government-funded Global Fund Liaison positions (whether centrally funded or cost-share) should be included in the staffing data.

Peace Corps Volunteers should *not* be included in the staffing data as they are not U.S. government employees. However, Peace Corps staff *should* be included.

**Funding and Time**

The database should include:

- Any partially or fully PEPFAR-funded (i.e. GHP, GAP, or other PEPFAR fund accounts) positions (program or non-program). This includes all previously agency-appropriations-funded (e.g. OE) staff who will be funded by PEPFAR program funds in FY 2014;
- All staff whose PEPFAR percentage of time is combined to equal one FTE; and
- Any *remaining* non-PEPFAR-funded (i.e. agency core funds) program position in which the incumbent is expected to work at least 30% of his/her average annual time on PEPFAR.

Each position's entry should reflect the amount of time spent working on PEPFAR and whether the position is partially or fully PEPFAR-funded. The funded costs for all positions should be reflected in the U.S. government Salaries and Benefits CODB category budget entry for direct hire, PSC, and PSA staff, and in the Institutional Contractors CODB budget entry for non-PSC/PSAs.

## Notes

*Program staff*: Those who work directly on PEPFAR programs or who provide leadership, technical, and/or management support for PEPFAR and program staff. Program staff includes the Ambassador, DCM, Mission Director, CDC Chief of Party, legal, contracts, financial, and Public Affairs/Public Diplomacy staff. Administrative staff who provide direct support to the program team also should be included.

*Non-Program staff*: Those who provide valuable administrative support to the PEPFAR team, including travel staff, drivers, and gardeners, but not direct program support.

*Aggregate Entries:* Country teams have the option of including in the database an aggregate entry for program staff who individually contribute less than 30% of their average time on PEPFAR, but are one of the same position who in aggregate, work 30% or more. In order to aggregate staff into one entry, the positions must have the same answer for "Funding Agency," "Agency Position Title," "Type of Position," "Employment Citizenship," "Employment Type," "Funding Type, "Schedule," and "Location." Enter the number of staff included in the entry in the "Number of Individuals" data field. In the "% Time Devoted to PEPFAR by Each Individual" data field, enter the aggregate amount of time that the positions spend working on PEPFAR annually.

*Inclusion of non-PEPFAR-funded and non-program staff:* While optional, you may also elect to include non-PEPFAR funded program or non-program staff in the database. However, do not include any staff that work on PEPFAR on a temporary or seasonal basis, such as during the COP season. *Do not include those working in ICASS-funded*

*offices (e.g. motorpool, GSO, FMO, EX, HR, etc.); staff working in ICASS offices and paid by ICASS contributions should be removed from the staffing data.*

*Inclusion of Global Fund Liaisons:* As in past years, Global Fund Liaison positions (whether centrally-funded or cost-share) should be included in Staff Information. For centrally-funded Liaisons, enter the record into the staffing database as "Non-PEPFAR Funded" (i.e. centrally or non-COP funded). As Missions pick up the funding of the Liaison position (full or cost share), enter the record as "PEPFAR Funded," or "Partially PEPFAR Funded" as relevant. Please contact your CSTL with any questions about funding stream for this position.

Organizational Chart: There may be instances for which a staff member is reflected on the organizational chart(s), but does not meet the criteria to be entered into the staffing database.

As a part of the cleaning and review process, HQ will review the submission to ensure that positions are actually marked as non-PEPFAR funded where appropriate to avoid skewing staffing analysis. If and when a Mission picks up the position – it can then be marked as either partially or fully PEPFAR-funded.

### 8.6.2 Attribution of Staffing to Technical Areas

Country teams are expected to reflect staff time across technical budget codes as appropriate. See examples below.

- A possible budget code distribution for a PMTCT Senior Technical Advisor is as follows: 70% MTCT, 20% HLAB and 10% HVMS. Note: the 10% attributed to HVMS for this position reflects staff time spent on managerial responsibilities.

- A possible budget code distribution for a Finance Specialist is as follows: 100% HVMS. Note: this position does not contribute to any technical areas and provides general administrative support.

For U.S. government Staff Salaries and Benefits and Staff Program Travel, country teams will update their staffing data and enter the top-line budget amount for each category, by fund account. Based on the calculated budget code FTE, a portion of the top-line budget amount will be attributed to relevant budget codes and to the M&O funding amounts.

For Institutional Contractors, country teams will enter the budget code planned funding amount for the appropriate technical areas, by fund account - i.e. the area(s) for which institutional contractors are providing personnel support on behalf of the U.S. government.

For Peace Corps Volunteers in FY 2014 COP, country teams should attribute all PCV funding to Management and Operations (budget code HVMS).

### 8.6.3 Staff Information Instructions

Enter staff demographic information in the following fields (data field definitions are included below):

**Operating Unit:** This field is important for analysis across countries. The appropriate OU will be pre-populated by the system.

**Number of Individuals:** Captures the number of staff represented by the entry (typically a value of one). However, if you have aggregated into one entry, several staff who together work 30% or more of their time on PEPFAR, please enter the number of staff included in the entry in the "Number of Individuals" field.

**Time Devoted to PEPFAR by Each Individual:** Refers to the annual staff time the person in the position spends on PEPFAR (10-100%). This is one of the key fields in determining the position's FTE. Enter the average percentage (10-100%) in the data field. If you have aggregated several staff, please enter the average percentage each person spends on PEPFAR (e.g. enter 10% if all three drivers devote this amount of time to PEPFAR).

**Staffing Status:** Refers to whether a position is currently staffed or not. Select whether the position is Filled, Vacant (previously approved in COP 2013 or prior), or Planned (new request for FY 2014 COP):

- Filled refers to currently encumbered positions;
- Vacant refers to positions that have been previously approved in a COP, but are currently empty; or
- Planned (new requests) refers to positions that are new for FY 2014 COP and have not been approved in previous COPs. All new planned positions will need to have a new staff justification narrative completed.

**Last Name:** If desired and the position is filled, enter the staff member's last name. *If there are multiple positions included in one entry, enter "multiple" in the last name field.*

**First Name:** If desired and the position is filled, enter the staff member's first name. *If there are multiple positions included in one entry, enter the positions' title in the first name field.*

**Funding Agency:** Select the agency the staff person is employed by from the drop-down menu. For contractors, select the agency that supports the position.

**Agency Position Title:** Country teams should use a detailed functional title appropriate for each position or use official titles. For example, "Senior Technical Advisor for PMTCT" or "M&E Advisor," or "Management and Program Analyst" and "Public Health Advisor." Teams should be as specific and consistent as possible in their titling methodology.

**Type of Position:** This field includes five categories that have been condensed from previous years. Please note for positions within categories (a) and (b)part or all of the funding will likely be attributed to technical budget codes; , whereas for positions within categories (c), (d), and (e), all of the funding will likely be attributed to the management and operations budget code (HVMS). . Select the type of position from the following list:

a. **Technical Leadership/Management** includes positions that head up the health/HIV team within the agency; e.g., Health Officer, CDC Chief of Party, and Deputy. This could be the head of the agency (as is usually the case with CDC) or could be someone who oversees all U.S. government health activities and spends only part of the time on the Emergency Plan (for example the head of the PHN Office under USAID). A U.S. Direct Hire Foreign Service officer filling an HIV/AIDS advisor position and thereby leading an HIV/AIDS team would also be placed in this category.
b. **Technical and Programmatic Oversight and Support** includes the technical staff within the health/HIV team who spend most of their time implementing or managing programs in technical areas, including Agreement Officer Technical Representatives (AOTRs), Project Officers (POs), and Public Health Advisors. Please also include here any entry and mid-level staff providing direct public health programmatic activities in this category (this is most relevant for CDC staff). Programmatic support positions within the health/HIV team or non-health/non-HIV staff who provide support to the

health/HIV team not captured in another category (e.g. Education, Reproductive Health, TB, Food & Nutrition) are also included in this category.

c. **Contracting/Financial/Legal** includes acquisition (contracts) and assistance (grants and cooperative agreements) officers and specialists and their support staff. A contracting officer represents the U.S. Government through the exercise of his/her delegated authority to enter into, administer, and/or terminate contracts, grants, and cooperative agreements, and make related determinations and findings. Contracting officers and specialists usually support an entire agency in country or will support an entire regional portfolio. If an agency utilizes the contracting officer services of another agency, include the position only in the contractor's home agency. This category also includes the financial management officer or specialist for the agency. These staff members support financial and budget analysis and financial operations functions. Legal includes any staff who provide legal advice and support to PEPFAR.
d. **Administrative and Logistics Support** includes any secretarial, administrative, drivers, and other support positions.
e. **US Mission Leadership and Public Affairs/Public Diplomacy** (PA/PD) include any non-health/HIV staff who provide management and leadership support to PEPFAR, such as the Ambassador, Deputy Chief of Mission, USAID Mission Director, or Political or Economic Officers, and any PA/PD staff.

**Employee Citizenship:** Select the citizenship of the staff member:

a. **US-based American citizen:** Direct hire (including military and public health commissioned corps), appointees (CDC), or PSCs hired in the U.S. for service overseas, often on rotational tours. They are paid on the U.S. Foreign Service or Civil Service pay scale or compensated in accordance with either scale. The U.S. government has a legal obligation to repatriate them at the end of their U.S. government employment to either their country of citizenship or to the country from which they were recruited.
b. **Locally Resident American Citizen:** Ordinarily resident U.S. citizens who are legal residents of a host country with work permits. U.S. government agencies recruit and employ them as LE Staff under Chief of Mission (COM) authority at Foreign Service (FS) posts abroad often as PSAs. They are compensated in accordance with the employing post's Local Compensation Plan (LCP).
c. **Host Country National (or legal permanent resident):** Citizens of the host country or ordinarily resident foreign nationals who are legal residents of the host country and hold work permits. They are employed as LE Staff at FS posts abroad and compensated in accordance with the LCP of the employing post.

d. **Locally Hired Third Country Citizen:** Foreign Service Nationals (FSNs) who are not citizens or permanent residents of either the host country or the United States and are hired locally in the country in which they are employed. They are compensated in accordance with the employing post's LCP.
e. **Internationally Recruited Third Country Citizen:** Foreign Service Nationals (FSNs) who are recruited from a foreign country other than where they are employed with whom the U.S. government has a legal obligation to repatriate them at the end of their U.S. government employment to either their country of citizenship, or to the country from which they were recruited.

**Employment Type:** Refers to the hiring authority by which the staff member is employed or engaged:

a. **Direct Hire:** A U.S. government position (AKA billet, slot, ceiling, etc.) authorized for filling by a Federal employee appointed under U.S. government personnel employment authority. A civilian direct-hire position generally requires the controlling agency to allocate an FTE resource. NOTE: Host country nationals that are appointed by a U.S. government agency should be listed as a Direct Hire.
b. **Personal Services Contractor (PSC**): An individual hired through U.S. government contracting authority that generally establishes an employer/employee relationship. Peace Corps uses PSCs to obtain services from individuals.
c. **Personal Services Agreement (PSA):** An individual hired through specialized Department of State contracting authority that establishes an employer/employee relationship.
d. **Non-Personal Services Contractor (non-PSC/PSA):** An individual engaged through another contracting mechanism by a non-U.S. government organization that does not establish an employer/employee relationship with the U.S. Government.

**Funding Type:** Select the appropriate choice for the position:

a. **PEPFAR Funded:** Any position funded by GHP-State, GHP-USAID, GAP, or other PEPFAR fund accounts.
b. **Partially PEPFAR Funded:** Any position partially funded by GHP State, GHP-USAID, GAP, or other PEPFAR fund accounts.
c. **Non-PEPFAR Funded:** Any position funded by agency core (State, Defense, and Peace Corps positions; CDC and USAID positions should be partially or fully PEPFAR funded).

**Schedule:** Refers to whether the position is a full-time or part-time position. It does NOT refer to how much time the position spends working on PEPFAR. Do not include any staff who works on PEPFAR on a temporary or seasonal basis, such as during the COP season.

a. **Full-time:** Considered to be ≥ 32 hours/week for FTE calculations.
b. **Part-time:** Considered to be <32 hours/week for FTE calculations.

Note: The FTE box will auto-calculate the full time equivalent (FTE) of the staff's overall time based on:

- Full-time (= 1) vs. Part-time (= .5),
- % Time Devote to PEPFAR by Each Individual 40% = 0.4; 100% = 1).

**Gender:** This year there will be a new question regarding staff working on gender. If a staff member works on gender, indicate 'Yes' and include a numeric value of 1-100 indicating the percent of time the staff member spends on gender. The amount of time spent on gender will *not* impact the allocations made to the Program Areas or total percent of time spent on PEPFAR.

For example, a possible scenario is that an OVC Senior Technical Advisor spends 30% staff time on gender issues. In the Staff Information tab, time spent on gender will be indicated with 'Yes' and a value of 30. In the Program Area tab, the budget code distribution will follow the division of time associated with the established budget codes (e.g., 80% OVC and 20% HVMS) with no reference to gender.

**Comments:** Country teams are required to provide additional details for specific vacant or planned records (Justify Vacant and Proposed New Positions). For existing positions, country teams may opt to add comments on an individual position that will aid in institutional memory for the team.

## 8.7 Peace Corps Volunteers

For each OU and in aggregate, Peace Corps Washington will submit to OGAC the number of PEPFAR-funded:

- Volunteers on board as of October 1, 2014;
- Volunteer Extensions on board as of October 1, 2014;
- Peace Corps Response Volunteers on board as of October 1, 2014;
- New Volunteers proposed in the FY 2014 COP;
- Volunteer Extensions proposed in the FY 2014 COP; and
- New Peace Corps Response Volunteers proposed in the FY 2014 COP.

- Peace Corps Washington will obtain this information from Peace Corps country programs.

## 9. Spotlight on New PEPFAR Guidance Documents

As PEPFAR pivots away from an emergency response, it is critical that we ensure the sustainability and quality of our programs. The end of the AIDS epidemic is within reach if we attain and maintain high quality national HIV programs that reach, test, treat, and retain patients in care. Now more than ever, in this fiscally constrained environment, we must be efficient and effective in order to justify the use of PEPFAR resources to US taxpayers, Congress, and other stakeholders. It is expected that country teams plan FY 2014 COP while considering new guidance to the greatest extent possible. These new strategies and guidance affirm PEPFAR's commitment that through smart investments based on sound science and a shared global responsibility; we can save millions of lives and achieve an AIDS Free Generation.

### 9.1 PEPFAR Guidance for Sustainability Planning

In pursuit of the overarching goal of an AIDS-free Generation, PEPFAR is striving to achieve high-impact national HIV responses that are country-owned—that is, led, managed, planned and monitored by government, civil society, the private sector, and other stakeholders in the partner country. The PEPFAR Guidance for Sustainability Planning will lay out an integrated framework for country and regional teams to systemically plan, implement and monitor actions to accelerate U.S. and host country efforts to achieve a durable and effective national HIV/AIDS response. This guidance contains background information about country ownership and sustainability; describes the association between U.S. government investments and country ownership; suggests the approach that PEPFAR teams should take to develop a sustainability plan; the content of the plan itself; and lastly, how implementation of the plan should be monitored.

Advancing sustainability demands continued change in the practices pursued by PEPFAR as the program transitions from the emergency phase of the program. This guidance will reflect how PEPFAR is changing the way we currently do business through both Sustainability Plans and Strategies as well as Country Health Partnerships. The Sustainability Guidance goes into effect for FY 2014 planning and reporting, and serves as follow up to PF and PFIP planning.

Please refer to PEPFAR's *Sustainability Guidance* (located on: PEPFARii.net for more guidance on required and suggested indicators and reporting).

## 9.2 PEPFAR Monitoring, Evaluation, and Reporting Strategy, Operational Guidance and Indicator Reference Guide (MER)

The Monitoring, Evaluation, and Reporting (MER) Strategy, Operational Guidance, and Indicator Reference Guide lay out an integrated monitoring and evaluation (M&E) framework for PEPFAR that is applicable across the HIV response, using the continuum of response as an overarching frame. Utilizing programmatic guidance to define direction and priorities to be monitored and evaluated, the MER provides a comprehensive synthesis of service delivery, capacity strengthening, and health systems strengthening measures, including indicators and other measurement methods across the technical areas. Country ownership and sustainability measures are also included. The MER recognizes that certain settings and populations merit special considerations for monitoring and evaluation. Further, the MER continues to drive towards increased focus on monitoring and evaluation of linkages, quality of the HIV response and the outcomes associated with efforts across a range of program areas.

The MER goes into effect for FY 2014 planning and reporting, and replaces the Next Generation Indicator Reference Guide. All PEPFAR Operating Units should consider the MER recommendations in planning for the monitoring and evaluation of supported activities. Additionally, all OUs should take note of the requirements associated with the identified subset of indicators that are specified for PEPFAR reporting. Targets should be submitted against these indicators and in alignment with the reporting guidance defined in the MER.

Please refer to PEPFAR's *Monitoring, Evaluation, and Reporting (MER) Operational Guidance and Indicator Reference Guide* (located on PEPFARii.net in the coming month) for more guidance on required indicators and reporting, including detailed information on what constitutes PEPFAR direct support.

## 9.3 PEPFAR Data Quality Standards of Practice

The third phase of PEPFAR seeks to promote greater country ownership with emphasis in reporting requirement to monitor cost and efficiencies of treatment. The PEPFAR's transition from an emergency U.S.-led effort to one increasingly sustained by individual countries highlights the need of focusing in enhancing the data quality of national systems. PEPFAR is committed to the collection and reporting of accurate data to inform decision making and program performance. Therefore, the focus of USG Missions is to collaborate and support host countries to measure and enhance the quality of the data collected through national systems at all levels (sites, districts, provinces, and national) of data collection and reporting.

High-quality data are the cornerstone for evidenced-based decision making. Attention to data quality (DQ) ensures that limited resources are used as effectively as possible, progress toward established goals is accurately monitored and measured, and decisions are based on the best available evidence. From the beginning, PEPFAR has promoted data quality improvement activities across all U.S. government programs. In support of this abiding commitment to DQ and in response to PEPFAR's emphasis on strengthening partner government systems, a new *PEPFAR Data Quality Standards of Practice* guidance is forthcoming (estimated release date October 2013).

The new guidance emphasizes a unified, coordinated U.S. government approach to data quality and more importantly focuses on strengthening the capacity of national governments and local institutions to plan and carry out DQ activities. The new guidance provides a template for planning DQAs, includes an inventory of DQA resources, and provides concrete ways to work with national governments to strengthen their data quality. U.S. government SI teams should reach out to host country partners and other key stakeholders with this new guidance to renew their commitment to improving the quality of programmatic data at all levels of the system.

In terms of data quality, the emphasis of USG Mission should be to provide support to host countries in the development of a national data quality strategy and this can be done by:

- Engaging stakeholders
- Assisting in the development of the strategy
- Developing DQA materials (e.g., protocols, SOP, and tools, training)
- Planning the DQA
- Implementing the DQA

## 9.4 PEPFAR Evaluation Standards Guidance

PEPFAR is implementing several processes for improved data collection in FY 2014, one of which requires a limited set of information from OUs regarding the implementation of evaluations. This new requirement will assist OUs and HQ in the management of and support to OU evaluation agendas, and simultaneously meets the recommendations from GAO and the IOM for more information about PEPFAR-supported evaluation studies. The specific data requirements for this exercise are in final stages of approval, and these data elements will be identified with the publication of the PEPFAR Evaluation Standards of Practice before the end of 2013. The data submission will be a supplemental document in the FY 2014 COP and will be available on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles.

## 9.5 Updated PEPFAR Gender Strategy

All PEPFAR OUs should read and refer to the updated PEPFAR Gender Strategy. This document consolidates the U.S. government strategies and agency specific guidance and policies as they relate to gender within foreign assistance programs. Collectively, these documents elucidate the United States' commitment to promoting gender equality as an integral component of foreign assistance and development efforts. The PEPFAR Gender Strategy outlines the types of activities that PEPFAR programs should be engaging in to integrate gender issues into HIV prevention, care and treatment, as well as the outputs, outcomes, and impacts that may result from these activities. Because the process for carrying out gender-related activities is critical, the guidance also specifies principles for engaging in gender activities. In addition, the strategy identifies populations to be considered for gender activities.

## 9.6 PEPFAR Quality Strategy (PQS)

The soon to be released PEPFAR Quality Strategy (PQS) builds upon existing quality infrastructure in partner countries. As the first global strategy of its kind, the PQS provides a framework for implementing improvement practices as programs shift towards country ownership and local partners. The PQS not only recognizes the importance of Quality Assurance, including standards, protocols, and guidelines, but also embraces the principles of Quality Improvement, a process that promotes programmatic shifts and the institutionalization of improvement practices. QA/QI has undoubtedly been happening at different levels of the health system since PEPFAR's inception. The PQS provides recommendations on how countries can continuously define their programmatic challenges and gaps, implement changes or interventions, measure progress, recognize and reward success, and ultimately improve the quality of their HIV health systems. The first phase of the PQS focuses on Clinical Services areas; future phases will encompass all PEPFAR-supported program areas.

The PQS goes into effect for FY 2014 planning and reporting. COP 14 submissions should include the current or planned PEPFAR country approach for HIV clinical services to: implement quality assurance activities, implement quality assurance activities, assess the costs and efficiencies gained through improvement practices, foster sustainability of improvement method, scale and increase coverage of improvement activities, institutionalize improvement practices in the host country, strengthen national capacity in collecting and using high quality improvement related data, and develop a learning agenda. Please refer to the PQS (located on www.PEPFARii.net).

## 9.7 PEPFAR Linkage, Engagement and Retention Strategy (PLERS)

The PEPFAR Linkage, Engagement & Retention Strategy (PLERS) applies the principles of the PQS and provides a framework for support of country efforts to improve linkage, engagement and retention along the continuum of care. The PLERS enables countries to identify barriers to and plans for improvement of linkage, engagement and retention based on country specific contexts. These barriers to and plans for improved LER may implicate, for example, an enabling environment, client or patient interest in care, improved health systems, and structural issues.

The PLERS goes into effect for FY 2014 planning and reporting. The PEPFAR Linkage, Engagement & Retention Strategy (PLERS) asks designated country teams to conduct a situational analysis to better understand their baseline data in order to most effectively and efficiently develop plans for improving linkage, engagement, and retention (LER). In the FY 2014 COP, all Botswana, Cambodia, Cameroon, Cote d'Ivoire, DRC, Ethiopia, Guyana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Vietnam, Zambia and Zimbabwe teams should describe their plans to conduct a situational analysis. If countries have conducted a situational analysis in the past year, they should contact the PLERS Task Force through their CSTL for further discussion. If countries not listed above are interested in conducting a situational analysis, they should also contact the PLERS Task Force through their CSTL. Country teams should carefully review the PEPFAR Quality Strategy and the PEPFAR Linkage, Engagement and Retention Strategy once released, to inform planning related to linkage and retention, including planning for the situational assessment. See the PLERS (located on www.PEPFARii.net) for more information.

## 9.8 PEPFAR Reassessing Care Priorities

Over the last ten years, PEPFAR has supported a range of interventions within Care and Support, aimed at reducing morbidity and mortality, improving quality of life, and preventing ongoing HIV transmission. These interventions address routine clinical staging and assessment, prevention of opportunistic infections, support for nutrition, safe water and hygiene, support for mental health services, pain and symptom management and end of life care, social services such as economic strengthening, and prevention services for people living with HIV (PLHIV).
Given increased access to ART, many PLHIV are living longer and healthier lives, and their needs may now be different. Given the changing context of care, PEPFAR is currently reassessing care priorities, reviewing the evidence for current interventions with regard to their impact on morbidity, mortality, retention in care, quality of life and prevention of further HIV transmission. PEPFAR recognizes that needs and priorities are likely to differ among countries and even within countries, and across different populations. Though some interventions may apply universally, others will depend on the country context. Further, programmatic considerations (e.g. existing programming,

infrastructure and resources in country, or complexity and cost of the intervention), may affect decisions about priority interventions. PEPFAR teams will also need to work closely with host country governments to ensure proposed PEPFAR priorities for care are harmonized with national priorities. The guidance will lay out considerations for PEPFAR programs to help guide these decisions. There will be a need for periodic reassessment of priorities, as the evidence base evolves, programs grow and mature, and needs change. Please refer to the PEPFAR Reassessing Care Priorities (located on www.PEPFARii.net) for more information.

# 10. Instructions for Supplemental Documents

## 10.1 Health Care Worker Salary Report

To submit this supplemental document upload the completed report to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013.

**Background:**

Country estimates of the number of health worker salaries that PEPFAR supports have become increasingly important. This information is critical to our ability to advance, with host country and international partners, strategies and approaches to address what may be the single largest barrier to improving HIV/AIDS care and health care in general in the countries in which we work: an adequate workforce.

Where relevant, PEPFAR teams will submit a report that estimates the number of health care workers whose salaries the program currently supports, in full or in part. This request includes all individuals that PEPFAR is supporting to implement and manage programs and deliver services through the private, non-government and government sectors. Please note that the request excludes U.S. government staff including direct hires, host country nationals, and contract staff working at US agency country offices or headquarters. The request includes, however, all U.S. government agency or contractor staff who may be sitting in government facilities and whose primary role is the provision of technical assistance and support for implementation. Examples are provided in the section on Definitions. PEPFAR team members are reminded to refer to agency-specific guidance on acceptable and non-acceptable forms of PEPFAR salary support to non-U.S. government host country staff.

We request that you estimate the number of health care workers receiving full or partial U.S. government support in three categories and upload this information as a

supporting document. Partial support is defined as anything from 1-99% and full support is defined as 100%. These estimates should be unduplicated numbers of workers to be supported through all COP activities. Please include only support from bilateral budgets. Information for Track One grantees and grantees with central funding will be provided through a separate data call at headquarters. **Please enter these estimates (according to the following definitions) into the template table** posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles **and upload it as a required supplemental document into FACTS Info.**

We also request that you indicate the maximum duration (e.g., months, years) that health care workers supported by PEPFAR on a "temporary" basis are eligible to receive PEPFAR support.

### Definitions:

Individuals may receive support ranging from partial support (anything less than 100%) to full support (100%). A health worker should only be counted once in any of the three categories. The three categories are outlined below followed by their definitions:

- Clinical (2 sub-categories)
    - Clinical care service providers (clinical)
    - Clinical service staff (non-clinical, non-managerial)
- Management (2 sub-categories)
    - Managerial and Support Staff (clinical service sites, public and private)
    - Managerial and Support Staff (non-clinical, government office sites)
- Community (1 category)
    - Community services staff

Clinical care service providers (clinical) - in facility-based clinical service delivery settings such as MTCT clinics; counseling and testing sites; treatment and care sites; and OVC family support units such as physician, clinical officer, nurse, midwife, nursing assistant, pharmacist, psychologist/social worker and other professionally trained providers that deliver direct patient care services.

Clinical service staff (non-clinical, non-managerial) - laboratory technicians, epidemiologist, data clerks, counselors and other professionally trained staff that provide non-clinical, non-managerial services within clinical settings.

Managerial and Support Staff (clinical service sites, public and private) at facility and community level. Managerial and administrative staff include senior management,

technical advisors, budget analysts, clerks, monitoring and evaluation staff, information technology, transportation, security, clerical and reception staff, etc.

Managerial and Support Staff (non-clinical, government office sites) at all levels of government. Included in this category are government workers who are receiving additional support in keeping with PEPFAR guidance, Peace Corps volunteers posted at district HIV/AIDS management offices, CDC employees or contractors placed in government facilities but whose primary task is technical assistance, and USAID institutional contractor technical advisor staff who are placed in governmental or non-governmental organizations.

Community services staff - community health care workers, outreach workers, adherence counselors, peer educator and counselors, DOTS workers, prevention counselors and staff for whom support will be provided to work in community-based service delivery settings such as home-based community care, prevention outreach, and community-based OVC programs. *Community managers and administrative staff are excluded from this count.*

If healthcare workers provide services in more than one category, for example nurses who provides both clinical services and community outreach, place their counts in the category where they spend the majority of their time.

Where it is not clear in which category to report a particular type of health worker, please use your best professional judgment as to which is the most appropriate category.

**Key Questions for all OUs:**

1) Please explain the 'transition' plan for moving all supported staff, partial and full, to non-USG funding mechanisms where this has been agreed upon with the government.

2) Please specify plans for each category listed above and the projected timelines for the transition.

## 10.2 HIV Medicines and Diagnostics

To submit this supplemental document upload the completed template to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013

As country programs scale-up to meet the World AIDS Day targets, the availability of funding for commodities is essential and often comes from multiple sources including PEPFAR, The Global Fund and other bilateral and multilateral entities. To date, we have

been collecting this information on an ad hoc, country-specific basis and through separate data call from CSTLs. However, given that the availability of funds for essential HIV commodities directly affects successful implementation of all other program areas, teams are asked to integrate this data request as part of the regular COP planning process.

**The HIV Medicines and Diagnostics supplemental template posted on the FY 2014 COP Planning section of the PEPFARii.net site under HQ > Planning and Reporting Cycles.** The purpose of the form is to understand the overall picture of the availability of funding for essential HIV medicines and diagnostics, including RTKs, lab reagents, ARVs, and Cepheid Xpert® MTB/RIF, a new diagnostic test that greatly reduces the time to confirm a TB diagnosis as well as resistance to rifampicin.

Collected data will be utilized in the COP review process to assess the degree to which PEPFAR is complemented by other resources in support of the overall national response. These data will also assist with planning and resource projections for the Emergency Commodity Fund. We intend that these data, collected in a uniform format, will obviate the need for ad hoc requests during the year.

## 10.3 Treatment Calculator

This supplemental document is required from all country teams that plan to support direct treatment targets in FY 2014 COP. Please submit this supplemental document two ways: 1) **By January 15, 2014** email the completed form to Lara Stabinski (StabinskiLL@state.gov), Rebecca Kahn (KahnRJ@state.gov) and your CSTL,; and 2) Upload the completed calculator to the FACTS Info FY 2014 COP document library before COP submission. Please ensure that in-country and agency financial points of contact are consulted and aid in the completion of the below calculator.

This tool was designed for COP 2012 to assist country teams in justifying FY treatment allocations, and to ensure that treatment budgets align with treatment targets. The tool continues to be a required element for teams in FY 2014 COP. To use the tool, complete sections 1 through 4. Sections 5 through 7 will then calculate the change in funding allocations to treatment over time. Country teams should also select the answer to questions 1 and 2 from the drop-down menu. Finally, please explain any factors that contribute to a change in allocation per patient (either increases or decreases) in section 8.

Only enter values in the yellow input cells. Gray-shaded cells automatically calculate based on previously entered values and are locked - no data entry is required for these boxes.

## 10.4 Clinical Cascade Worksheet for Target Setting and Budgeting

This supplemental document is required from all country teams that plan to support Treatment, PMTCT or HIV Counseling and Testing Programs in FY 2014 COP. To submit this supplemental document upload the completed form to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013.

This Excel Spreadsheet format tool was designed to assist country teams in aligning targets and budgets across the clinical cascade. To use the tool, complete columns B through T for all relevant populations. Columns U and V are error check cells for Care and Treatment Targets that will auto-populate, based on inputs.

## 10.5 Family Planning/HIV Integration Narrative

The Family Planning/HIV Integration narrative is required for all countries where applicable. To submit this supplemental document upload the completed overview template to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013.

Submit a 1 page, MS Word document narrative to be added to the FACTS Info document Library and titled 'COUNTRY X FP HIV Integration Narrative'. Please submit this supplemental document and upload the completed form to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013.

In order to better understand each country's strategy for FP/HIV integration, all countries are required to submit a supplemental narrative with the COP. Please address the following questions:

1) Does the government have a national strategy for FP/HIV, or broader RMNCH/HIV integration? If so, please describe this strategy. How is PEPFAR contributing to or supporting this strategy?
2) What are the PEPFAR FP/HIV integration priorities for FY 2014 for the key FP/HIV technical areas identified in the Technical Considerations (e.g., PMTCT, key populations, PHDP, Adult Care and Support, etc.)?
3) How are you coordinating FP/HIV integration at the service delivery level with national governments, bi-lateral donors (including USAID FP team), multilateral donors, the private sector, civil society, and other key stakeholders?
4) How will you support access to non-discriminatory safe pregnancy counseling, including healthy spacing and timing of pregnancy, for PLHIV who wish to have

children?

5) With whom will you partner to ensure access to contraceptive commodities for the populations PEPFAR serves?

## 10.6 Civil Society Engagement Overview

To submit this supplemental document upload the completed overview template to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013.

Submit this information as a supplemental document of no more than 2 pages.

**A-** Please describe the process used to fulfill the requirement to consult civil society, incorporate feedback, and brief civil society on the final FY 2014 COP submitted to headquarters. Name the organizations or networks that were consulted.

**B-** Answer Yes or No to the questions posed below.

- Were goals, objectives and targets by program area discussed?
- Were changes highlighted from prior year programs and their expected impact?
- Was impact modeling utilized?
- Were changes in PEPFAR targets and strategies over time included?
- Were discussions held on the role of local civil society in the response and changes in the role over time?
- Were local civil society advocacy efforts discussed such as:
    - Increasing government transparency and accountability
    - Increasing quality and uptake of services
    - Decreasing stigma and discrimination
    - Promoting greater shared responsibility

Please provide information on written comments solicited in the section below.

**C-** How were comments provided by local civil society incorporated into the FY 2014 COP?

**D-** Please provide the following information from the COP planning budget process.

- What percentage of new FY 2014 program funding (minus the M&O budget) will be received by Prime Partners who are local civil society organizations?
- If feasible, estimate the percentage of new FY 2014 program funding will be received by local civil society organizations as sub-recipients?

The Indicator teams will report on will be included in the MER strategy to be released shortly

## 10.7 Evaluation Plans

To submit this supplemental document upload the completed template to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013.

Evaluation planning is important to ensure that evaluation resources are allocated appropriately. Much of this work will take place in-country, jointly developed with national partners, PEPFAR, and other stakeholders. The yield of this effort will include, at a minimum, an overarching national agenda for evaluation, as well as an evaluation study inventory maintained and updated on an annual basis. Starting in the FY2014 COP/ROP cycle, Operating Units (OUs) will submit information relevant to the joint evaluation agenda and to the actual studies in-progress, planned, and completed. The primary utility of this information is multifold:

- To enable PEPFAR to track and report on evaluations being conducted
- To monitor the implementation of PEPFAR evaluation standards
- To reduce duplication of evaluation resources and efforts
- To share best practices
- To improve dissemination and use of evaluation findings and recommendations

This information will be reviewed during the FY 2014 COP/ROP reviews, not for the purpose of formal approvals, but rather to ensure that evaluation activities in OUs reflect the national priorities and are focused on key issues in national and global agendas. Providing this information to HQ also allows for improved monitoring of evaluation activities across all of PEPFAR, consistent with recommendations from GAO and the IOM. Future submissions will occur in conjunction with the APR.

To assist in this process, a worksheet template is being provided for submission as a supplemental document in the FY 2014 COP/ROP. This worksheet includes two sections: Evaluation Strategy, and Evaluation Planning and Reporting. Monitoring of the evaluation worksheet will be conducted at the OU level. Both the Evaluation Standards of Practice document and the worksheet will be forthcoming.

## 10.8 Laboratory Construction or Renovation Project Plan Supplemental

To submit this supplemental document upload the completed template to the FACTS Info FY 2014 COP document library as part of the COP submission on March 3, 2013.

Required for all BSL-3 and enhanced BSL-2 laboratory projects. Please provide the following as a supplement to your project proposal:

- Receiving institution information:
  - Name of receiving institution
  - Address of receiving institution
  - A point of contact at the institution
- Purpose of proposed lab:
  - Expected containment level (BSL-2 enhanced or BSL-3)
    - If enhanced BSL-2, what specific enhancements are planned?
  - Rationale for why that containment level is required
    - Presentation of an analysis of alternatives, if appropriate, or plans to conduct one
  - List of Select Agents (if any) and toxins (if any) that the lab anticipates handling
- Proposed timeline:
  - Including additional planning, funding, design and construction
  - For transition to host country oversight
- Sustainability:
  - What Ministry/organization/institution will be responsible for the long term sustainability of the lab?
  - Involvement of other domestic/international partners

## Version

| Version | Updated Items |
|---|---|
| Version 2: Released November 8, 2013 | • Updated Treatment Calculator due date to be January 15, 2014.<br>• Deleted mention of the Linkages supplemental document require- not required.<br>• The title of section 3.3 to Close Gaps in HIV/ TB Collaborative Activities rather than 'areas' as in Version 1 of the guidance.<br>• Updated Implement Mechanism Outlay Plan instructions to be by quarter rather than 'monthly' as indicated in Version 1 of the guidance. |

# Appendices