TECHNICAL REFERENCES

FOR USAID FY 2008 OPERATIONAL PLANS

February, 2008

REFERENCES

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These references are provided to transmit additional information specific to USAID programs. They are recommendations and are not intended to serve as formal guidance. Where sector specific goals are identified, these goals are assumptions which feed into the development of the references. Individual Missions will not be held accountable for meeting these goals. If you have questions, please contact the relevant Points-of-Contact for further assistance:

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AVIAN INFLUENZA

Avian Influenza (AI) funds will be allocated based on the progression of the virus, the role of other donors, the nature of the specific need in the region or country, and the activities taken on by other parts of the U.S. Government. With this in mind, the process for allocation of AI funds will be controlled centrally from Washington; all AI allocations and AI-related implementation plans must be reviewed and approved by the Deputy Director of the AI Unit in order for funds to be obligated. The plans will be reviewed in consultation with Regional Bureaus and affected countries. Plans must include a description of program activities, implementing mechanisms, AI activity codes, funding amounts, and funding sources. Missions should not include AI funds in their Operational Plans, unless the Mission has received prior approval from the AI Unit and the Office of the Director of Foreign Assistance (DFA) to reprogram funds for AI (see below). The AI Unit will collaborate with the Avian Influenza Action Group at the Department of State as it considers what activities should be funded and which countries will receive AI funding. In order to enhance the efficiency of AI funding, the AI Unit will predominantly consider regional activities supported through central mechanisms or various international organizations. When country-level funding is considered as the most effective and appropriate way to proceed, the AI Unit will work with the Regional Bureau and the Mission to determine the appropriate mechanism and how the activities will be managed.

All AI activities will support the operational field activities for which USAID has responsibility under the U.S. *National Strategy for Pandemic Influenza: Implementation Plan.* Expenditure of funds for any AI activity will be coded and tracked through the Avian Influenza Monitoring and Evaluation and Budget Analysis (AIMEBA) database. All operating units are also required to provide activity tracking codes for all approved activities. These codes are available in AIMEBA. Missions are encouraged to be creative and to consider existing platforms, including central mechanisms where possible, for AI efforts. In the event that the mission or bureau wishes to reprogram non-AI funds for work in AI, a request form that indicates the source of the funding, the nature of the work, and the amount must be completed and submitted to the AI Unit through regional bureau AI points of contact. The AI Unit will consider the request and make a final determination based on the technical merit of the activity, availability of funds within existing statutes and earmarks, and the activity's appropriateness given the level of threat in the country. Missions and regions will not be reimbursed for reprogrammed funds. This request form will be reviewed for technical appropriateness by the AI Unit and then approved; only after approval has been granted by the AI Unit and the Office of the Director of Foreign Assistance can the funds be obligated.

All obligations of AI funds must be entered into the AIMEBA database so obligations and expenditures can be tracked by country, mechanism and activity code. The AI Unit uses AIMEBA to track the progress of activities at the mission, bureau and central levels and maintain control over the way funds are being utilized. If the mission or bureau wishes to make a change in their plan, AIMEBA requires that they get AI Unit and DFA approval before the change can be made. All operating units are required to submit reports on the status of AI activities to meet Congressional reporting requirements. Per AI Unit guidance, Missions will also be required to respond to queries on obligations and expenditures of AI funds as well as monitoring and evaluation indicators.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

I. OVERVIEW

The USG objective for the Family Planning and Reproductive Health (FP/RH) Element is to expand access to high-quality, voluntary family planning services and information and reproductive health care on a sustainable basis. This element enhances the ability of couples to decide the number and spacing of births, including timing of first birth, and makes substantial contributions to reducing abortion; to reducing maternal and child mortality and morbidity; and to mitigating adverse effects of population dynamics on natural resources, economic growth, and state stability.

This supplemental information is provided to assist missions to program their FP/RH resources towards achieving this objective.

Over the 2008-2012 period, the following progress is expected:

- **Aggregate goal**: At the global level across 40 countries,[1] the modern contraceptive prevalence rate (MCPR) will increase one percentage point a year, a goal that has been achieved consistently over the past three years.
- **MCPR goal**: Within this set of countries, the 25 countries that have an MCPR of 10-50% and receive at least $4 million in FY08 population funds will achieve a one percentage point increase in MCPR annually for the five-year period 2008-2012.
- **Equity goal**: In addition, 10 countries where MCPR at the national level is between 30 and 50% will each achieve a one percentage point increase in MCPR annually in the lowest two wealth quintiles for the five year period 2008-2012. (Countries with MCPR below 30% should also be programming to reach the poor.)
- **Graduation goal**: In addition, the USG expects to phase-out FP/RH assistance to 5 countries over this same period.

The countries that fall into these various categories are listed in the tables titled "PRH Priority Countries" in this section and "Graduation Status" in Section IV.

Mission programs should be striving towards improvements in:

- Modern contraceptive prevalence rate overall and in the lowest two wealth quintiles.
- Proportion of demand for family planning satisfied with modern FP methods.
- Proportion of births spaced at least three years apart.
- Proportion of women aged 20-24 who had their first birth before age 18.

[1] The base set of 40 countries, which are all slated to receive at least $2M in POP funding in FY08, were selected based on the following criteria:

- Total fertility rate (or total abortion rate in the case of E&E countries)
- Modern contraceptive prevalence rate
- Number of high risk births
- Total births in excess of replacement fertility (TFR > 2.6)
- Number of married women of reproductive age with unmet need for spacing or limiting
- Population/resource balance

Excluded are countries that are expected to graduate from FP/RH assistance over the 2008-2012 period.

- Proportion of births that are parity five or higher.

Country programs should plan to continue to fund survey data collection programs, i.e., DHS or CDC/RHS, that collect these outcome measures to complement the output-focused indicators collected from implementing partners that will form part of the mission's OP submission. While missions are not expected to report these outcome indicators in their OP, USAID will continue to track and report them centrally.

The selection and prioritization of programming approaches and areas of focus will differ across countries. Specific needs often vary by geographic region. In most Sub-Saharan African and South Asian countries, unmet need remains high and actual family size continues to exceed desired family size. The USG programs are designed to increase awareness of, access to, and voluntary use of family planning. In PEPFAR focus countries and where HIV prevalence is high, it is particularly important to promote practical integration of FP/RH and HIV activities, especially through wrap-around funding. In Latin America and East Asia, a number of countries are approaching graduation from USG FP/RH assistance. In these countries, the principal challenges are to address sub-national disparities and inequities in access to RH/FP services as well as to solidify program sustainability. In Eastern European countries, the total fertility rate is often at or below replacement and abortion is widely used as a method of fertility control. The USG programs in this region are designed to increase awareness and use of contraception as a substitute for abortion.

Program maturity as measured by the modern contraceptive prevalence rate could also be used as a guide to the selection and prioritization of programming approaches. Section II ("Programming by Country Classification") below groups countries into three categories—low, medium, and high modern contraceptive prevalence—and suggests areas of programmatic emphasis in each category. These categories may be useful as a starting point for identifying appropriate program interventions, but they should not be viewed as either prescriptive or comprehensive.

See Section III below ("Questions to Consider to Guide FP/RH Program Design") for a list of questions to guide the overall design process and to inform the preparation of the country Operational Plan. Also see Section IV for countries approaching graduation from FP/RH assistance.

FP/RH Priority Countries

Country	Meet Aggregate Goal*	Meet MCPR Goal**	Meet Equity Goal***
Bangladesh	√	√	√
Bolivia	√	√	√
Guatemala	√	√	√
Jordan	√	√	√
Kenya	√	√	√
Nepal	√	√	√
Peru	√	√	√
Philippines	√	√	√
Russia	√	√	√
Ukraine	√	√	√
Cambodia	√	√	
Ethiopia	√	√	
Ghana	√	√	
Haiti	√	√	
India (UP)	√	√	
Madagascar	√	√	
Malawi	√	√	
Mozambique	√	√	
Pakistan	√	√	
Rwanda	√	√	
Senegal	√	√	
Tanzania	√	√	
Uganda	√	√	
Yemen	√	√	
Zambia	√	√	
Afghanistan	√		
Albania	√		
Angola	√		
Armenia	√		
Azerbaijan	√		
Benin	√		
DR Congo	√		
El Salvador	√		
Georgia	√		
Guinea	√		
Honduras	√		
Mali	√		
Nicaragua	√		
Nigeria	√		
Tajikistan	√		

* Countries with at least $2 million in FY08 funding.

** Countries with MCPR between 10-50 percent and at least $4 million in FY08 funding.

*** Countries with MCPR between 30-50 percent and at least $4 million in FY08 funding.

II. PROGRAMMING BY COUNTRY CLASSIFICATION

Low Prevalence (<10% MCPR) countries characterized by:

- High fertility rates
- Low contraceptive access and use
- Demand may be low or unsatisfied demand may be high
- Highest unmet need tends to be in higher wealth quintiles

Program focus:

- Train health personnel
- Provide information and counseling, including healthy birth spacing
- Expand contraceptive supplies and distribution
- Improve access and quality to reach underserved
- Create supportive policy environment

Medium Prevalence (10-50% MCPR)

- Declining fertility rates
- High unsatisfied demand and rapidly increasing prevalence
- Expanding, but limited method mix

Program focus:

- Expand method choice, including long-term methods
- Fund rapid expansion of services
- Expand supplies and services through private sector
- Address operational policy barriers
- Address gender norms and equity issues

High Prevalence (50+% MCPR)

- Low fertility
- High contraceptive prevalence

Program focus:

- Quality
- Availability of long term methods
- Expanding private sector participation
- Sustainability, contraceptive security, and financing
- Attention to underserved populations, including adolescents
- Address equity in access to services
- Graduation

The State/F Program Hierarchy defines the activities that may be included under the FP/RH element. In general and regardless of country classification, most mission programs are expected to undertake some programming under each of sub-elements that are unique to FP/RH. The Health Governance and Finance (HGF) sub-element that is common to most of the Health Elements deserves some comment in this regard, in part to distinguish it from the Policy and Systems Strengthening sub-element under FP/RH. The HGF sub-element covers activities that are designed to reduce key governance and financing constraints to achievement of *multiple*

health elements. The Policy and Systems Strengthening Element should be used for policy activities that are specific to FP/RH. For example: An activity that seeks to change a policy that allows only doctors to insert IUDs would get coded under *Policy and Systems.* An activity that works with the MOH to rationalize the allocation of health staff in general would go under *Health Governance & Finance*, probably under multiple elements.

III. QUESTIONS TO CONSIDER TO GUIDE FP/RH PROGRAM DESIGN

1. Where are we: At what stage is the FP/RH program? What is modern CPR at the national level and by quintile? What elements of a FP planning program are in place and what should be considered next? Where should we be headed?

2. Policy environment and government commitment: Is the policy environment conducive to FP programming? Is there active support? From the MOH, MOF? Other entities? Is there need for advocacy? What are the competing priorities? Who are the "champions" and how can they help create a supportive environment?

3. Family Planning Contribution: How does FP contribute to health and development in our setting? Is there emphasis on FP itself as an intervention? As part of an integrated MCH program? Is it integrated within PRSPs and MDGs? What data are available to present to decision makers that demonstrate FP's contribution?

4. Gender: As required by the ADS 201, 203, and 302 series, programs should consider: How will gender relations affect the achievement of sustainable results? How will proposed results affect the relative status of men and women? Are women and men involved or affected differently by the context or work to be undertaken? How would this difference be an important factor in managing for sustainable program impact?

5. DHS and other data: What do the data indicate about knowledge, use and demand? Is there unmet need for limiting/spacing? How do knowledge, use and need differ? Rural? Urban? Wealth quintiles? By region? For particular population sub-groups? For particular type of method or service? Is there a strategy in place to address the situation? Are there myths/rumors that affect use?

6. Infrastructure: What infrastructure is in place for health services? Where are people going for services? What is the role of the for-profit and NGO private sector and can it be expanded? Is there a clear understanding of why services are or are not being utilized – e.g., policies, barriers, human capacity, organization of services? Is there a need for policy/program assessments and/or reforms?

7. Mix of service delivery modalities: Is there a good mix of service provision by public, NGO, social marketing and pure private sector? Is CBD appropriate both for access to services and supporting FP social norm? Any mobile service delivery, especially for longer-term methods? Are communities involved in developing and overseeing services?

8. IE&C: Is there an effective system to inform potential clients of available services and the value of family planning? Is birth-spacing appropriately addressed? Is good counseling provided to promote contraceptive choice and continued use of selected methods?

9. Job aids: Are quality job aids available and used by providers? (e.g. family planning clinical guide; pregnancy checklists; OC, injectable and IUD check lists; FP methods flip chart; wall charts, systematic screening.)

10. Technical guidelines and standards: Are service delivery guidelines based on current global standards such as WHO Medical Eligibility Criteria and Selected Practice Recommendations? Are medical barriers minimized?

11. Contraceptive commodities: Are there adequate supplies of all methods at service delivery sites? Is donor funded supply insured? Is there adequate planning and execution of the supply chain. Is there a long-range plan for contraceptive security?

12. Facilities, equipment and supplies: Are these adequate?

13. Human capacity: Are adequate staff trained, deployed, compensated and motivated to provide FP services? Are tasks appropriately assigned (e.g., appropriate "task shifting") to lowest practical level? Is the provider perspective considered? Is approach to supervision supportive to service delivery? Is there strong leadership and management of the program?

14. Other donors/partners: Is there a common framework for FP programming? If so, how does/can USAID contribute? If not, how can USAID work with others in this direction? What is being programmed/planned? By government? By other donors? What are the gaps and emerging needs that will complement ongoing activities?

15. Financial sustainability: What can be done to assure long-term sustainability? Is the government budgeting adequately for services? Is there a budget line item for contraceptive commodities? Are there policies in place that stimulate private sector service delivery? Do health insurance programs include FP?

16. Cost for services and market segmentation: Are costs for services reasonable relative to willingness to pay? Is there appropriate "market segmentation" so that those better off use the private sector etc.

17. Method mix: Recognizing there is no ideal mix, is there a reasonable balance of methods? Is there adequate attention to longer-term methods such as IUD, implants and VSC?

18. Underserved: Are underserved groups (e.g., men, peri-urban, rural, poor, youth) addressed, recognizing the possible trade-off in cost?

19. Appropriate service integration: Recognizing the program limitations, is there operationally practical synergistic integration with other health service delivery (e.g., child survival, maternal health, pre-natal care, post-partum services, post abortion care, HIV)? Are there acute reproductive health needs and related issues to address? Fistula? Female genital cutting? Gender-based violence?

20. Voluntarism and informed choice: Are there adequate systems in place to assure voluntarism and that accurate and comprehensible information is provided to clients on the benefits and side effects of methods? Are a range of methods available either at the service site or through referral? Are all USG statutory and policy requirements being met?

IV. INFORMATION FOR COUNTRIES APPROACHING GRADUATION FROM FP/RH ASSISTANCE

With greater demands for limited FP resources, especially coming from Africa and other high priority countries, and straight-lined budgets for FP assistance, GH and LAC collaborated to form a FP/RH Graduation Working Group in 2004, which has expanded to include E&E and ANE.

The Working Group developed a *Technical Note* that describes a pro-active strategy to identify criteria for graduation from FP/RH assistance and actively plan and manage a transition process of two to ten years (depending on what state of transition a given country is in) to help countries achieve long-term sustainability in their FP programs. Note: This does not imply that all health programs will come to an end nor that USAID missions will be closed.

FP/RH Graduation Thresholds:

- Total fertility rate <= to 2.6.
- Modern contraceptive prevalence rate >= 60% or more of married women of reproductive age.
- Modern contraceptive prevalence rate >= 50% of married women of reproductive age in the lowest income quintile.

Other Factors to be Considered:

- Access to a range of products and services, including widespread availability of different methods of contraception and several different sources of services, should be assessed across all regions and population groups.
- Sustainability of the family planning program should be assessed through a review of dependency on USAID financing of products and services in the public and private sectors; existing government and/or NGO or commercial commitment and planned funding for these products and services; and other available sources of funds and technical support.
- Quality of care including informed choice should be assessed across the major service providers (public sector, NGOs, and private commercial sector).
- Special circumstances such as large population size (over 80 million), low per capita income, pervasive inequities in access or quality of care, or other important concerns should be identified and taken into consideration in planning the duration of phase-out of USAID assistance.

A phase-out strategy would normally cover a period of 2-6 years and in certain circumstances might cover a period up to 10 years.

The *Technical Note* proposes that USAID prepare a phase-out plan in each country where the indicators begin to approach the FP/RH graduation thresholds. The phase out plan should articulate a process to reinforce the national commitment to and existence of adequate financing, sustainable skills and leadership, and attention to underserved populations. The phase out plan should also describe ways of continuing relationships with former counterparts.

Phase out requires particularly careful planning and possibly longer timeframes in large countries given the impact of any faltering in program performance and in countries with poor economic indicators in order to address issues of equity in access to services in the absence of USAID support.

Graduation Status:

Country	**Final Funding Year**	**Status of FP/RH Graduation Plan**
Indonesia	2007	Completed before initiative
Jamaica	2007	Final, approved
Dominican Republic	2009	Final, not approved
Egypt	2010	Completed before initiative
Paraguay	2010	Final, approved
Peru	2011	Final, not approved
Nicaragua	2011	In draft
El Salvador	TBD	In draft
Bangladesh	TBD	Sustainability plan, not graduation plan due to economic and population size criteria
Honduras	TBD	In draft
Select E&E countries	TBD	Beginning discussions

GENDER

Gender issues can re reinforced in several sections of the *FY2008 Operational Plan Guidance*. These are:

Indicators
Most of the standard indicators in the FACTS database that refer to people are sex disaggregated. Staff preparing Operational Plans should ensure that the targets they include are sex disaggregated. Implementing partners should be informed and commit to collecting information on how programs affect women and men.

Key Issues
There are two key issues related to gender: reducing gender-based violence and exploitation and increasing gender equity. Missions and Operating Units should select them when appropriate. Posts must include a dollar amount for the key issues they select, representing the portion of the money that affects or reaches that issue. There is also a narrative associated with each key issue.

Target Populations
Annex XIX "Definitions for Implementing Mechanism Information" of the Operational Plan Guidance also contains a long list of possible target populations for our programs. Many of these are important from a gender perspective.

Element Narrative and Implementing Mechanism Narrative
These two narrative sections can be used to explain gender emphasis or approaches in your programs, as well as their targets and expected impact.

MALARIA
Technical References for Non PMI-Focus Countries

(Please note that this reference does not apply to the current PMI focus countries – Angola, Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Rwanda, Senegal, Tanzania, Uganda, and Zambia. Guidance for these country programs is provided in Annex XIII of the *FY2008 Operational Plan Guidance*).

BACKGROUND

In late June 2005, President Bush announced a new five-year, $1.2 billion initiative to rapidly scale up malaria prevention and treatment interventions in 15 high-burden countries in sub-Saharan Africa. The goal of this Initiative is to reduce malaria-related mortality by 50%. This will be achieved by reaching 85% coverage of the most vulnerable groups – children under five years of age, pregnant women, and people living with HIV/AIDS – with proven preventive and therapeutic interventions. The PMI is headed by a Coordinator appointed by the White House.

Beginning in FY06, USAID made significant changes to its malaria programs that fall outside of the 15 PMI focus country programs in order to combine all malaria activities into a single, strategic, global malaria program. Among these changes were (1) the requirement that all planned malaria programming be reviewed and approved by the PMI Coordinator; (2) that the proportion of malaria funding devoted to purchasing life-saving commodities be set at high levels; and (3) that indoor residual spraying (IRS) be strongly supported, where this intervention is appropriate. PMI non-focus programs are also required to provide regular and detailed reports to Congress on how all malaria funds are allocated, the results achieved, and the impact on populations vulnerable to malaria.

TECHNICAL RECOMMENDATIONS

40% Supporting Commodities: For FY08, all country programs that include malaria element funding (PMI non-focus countries) must allocate a minimum of 40% of their budget to lifesaving commodities. The definition of lifesaving commodities is below.

Indoor Residual Spraying (IRS) Activities (IRS): For FY08, all PMI non-focus country programs are encouraged to support IRS activities if spraying is a component of the host country's National Malaria Control Program. USAID/Washington will discuss with select Missions the inclusion of IRS in their malaria programs.

Use of Malaria Funding: Malaria funds used for administrative costs must be shown to directly support the in-country malaria program.

Regional Malaria Programs: Existing regional malaria programs are encouraged to include commodities and IRS in their programs, where appropriate, but are not required to meet the 40% commodity rule.

Approval of PMI non-focus malaria plans: Given the importance and high visibility of the USAID malaria program, the USAID Malaria Coordinator will review and clear all PMI non-focus country and regional program submissions into the FACTS database to ensure (1)

conformance to the above requirements; (2) implementation of the proven malaria prevention and treatment interventions as well as strategies to reduce the threat of anti-malarial drug resistance (as described in the Malaria Sub-Elements); and (3) adherence to the objectives and operating principles of the PMI.

Types of Lifesaving Commodities

Approved malaria commodities are as follows: insecticide treated nets (ITNs) including long-lasting insecticide treated nets (LLINs); Artemisinin-based combination therapy (ACT) drugs; sulfadoxine-pyrimethamine (SP) for intermittent preventive treatment (IPT); rapid diagnostic tests (RDTs); lab supplies and equipment including reagents, microscopes, slides, and hemacues; drugs for severe malaria including equipment for parenteral administration.

For indoor residual spraying (IRS): Allowable commodities include insecticides, temporary storage, safety gear, and spraying equipment.

Any other commodity as approved by the PMI Coordinator.

Non-Lifesaving Commodities

Other assets such as buildings, educational materials, furniture, vehicles or other modes of transportation, other essential drugs, and other health equipment are not considered lifesaving commodities.

Distribution Costs

Funding for commodities includes the costs of goods; freight; insurance to port; clearance costs (temporary storage, required quality assurance testing); and transport to district/regional warehouses. No other costs can be considered as funding for commodities.

MATERNAL AND CHILD HEALTH ELEMENT
STRATEGIC APPROACH

Overview

Maternal and child health continues to be a cornerstone of USAID's health sector programming. For over twenty years, USAID has been a global leader in the development of cost-effective interventions and program strategies that have been applied by field missions, partner countries, and other international organizations to reduce the burden of morbidity and mortality among mothers, infants, and children. The results of this collective action has been the saving of roughly six million children's lives each year, compared to mortality rates that existed before the global child survival program. While globally the maternal mortality ratio has not been reduced as successfully, ten countries with strong USAID maternal health programs have achieved declines of 21 to 52% percent within a decade.

Largely because of this documented at-scale success, MCH continues to have strong bipartisan support in Congress. The principles of USAID's successful approach to improving maternal and child survival are laid out in the guidelines for use of Child Survival and Health funds and detailed in this Technical Reference. These principles include:

- Designing programs to achieve direct impact in mothers' and children's survival and health at population (national or significant sub-national) scale;
- Testing new interventions and innovative approaches in receptive environments;
- Designing programs based on research evidence and program-based learning linked with agreed-upon national strategies;
- Placing emphasis on reaching the underserved and un-served rural and urban populations and extending preventive and curative services to the community;
- Achieving impact by increasing availability and use of appropriate high impact interventions, through delivery approaches that fit the program capabilities and needs of each country;
- Helping countries to strengthen key elements of their health systems in ways that contribute to measurable improvement in maternal and child health outcomes;
- Working in the context of collaboratively developed plans, applying USAID resources in ways that achieve greatest impact in relation to other resources in the sector;
- Monitoring progress toward specified targets.

In practice at country level, MCH programming is often carried out as part of integrated programs that may include family planning and reproductive health, malaria, other infectious diseases, and HIV/AIDS activities. Such integrated approaches often represent efficient and cost-effective use of USAID and host country resources. In such integrated programs, costs of cross-cutting activities such as broad-based health system strengthening, capacity building, and monitoring activities that encompass multiple elements should be appropriately shared among these elements.

Goals

Program experience demonstrates that MCH activities focused on reducing under-five and maternal mortality achieve the greatest impact in countries. Experience in countries like Nepal, Madagascar, Ethiopia, Cambodia, Indonesia and others demonstrates that it should be possible to reduce both under-five and maternal mortality substantially. Over the 2008-2012 period, the following progress is expected:

- Reduction of under five mortality by 25% in high-mortality burden countries,
- Reduction of maternal mortality by 25% in high-mortality burden countries
- Reduction of child malnutrition by 15% in a subset of these countries, by 2012.

To support countries in the achievement of this goal, USAID should focus on scaling up the high-impact maternal, newborn, and child interventions most relevant for each specific country. It is expected that the approach outlined in this document will be of value to any country receiving funding for the MCH Element.

Recommended Components of an MCH Element

1. A shared **assessment** with government and other key stakeholders (in most countries, this has already been done) that includes epidemiology; equity analysis; progress to date; policy environment; stakeholder roles and commitment; geographic and cultural realities; health communications capability; infrastructure; personnel mandate, capability and availability; service delivery capability and opportunities; health financing mechanisms; health information and quality improvement systems; drugs, commodities and equipment availability and systems.

2. Identification of MCH **gaps** relevant to moving to the next level of country category and of major unmet needs (including equity issues) in maternal and child survival and health and nutrition.

3 Shared **5 year targets** with country government and key stakeholders for maternal and under-five mortality reduction and improvement of children's nutritional status.

4. Identification of the set of **high impact interventions** most relevant for the country program, based on major causes of death and the proximate determinants and health systems capacity, including:

    - *interventions rapidly scalable through existing capacity, such as antenatal care, active management of the third stage of labor, treatment of postpartum hemorrhage, essential newborn care, vitamin A, immunization, oral rehydration therapy and zinc treatment for diarrhea, antibiotic treatment of pneumonia in infants and children, "point-of-use" water disinfection;*
    - *interventions requiring enhanced delivery capacity, such as safe and clean delivery, skilled attendants at birth, essential and emergency obstetric care, antibiotic treatment of severe newborn infection, exclusive breastfeeding and adequate infant and young child feeding, management of severe childhood illness.*

5. Identification of **program approaches** to achieve greatest possible coverage of these high-impact interventions, based upon culture, geography and health systems capacity to scale up.

This may include facility services, outreach services, community services and education, social marketing, or other approaches as relevant to achieving population-based impact

6 Identification of relevant **health systems strengthening** support, including governance and finance sub-element results, with defined links to achieving and sustaining impact and coverage targets.

This may include management, health information systems, healthcare financing, rational pharmaceutical management, quality improvement, and human resources development

7. Identification of the **population** to be targeted.

In a sub-national geographic population, identification of the extent to which the population represents the country's poor and underserved women and young children, as well as how the USAID sub-national program will contribute to broader national level capacity and programs to deliver high impact interventions to the most vulnerable.

8. Definition of the **role of USAID's investments** in relation to the investments and implementing capacity of the host government, other major partners (including multilateral and bilateral donors, the Global Fund for AIDS, TB, and Malaria, GAVI, major foundations, the commercial private sector and NGOs), and other USG investments including Title II, the Presidential Malaria Initiative, the Presidential Emergency Plan for AIDS Relief, and OFDA programs.

Based on these analyses, USAID's MCH country plans should identify the major interventions and health systems support to be funded, the program approaches through which they will be implemented, and their planned contributions to the MCH five-year objective.

In program planning, consideration should be given to sequencing the implementation of the identified interventions and approaches (over time or geographical areas), in order to:

1. *rapidly expand coverage to ≥ 80% for the most feasibly scalable high impact interventions through existing capacity;*
2. *enhance country capacity to increase coverage or sustainability of those interventions, and/or achieve increased coverage of additional high impact interventions.*

Indicators and Monitoring

In accordance with F guidance, the MCH Element monitoring plan will include identification of outputs attributable to USG to be measured on an annual basis.

In addition, missions are encouraged to identify outcomes by sub-element, including coverage of key interventions, with baselines and overall five-year targets for these outcome indicators and for relevant health systems outcomes in their PMPs..

Missions should also establish plans for monitoring annual indicators and progress toward five-year targets. Recommended components of these plans include:

a. establishing baselines of relevant output, outcome, and impact indicators;
b. plans for DHS or other population-based surveys, facility-based monitoring, and program monitoring

Participation in periodic progress reviews by government, USAID and key partners is strongly encouraged.

Support from USAID/Washington

The Bureau for Global Health and the respective regional bureaus will collaborate to support missions in developing/revising the MCH Element in their operational plans. Available assistance includes:

- latest technical information and estimates of impact to assist in choice of interventions and delivery approaches;
- statistical and analytic support and, in some cases, cost-sharing of interim surveys (between DHS rounds) to develop baselines and estimate one-year and five-year targets;
- technical assistance in development of operational plans; technical review of those plans by country health teams; and
- facilitation of coordination with HQ and regional level offices of key partners (UNICEF, WHO, World Bank, etc.) and global alliances (*e.g.*, GAVI, GAIN, Health Metrics Network, Partnership for Maternal, Newborn and Child Health, White Ribbon Alliance) to promote effective cooperation of their in-country activities with USAID's country strategy development and programming.

High-impact, rapidly scaleable interventions for MCH include the following**:**
(Note: It is not recommended that missions include all these interventions in their programs, but use this listing of evidence-based interventions to identify those most relevant for USAID investment, based on the country's needs and USAID's comparative advantages.)

Antenatal care – interventions, depending on epidemiology and health system capacity, focus on provision of iron folate supplements, de-worming, intermittent presumptive treatment of malaria, insecticide treated nets, HIV and syphilis control, and counseling to use a skilled birth attendant and seek timely emergency care in the event of a complication. (Tetanus toxoid immunization is included under immunization sub-element 1.6.4)

Active management of the third stage of labor – requires provision of an uterotonic drug immediately after birth of the baby, delivery of the placenta by controlled cord traction, and external uterine massage by a skilled birth attendant for prevention of postpartum hemorrhage. In the absence of a skilled birth attendant, a uterotonic alone may be administered.

Treatment of postpartum hemorrhage – includes assessment of the cause and, if uterine atony; provision of a uterotonic, removal of the placenta or fragments as necessary, emptying the bladder, and external or bimanual uterine compression; and recognition of severe hemorrhage that requires referral.

Essential newborn care – focus is on immediate warming and drying, clean cord care, and initiation of breast feeding.

Vitamin A – focus is on supplementation, the provision of Vitamin A capsules to children 6-59 months twice annually.

Immunization – focus is on full immunization for children, defined as three doses of DTP and immunization against measles and polio prior to age 1, and immunization with tetanus toxoid for pregnant women to prevent neonatal tetanus; introduction of new vaccines in countries with high coverage of routine immunization.

Prevention of diarrhea – focus is on point-of-use (typically household or school) water treatment to ensure the safety of drinking water, coupled with associated improvements in key hygiene behaviors, such as correct water handling and storage; effective handwashing; and safe feces disposal.

Treatment of diarrhea – focus is on home-based treatment with oral rehydration therapy (use of ORS, recommended home fluids, and/or increased fluids with continued feeding) to prevent severe dehydration, and treatment with zinc to reduce the severity and duration of diarrhea.

Treatment of pneumonia – focus is on community-based treatment of pneumonia with antibiotics, and effective recognition of severe illness with appropriate referral.

Skilled attendants at birth – a doctor, obstetrician, nurse or midwife with midwifery skills in basic essential obstetric care (normal birth and initial treatment of complications) that includes use of partogram, infection prevention, active management of the third stage of labor, essential newborn care, recognition, and initial treatment of newborn asphyxia, hemorrhage, infection, hypertensive disorder, prolonged labor and post abortion complications, and timely referral, as necessary.

Emergency obstetric care – includes treatment of life-threatening complications such as medical management of hypertensive disorder, blood transfusion, cesarean section, hysterectomy, and resuscitation.

Treatment of severe newborn infection – includes assessment of symptoms and treatment with antibiotics, additional respiratory, nutritional and fluid support, as feasible and needed.

Treatment of severe childhood illness – includes assessment of symptoms, and treatment with antibiotics, anti-malarials, and provision of respiratory, fluid, and nutritional support, as needed.

Infant and young child feeding – includes breast feeding from immediately after birth, including colostrum, exclusive feeding on demand for the first 6 months of life and, for 6-23 month olds, in addition to continued breast feeding, addition of soft/semi-solid foods made from a variety of food groups in age-appropriate feeding frequency; focus is on multi-channel breastfeeding promotion and support, community-based growth promotion, and implementation of "essential nutrition actions" through existing community and facility services; also therapeutic nutrition, especially Community-Based Therapeutic Care (CTC) with Ready-to-Use Therapeutic Foods (RUTF), where implemented as part of MCH programs.

MCH BASELINES AND TARGETS

Impact Indicators	Baseline (2007)	Target (2012)
• Under five mortality rate • Maternal mortality rate • Skilled attendant at birth in lowest two quintiles • Per cent of children underweight	_____ _____ _____ _____	_____ _____ _____ _____
Sub-Element / Intervention Indicators (as relevant to country program)		
1. Birth Preparedness & Maternity Services *Outcomes* • % women with ≥ 4 ANC visits • % women with skilled attendant at birth *Outputs* • # ANC visits • # deliveries with skilled attendant • # deliveries with active management of 3rd stage of labor • # Post-partum visits • # personnel trained in maternal/newborn care	 _____ _____ _____ _____ _____ _____ _____	 _____ _____ _____ _____ _____ _____ _____
2. Treatment of Obstetric Complications & Disabilities Outputs • # fistula repairs • # persons trained in fistula care counseling and community mobilization	 _____ _____	 _____ _____
3. Newborn Care & Treatment *Outputs* • Newborns receiving essential newborn care • Newborns treated with antibiotics for infection	 _____ _____	 _____ _____
4. Immunization *Outcome*		

• DTP3 coverage *Output* • Number of children given DTP3	_____ _____	_____ _____
5. Maternal & Young Child Nutrition *Outcomes* • % under-five children underweight • Infants exclusively breastfed ≥ 6 mos • Children receiving vitamin A supplement in last 6 mos *Outputs* • # of children receiving vitamin A supplementation • Children reached by nutrition programs	 _____ _____ _____ _____ _____	 _____ _____ _____ _____ _____
6. Treatment of Child Illness *Outcomes* • Children with diarrhea treated with: a. Oral Rehydration Therapy b. Zinc • Children with pneumonia taken to appropriate care *Outputs* • Number of diarrhea cases treated with a) ORT; b) zinc • Number of pneumonia cases treated	 _____ _____ _____ _____, _____ _____	 _____ _____ _____ _____, _____ _____

PROGRAMMING IN POLIO ERADICATION (FY 08)

USAID anticipates continuing funding for polio eradication in FY 2008 at the historical level of $32 million. Since the global polio eradication initiative began in 1996, there has been a 99% decline in the number of polio cases worldwide and the development of a sensitive, sophisticated surveillance system capable of genetic sequencing of polio virus samples. The data generated by the surveillance system guides all decisions within the polio program and will ultimately be used to determine if countries, regions, and the world are eligible for polio-free certification.

Polio remains endemic (has never stopped transmission) in: India, Nigeria, Pakistan and Afghanistan. Polio has been reintroduced and is currently circulating in: Angola, DR Congo, Chad, Niger, and Somalia (2007).Polio was recently circulating in: Nepal, Cameroon, Bangladesh, Kenya, Ethiopia, Namibia, Indonesia, Yemen (all 2006); Sudan, Mali, Eritrea (all 2005); Guinea, CAR, Cote d'Ivoire, Burkina Faso, Benin, Egypt, Botswana (all 2004); Ghana and Togo (both 2003); and Zambia (2002).
Isolated Importations have been detected in countries such as Saudi Arabia, Oman and Australia without secondary spread. Every country is at risk of importations.

All countries need to continue polio surveillance for a minimum of three years after the last case of polio is detected anywhere in the world. In many USAID-assisted countries in Africa and ANE, USAID is the sole or primary donor for surveillance. GH can not stress enough the importance of sustaining funding for polio surveillance until the world is certified polio-free. Surveillance activities include: training and deployment of surveillance officers and disease 'informants', costs of weekly active case search and passive zero-case reporting, case investigation and contact tracing; stool sample collection and transportation to an accredited laboratory; publication of weekly surveillance bulletins; laboratory accreditation, lab equipment including cell lines, reagents and materials; training of lab technicians and procurement of proficiency panels and provision of technical assistance. Communication to promote rapid care-seeking behavior and reduce the time between onset of paralysis and sample collection/case investigation may also supported. In most USAID-assisted countries, the polio surveillance system forms the backbone of all integrated disease reporting for diseases of public health importance and essential for implementing the International Health Regulations.

USAID also provided funding for supplemental immunization campaigns, communication and NGO support in a more limited set of countries depending on the epidemiology of the virus. It may take 7-10 or more doses of Oral Polio Vaccine in nearly 100% of under age 5 children to build population immunity high enough to stop transmission. Endemic, recently endemic, and re-infected countries must continue to conduct high quality supplemental immunization campaigns in order to build population immunity sufficient to stop transmission or to prevent importations. Generally these campaigns are house-to-house with some fixed-posts, and may be coupled with other health interventions e.g. vitamin A or bednets. Countries neighboring known and recently infected countries also conduct supplemental campaigns, but these may be less frequent or geographically restricted. High quality immunization campaigns require attention to both the service delivery aspects (getting the vaccine to children) and demand creation aspects of the campaign (willingness to accept or seek out vaccination.)

Activities may include: Getting vaccines to all children under 5, especially newborns and children in transit/migrants/refugees/IDPs, every round, requires detailed district-level or, increasingly, street-by-street planning, mapping, vaccinator/supervisor training, cold chain for vaccine distribution, and operational costs during the campaigns (e.g. per diems, transportation, supplies such as tally sheets, chalk, markers, etc). Sustaining and increasing acceptance of vaccination requires effective communications (mass media, print, interpersonal communication) using rapid analysis of social, cultural, epidemiologic and operational data to fine tune messages and determine the best channels/people to deliver the message. Misinformation about vaccines and religious or cultural practices often result in vaccine refusals/reluctance which can be large enough to sustain a pool of susceptible, under-vaccinated children – and polio continues to circulate. Coordination between implementing partners, host governments, religious and community leaders increases the effectiveness of the program. Every campaign should use independent observers to extensively monitor and evaluate gaps and track/revisit missed or absent children. Results of each round should be conveyed to stakeholders for refinement and action in subsequent rounds. A vibrant inter Agency Coordination Committee provides national and state/provincial level forums for policy setting and planning. Country-specific Technical Advisory Group meetings provide a chance for external review of all aspects of the program. Support for routine immunization alone, even if it includes OPV, can not be supported per the congressional directive. Only activities with the primary goal of polio eradication can be supported with polio earmarked funds.

Polio eradication is a global USG priority and long-standing commitment under the G8 and other international forums. To honor this commitment, GH will work with the Office of the Director of Foreign Assistance to recommend specific levels for polio in priority countries. These levels will assure ongoing support for vital polio surveillance activities and take into account what we know about planned supplemental campaigns based on the epidemiology of the virus, NGO support (India, Angola, Ethiopia, Nepal), communication needs and the availability of other donor funds. GH and regional funds have a small portion available for outbreak response in the event of importations. These levels will be transmitted to the field in a separate communication.

For those programs receiving polio funds, please use the non-polio AFP rate as the sub-element indicator. The minimum level should be 2/100,000 in children under age 15.

USAID/W has several mechanisms with WHO, UNICEF and NGOs to support polio eradication activities. Please contact Ellyn Ogden, USAID's Worldwide Polio Eradication Coordinator (202) 257-7308, Mary Harvey (Africa) and Gary Cook (ANE) for additional information and guidance on how best to program these

TUBERCULOSIS
Recommendations for Priority Countries

As part of the refocusing of USG resources to achieve greatest impact, USAID's objective is to detect of at least 70% of estimated TB cases and to successfully treat at least 85% of those detected cases in 19 USG focus countries by 2011. By 2015, the USG goal is to reduce, by 50%, the number of deaths due to TB in the 19 USAID focus countries. This initiative will expand and scale up priority interventions in accord with the WHO STOP TB Strategy.

Achievement of these targets will contribute to the achievement of the epidemiological targets as set forth in the STOP TB Partnership's "Global Plan to STOP TB 2006 – 2015" which are: to sustain or exceed the 70/85 targets; by 2015, to reduce the burden of TB disease (prevalence and deaths) by 50% relative to 1990 levels; and to eliminate TB as a global public health problem by 2050.

Countries included in this initiative are those receiving ≥ $1.5 million funds/year for TB in FY 2007 or planned in FY 2008. These countries have the following characteristics:

- Magnitude of the epidemic – countries which are among the list of high-burden countries
- Severity of the epidemic – high incidence of TB (estimated incidence rates of >100/100,000)
- HIV/AIDS burden
- Risk of an escalating epidemic of multi-drug resistant TB or extensively drug resistant TB
- USAID in-country presence with expectation of a sustained USAID country program (at least 3-5 years)
- The potential to leverage USAID resources with grants funded by the Global Fund to Fight AIDS, TB and Malaria (GF)

Priority countries based on above criteria:

Africa	ANE	E&E	LA/C
DR Congo	Afghanistan	Russia	Brazil
Ethiopia	Bangladesh	Ukraine	
Kenya	Cambodia		
Mozambique	India		
Nigeria	Indonesia		
South Africa	Pakistan		
Tanzania	Philippines		
Uganda			
Zambia			

How the TB Initiative will work within the F Planning and Reporting Processes

- Using information in the following pages entitled "General References for TB Focus Countries" and "Technical References", countries will develop their operational plans (OPs) for the TB element
- Each country will follow overall F guidelines to develop a monitoring plan for the TB Element, establishing best possible baselines and identifying one-year targets (to guide year 1 target setting, a template containing F-approved TB targets is included at the end of this section)
- Annual progress reports and indicators submitted to F on initiative countries' TB Elements will be rolled up for presentation to Congress and other stakeholders

Support from USAID/Washington

The Bureau for Global Health and the respective regional bureaus will collaborate to support missions in developing their OPs. Specific assistance that can be provided includes:

- latest technical information and evidence to assist in choice of interventions and delivery approaches;
- statistical and analytic support to develop baselines and establish five year targets;
- technical assistance in development of annual operational plans;
- facilitation of coordination with HQ and regional level offices of key partners (WHO, World Bank, CDC, The European Union, KNCV, etc.) to promote effective cooperation of their in-country programs with the USG's country strategy development and programming;
- technical assistance to help ensure that regional and sub-regional activities complement and support the plans of the focus countries; and
- coordinated GH core-funded activities to ensure that focus countries have the highest priority to benefit from these activities.

GENERAL REFERENCES FOR TB FOCUS COUNTRIES

A. FACTS Program Element Overview

Please address the areas listed below as best as possible given the 2,500 character limit.

- **Agreement by the host government and the National TB program** to work with USAID.

- Identification of principal **high-impact interventions** for the OP, based on epidemiology and health systems capacity; this section should include plans to phase in interventions recommended in the STOP TB Strategy over time or geographical areas.

- Rapidly expand coverage to 100% for component 1 of the STOP TB Strategy, which is to *pursue high quality DOTS expansion and enhancement*. Specifically, this includes political commitment with increased and sustained financing, case detection through quality-assured bacteriology, standardized treatment with supervision and patient support, effective and reliable drug supply and management system, monitoring and evaluation system, with measurement of impact.

- Strengthen host country capacity and achieve increased coverage of the additional components of the STOP TB Strategy which are to address TB/HIV and Multi-drug resistant (MDR) TB, including extensively drug resistant TB (XDR TB), to contribute to health system strengthening, to engage all providers (private sector, FBOs, NGOs, non-MOH providers, and hospitals), to empower people with TB and communities, and to enable and promote research. (Note: More detailed technical information is provided in "Technical Reference," below). If you are working on MDR and XDR TB, it is very important to include the relevant sub element (3.1.2.4 Multi drug resistant TB) in your OP.

- Identification of the **population** to be targeted: Magnitude or severity of the TB epidemic, TB/HIV or MDR/XDR-TB as well as other factors such as lack of adequate funding from other sources should be considered in selecting geographic areas to target. Country level programs that intend to help expand services in specific sub-national geographic areas (e.g. districts, provinces, states) must specify the geographic areas that will be assisted and provide a rationale for why these geographic areas will be targeted. The OP must clearly describe how assistance to the specific geographic areas will contribute to achievement of the 70/85 targets at the national level.

- Identification of **program approaches** to achieve greatest possible coverage of high impact interventions, based upon culture, geography and health systems capacity to scale up. This may include strengthening service delivery, community services and education, social marketing, or other approaches as relevant to achieving population-based impact.

- Identification of **health system strengthening** results, with defined links to achieving or surpassing and sustaining the 70/85 targets. This may include support to Global Fund TB grants, Human resource development (HRD) for TB control, drug and laboratory commodity management strengthening, and advocacy to ensure inclusion of TB control activities in SWAPs, PRSPs and health sector policies.

- Description of the **role of USAID's investments** in relation to the investments and implementing capacity of the host government, other major partners (including multilateral and bilateral donors, the Global Fund for AIDS, TB, and Malaria, the private sector, NGOs, CDC, WHO, etc.), and the Presidential Emergency Plan for AIDS Relief, and other USG investments.

- Identification of **outcomes attributable to USG** for USAID program areas. These will include coverage of key interventions with overall five year targets, and relevant benchmarks.

- **Plans for monitoring** of annual indicators and progress toward five-year targets and for participation in annual progress review by government, USAID and key partners, including:
  - plans to support TB prevalence surveys, drug resistance surveys, surveillance of TB/HIV co-infection, facility-based monitoring, special program monitoring as appropriate;
  - participation in coordinated national TB program reviews with in-country and external technical partners.

TECHNICAL REFERENCE

- ***Link to five-year plans of National TB Programs (NTPs)*** – NTP five-year plans should serve as the basis for planning. USG can help to develop these plans and USG assistance should support the priorities outlined in these plans.

- ***Coordination of CSH/TB funds with PEPFAR –*** TB and TB/HIV activities need to be well coordinated regardless of the funding source. In particular, countries that receive CSH/TB as well as PEPFAR funds should describe (in the operational plan) how these resources and activities are coordinated and complement each other. Operating units are encouraged to look for opportunities to enhance collaboration such as forming interagency technical working groups, organizing joint planning retreats, conducting interagency portfolio reviews and/or technical assistance visits, or other means to ensure effective coordination. Technical assistance is available to facilitate this process and planning. USAID TB team members participate in reviews of HIV/TB components of COPs, and PEPFAR TB/HIV-AIDS working group members will also assist with technical reviews of USAID TB operational plans of PEPFAR countries. This should be addressed in the Program Element Overview Section C, Discussion of USG Participants.

- ***Technical interventions of the STOP TB strategy*** – The new STOP TB strategy launched by the WHO in March 2006 will guide technical interventions to be supported by USG TB programs. The components of the STOP TB Strategy address the areas below:
    - DOTS expansion and enhancement – political commitment; sustained financing and monitoring of resources for TB control; case detection through quality assured bacteriology; standardized treatment with supervision and patient support; reliable supply of quality-assured drugs and diagnostic equipment and supplies; strengthening of program management, monitoring and evaluation; interventions to improve DOTS quality.
    - Engagement of all public and private providers in DOTS (PPP) – involving non-MOH health care providers, private sector, hospitals and NGOs in DOTS; ensuring coordination of theses providers with the public sector MOH; international standard of TB care.
    - Improvement of management of TB/HIV co-infection – build capacity for joint TB/HIV planning, monitoring and evaluation; surveillance of HIV prevalence in TB patients; active TB case finding in PLWHA; HIV counseling and testing in TB patients; cotrimoxazole preventive therapy; referral of HIV+ TB patients to ARV treatment services; isoniazid preventive therapy; and TB infection control in health facilities and congregate settings.
    - Multi-Drug Resistant TB (MDR TB) (including XDR TB) – introduction and expansion of DOTS Plus for MDR TB including detection, diagnosis and treatment of drug resistant TB; drug resistance surveillance; XDR TB outbreak investigation and contact tracing; second line drug management; TB infection control in health facilities and congregate settings
    - Care and support people with TB – community participation in TB care and prevention; advocacy, communication and social mobilization; patient charter for TB care (describes rights and responsibilities); enablers to help TB patients adhere to treatment; engagement of civil society organizations;

- Operations research to improve program performance and to assess impact; targeted evaluations test model approaches
- Monitoring and evaluation – USG programs which undertake external monitoring and evaluation (every one to two years) have been demonstrated to produce better results. USG should also participate in coordinated national TB program reviews with in-country and external technical partners. Baselines should be established for relevant indicators.
- Health systems components (e.g., policy, financing, human capacity) and advocacy to ensure inclusion of TB control activities in SWAPs, PRSPs and health sector policies
- Support Global Fund TB grants – Successful application to the GF and good performance on GF grant implementation is an important element of health system strengthening. USG programs should provide technical assistance to help countries prepare GF grant proposals and to address grant implementation bottlenecks.
- Human resource development (HRD) for TB control – Pre-service and in-service training; curriculum development and training materials; and HR information to track deployment, rotation, and trained staff; and institutional capacity building to strengthen national or sub-regional training institutions
- Drug and laboratory commodity management strengthening, including selection, product quality assurance, procurement, and distribution

- ***Implementation mechanisms and partners*** – All programs should work in coordination with the NTP. Sprinkling of small amounts of TB funds to multiple partners and funding of implementing partners who lack experience in TB should be avoided. Potential partners include MOH, PVOs, NGOs, FBOs, other civil society organizations, private sector, professional societies, and training institutions.

- ***Collaboration with other bilateral and multilateral donors*** – USG funding should be leveraged and coordinated with other bilateral and multilateral donors and technical partners (ex. World Bank, GFATM, Global TB Drug Facility, WHO, CDC); USG should participate in STOP TB Partnerships at the country level and/or interagency coordinating committees.

- ***USG oversight*** – All countries with TB funding need a designated point person to manage and guide TB activities. USG staff oversight (e.g. full time or part time staff focused on TB) should be commensurate with the TB funding level.

Indicators

Outcome Indicators	**FY 07 Actuals (based on all funds)**	**FY 08 targets (based on all funds)**	**FY 09 targets (to be achieved from FY 08 NOA)**
• Percent of the estimated number of new smear-positive pulmonary TB Cases that were detected under DOTS (i.e. Case Detection Rate) • Percent of registered new smear-positive pulmonary TB Cases that were cured and completed treatment under DOTS (i.e. Treatment Success Rate) (Both indicators reported at national level) Corresponding sub element: 1.2.1 – DOTS expansion and enhancement	_____ _____	_____ _____	_____ _____
Sub-Element / Intervention Indicators (as relevant to country program)			
High quality DOTS expansion and enhancement <u>Outcome</u> • Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG supported areas • Percent of registered new smear-positive pulmonary TB Cases that were cured and completed treatment under DOTS (i.e. Treatment Success Rate) (Both indicators reported at <u>sub-national level)</u> Corresponding sub element: 1.2.1 – DOTS expansion and enhancement Outputs • Number of people trained in DOTS • Average population per laboratory performing TB microscopy • % of laboratories performing TB microscopy with over 95% correct microscopy results Corresponding sub element: 1.2.1 – DOTS expansion and enhancement	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
TB/HIV Collaborative Activities Output • % of all registered TB patients who are tested for HIV Corresponding sub element: 1.2.3 - Improve management of TB/HIV	_____	_____	_____
MDR TB Output • The existence of a national MDR-TB quality control standard at the national level • Treatment success rate in USG assisted	_____ _____	_____ _____	_____ _____

DOTS Plus programs to treat MDR TB Corresponding sub element: 1.2.4 – Multi Drug Resistant TB			
Public private partnerships for TB control Output • Number of TB cases reported to NTP by non-MOH sector Corresponding sub element: 1.2.1 – DOTS expansion and enhancement	_____	_____	_____
Capacity building for TB element Output • Number of people trained in TB element Corresponding sub elements: 1.2.1 – DOTS expansion and enhancement; 1.2.3 - Improve management of TB/HIV; 1.2.4 – Multi Drug Resistant TB; 1.2.5 – TB Care and Support NOTE: This indicator will replace "number of people trained in DOTS" so that training provided for the sub-elements of TB (beyond 1.2.1) is captured.			

WATER SUPPLY AND SANITATION

Background

Water supply and sanitation, and related hygiene and water resources management activities, contribute significantly to several Objectives and Program Areas within the Framework for Foreign Assistance, with various Elements and sub-Elements that explicitly specify water-related activities or implicitly allow their inclusion. This document amplifies the definition of the Water Supply and Sanitation Element (see "Foreign Assistance Standardized Program Structure and Definitions") to provide additional information on what activities contribute to the Element and the role played by other key water- and sanitation-related Elements in the Program Structure.

The overall strategy for USG-supported water-related activities was articulated in the *Paul Simon Water for the Poor Act of 2005: Report to Congress*, U.S. Department of State, June 2006; http://www.state.gov/documents/organization/67716.pdf. Among the principal objectives is to increase access to, and effective use of, safe water and sanitation to improve human health. The Act requires annual reporting on USG efforts to implement the strategy, which includes USG support to help reach the Millennium Development Goal targets in increasing access to improved water supply and basic sanitation.

Water Supply and Sanitation Element (3.1.8)

The focus of the Water Supply and Sanitation Element is on the provision of sustainable access to improved sources of drinking water[2] and improved sanitation facilities[3] to people who did not formerly have access.[4] Activities under all sub-Elements must clearly establish a connection to increased service access through:

- direct support of household, other private, community, or municipal infrastructure for water supply and sanitation;

- support of institutions, governance, and financing arrangements that strengthen the delivery of water supply and sanitation infrastructure services, such as utilities, water

[2] "Improved sources of drinking water" include household water connections, public standpipes, boreholes, protected dug wells, protected springs, rainwater collection and bottled water (if a secondary source is also improved). Examples of unimproved drinking water sources include unprotected wells; unprotected spring, rivers or ponds; vendor-provided water or tanker truck water.

[3] "Improved sanitation" relies on technologies that are more likely to ensure privacy and hygienic use, e.g. connection to a septic system or public sewer, pour-flush latrines, simple covered pit latrines, and ventilated improved pit (VIP) latrines. Unimproved sanitation facilities include public or shared latrines, open pit latrines, and bucket latrines. Note that the exclusion of "shared" or "public" facilities from the improved category is not absolute and may be reconsidered on a case-by-case basis, if provision is made for adequate and hygiene maintenance.

[4] No specification is made regarding target or vulnerable populations, such as young children or people living with HIV/AIDS. If such targeting is part of the OP investment strategy under this Element, there should be explicit disaggregation for these sub-populations in the monitoring and evaluation plan.

users associations, municipal or other local credit, revolving funds, and public-private partnerships.

The Water Supply and Sanitation Element covers activities focused on increasing service access in all Framework country category types and through all sectoral programs (e.g., health, environment, urban, Title II/food security, etc.).

Activities covered under other elements and not part of the 3.1.8 Water Supply and Sanitation Element include:

- water supply and sanitation services and commodities delivered as part of the Assistance and Recovery Element under Humanitarian Assistance (HA 1.2) or the Alternative Development Element under Peace & Security (P&S 4.2), for which improved access should be included as part of reporting against these Elements (see also "Key Issues" and "Indicators", below).

- household-level water quality interventions, as well as improvement of personal and domestic hygiene and sanitation behaviors, which should be addressed under the Maternal and Child Health Element of IIP/Health, as part of the "Household Level Water, Sanitation, Hygiene and Environment" sub-Element (IIP 1.6.7). Because these activities are essential to fully realize the health gains associated with improved access to infrastructure, Operational Plans including the Water Supply and Sanitation Element should also include funds for these mainly behavioral interventions under the Maternal and Child Health Element. Examples are point-of-use water treatment, handwashing, and sanitation promotion, including support of institutions and institutional relationships to strengthen and sustain such activities.

- watershed management activities to protect drinking water supplies, or large-scale infrastructure development to divert or store water, which should be addressed under the Economic Growth Objective, Environment Program Area, Natural Resources and Biodiversity Element (EG 8.1).

- activities to reduce, mitigate, prevent, or treat municipal and industrial water pollution which should be addressed under the Economic Growth Objective, Environment Program Area, Clean Productive Environment Element (EG 8.2).

- solid waste management and related activities, which should be addressed under the Economic Growth Objective, Environment Program Area, Clean Productive Environment Element, "Sound Management of Waste" Sub-Element (EG 8.2.6).

Water Key Issue Area

"Water" has been identified as a key issue in the Foreign Assistance framework in order to assist the Agency in annual required reporting for the Paul Simon Water for the Poor Act, as well as tracking annual attributions to the 'water supply and sanitation' Congressional earmark.

The Guidance Annexes for the FY 2008 Operational Plan and FY 2007 Performance Report provide full definitions for the "Water" key issue area, including four sub-key issues: Drinking Water Supply and Sanitation, Watershed/Water Resources Management, Water Productivity, and Disaster Preparedness. All activities described under the Water Supply and Sanitation Element will be reported against the "Drinking Water Supply and Sanitation" sub-key issue. Activities covered under other elements and not part of the 3.1.8 Water Supply and Sanitation Element, as outlined in the section above, should also report contributions to one of the four sub-key issues.

To ensure accuracy and minimize the need for multiple data requests from Operating Units, care should be taken in attributing funding in the water sector across the four sub-key issue areas in "Water". They are mutually exclusive of each other and double-counting is not allowed.

Operational Plan preparation [5] [6]

Additional recommendations regarding the assignment of activities to specific sub-Elements of the Water Supply and Sanitation element is as follows:

- Within the Water Supply and Sanitation Element, activities focused directly on the provision of new access to improved services contribute to "**Safe Water Access**" and "**Basic Sanitation**" sub-Elements (IIP 1.8.1 and 1.8.2, respectively).

- Activities focused on policies, governance, or financing to strengthen institutions (e.g. utilities), improve service quality, ensure long-term financial and ecological sustainability, and better manage demand for water supply and sanitation services contribute to the **"Water and Sanitation Policy and Governance**" (IIP 1.8.3), "**Sustainable Financing for Water and Sanitation Services**" (IIP 1.8.4), and "**Water Resources Productivity**" (IIP 1.8.5) sub-Elements. While these sub-Elements may broadly improve quality of services, specific linkages should be articulated between these investments, institutional strengthening, and increasing access to sustainable water supply and sanitation services.

- Financing or policy reform related to all domestic wastewater collection and small-scale community wastewater treatment should be included within the spectrum of utility and municipal governance and reform and financing under the **"Water and Sanitation Policy and Governance**" (IIP 1.8.3), "**Sustainable Financing for Water and Sanitation Services**"

[5] Note that current Agency ADS guidance on the use of CSH funds for water supply and sanitation activities still applies. See "Guidance On The Definition And Use Of The Child Survival And Health Programs Fund and the Global HIV/Aids Initiative Account FY 2004 Update" (http://www.usaid.gov/policy/ads/200/200mab.pdf) for further information. Updates to this Guidance, as they are released, will supersede the FY04 guidance.
[6] Readers are referred to the Foreign Assistance Standardized Program Structure and Definitions for definitions of the sub-Elements referenced in this section.

(IIP 1.8.4) sub-Elements. All wastewater collection and conveyance, and small-scale wastewater treatment infrastructure integrated into an overall sanitation activity should be included under the "**Basic Sanitation**" sub-Elements (IIP 1.8.2). The relatively few instances of USG investment in stand-alone large-scale construction activities for wastewater treatment which are typically focused on the protection of water quality, or policy and financing efforts related to such large-scale treatment facilities, should be addressed under the Economic Growth Objective, Environment Program Area, Clean Productive Environment Element (EG 8.2), as should all industrial wastewater treatment and water-related clean production activities.

Indicators

As noted above, indicators associated with different aspects of the water sector are located in different parts of the Foreign Assistance Framework and FACTS database. Following are those indicators that will be most relevant for reporting on programs under the Water Supply and Sanitation Element only (NOTE: Confirm latest wording and definitions in the forthcoming FACTS guidance).

Water Supply and Sanitation Element

- Number of people in target areas with access to improved drinking water supply as a result of USG assistance
- Number of people in target areas with access to improved sanitation facilities as a result of USG assistance.
- Average number of hours per day that households in areas assisted by USG programs have potable water service.

In addition to the standard OP indicators, Missions are encouraged to use the following standard language for a custom indicator on cost-recovery, where applicable to their programs: "Percent of operations and maintenance costs for water supply and sanitation services covered through customer charges in USG-assisted target areas."

Other related and relevant indicators may also be found under Maternal and Child Health Element, Natural Resources and Biodiversity Element, and Clean Human Environment Element.

HEALTH GOVERNANCE AND FINANCE
Health Systems Strengthening Technical Reference

1. **Question:** Even though the Health Area does not include a health systems strengthening element, can we continue activities to address health systems constraints?

Answer: Yes, you may continue activities that address health system constraints to the use of USG health sector strategic priority services as represented by the Health Program Elements. Note that the Operating Plan covers health systems strengthening at the sub-element level.

Single element and cross-cutting health system investments should have strong links to USG PHN interventions and outcomes. For example, if people in your country do not get assisted deliveries or sick child care because they cannot afford to pay user fees, then health financing policies and practices should be examined for ways to remove these constraints. It is warranted and advisable for you to undertake health financing activities if you can identify approaches that clearly aim at and measure success by increasing use of delivery or sick child services, even if they also have other benefits.

2. **Question:** Does the new Operating Plan change the practices and guidelines on funding of health system strengthening?

Answer: No. Helpful information on funding is contained in the USAID Child Survival and Health Guidance and in the other health element Supplemental references for Operating Plans. Health systems activities must benefit USG health program elements. All program elements (HIV/AIDS, Tuberculosis, Malaria, Avian Influenza, Other Public Health Threats, Maternal and Child Health, Family Planning and Reproductive Health) can support element-specific and cross-cutting health systems activities that benefit the program element objective (e.g., HIV/AIDS resource tracking, national health accounts in order to carry out HIV/AIDS resource tracking).

3. **Question:** What are the health systems strengthening sub-elements designated for use in the OP?

Answer: There are three specialized health systems sub-elements: Host Country Strategic Information Capacity (all elements), Other Policy and System Strengthening (HIV/AIDS and FP/RH only), and Antimicrobial Resistance (Malaria, and MCH only). If a health system strengthening activity addresses only one health element and does not fit any of the above sub-elements, then it is coded using the relevant medical or public health SubElements, such as the SubElement for Immunization or for Treatment of Obstetric Complications and Disabilities.

In exceptional cases, such as where numerous medical and public health sub-elements would be required to account for a cross-cutting activity within a single element, assign the Health Governance and Financing SubElement (available for all elements except HIV/AIDS and Water Supply and Sanitation). If a health systems activity covers more than one health element, then definitely assign the Health Governance and financing SubElement. See **Table 1**, below, for details on which sub-elements apply within each health element.

Table 1. Guide to Selecting Among the Available Sub-Elements related to Health System Strengthening by Health Element

Health Elements[1]	For Health Systems Activities within a Single Program Element				For Health Systems Activities Covering Multiple Health Elements
	Host Country Strategic Information Capacity 1	**Anti-Microbial Resistance** 2	**Other Policy and System Strengthening** 3	**Any of the Medical and Public Health Sub-Elements, or, if needed, Health Governance & Finance (HGF)[2]** 4	**Health Governance & Finance (HGF)** 5
HIV/AIDS	X		X		
Tuberculosis	X			X	X
Malaria	X	X		X	X
Avian Influenza	X			X	X
Other Public Health Threats	X			X	X
Maternal and Child Health	X	X		X	X
Family Planning/ Reproductive Health	X		X		X
Water Supply and Sanitation	X			X	

[1]Annex C: Foreign Assistance Standardized Program Structure and Definitions
[2]Note: Operating Units should make efforts to report activities that address specific earmarks under other sub-elements, the health governance and finance sub-element can be used for overarching activities that support multiple health elements.

4. **Question:** What are examples of the health systems strengthening sub-elements for use when health system strengthening work is being done within a single element?

Answer: The choice here will depend on the particular element in which you are conducting health systems activities (see also Table 1, above):

a. For any health element, use Host Country Strategic Information Capacity SubElement where appropriate to the activity. An example of such an activity is: The collection, analysis and dissemination of national health accounts sub-accounts to track resources for child health.
b. For Malaria and Maternal and Child Health, use Anti-microbial Resistance SubElement where appropriate to the activity. An example of such an activity is training of health workers administering antibiotics on techniques of counseling patients about the importance of compliance with drug treatment regiments.
c. For HIV/AIDS and FP/RH, use Other Policy Analysis and System Strengthening SubElement where appropriate to the activity. An example of such an activity is Workforce Analysis for Family Planning/Reproductive Health.
d. For MCH, TB, AI, Other Public Health Threats, and Malaria, use any of the medical and public health SubElements which are cover the purpose of the activity. An example of such an activity is support to establish Improvement Collaboratives for

networking quality assurance activities in a program for treatment of obstetrical complications and disabilities. In exceptional cases, such as where numerous medical and public health sub-elements would be required to account for a cross-cutting activity within a single element, assign the Health Governance and Financing SubElement (available for all elements except HIV/AIDS and Water Supply and Sanitation). Operating Units should make efforts to report activities that address specific earmarks under other sub-elements, reserving the use of the health governance and finance sub-element for overarching activities that support multiple health elements.

5. **Question:** When do you use a cross-cutting health systems strengthening sub-element?
Answer: Use Health Governance and Finance (HGF) when there are systemic constraints on achieving your health element goals and where it would not be cost effective or efficient to address these constraints solely through disease-specific programs. Constraints may be in the areas of overall health system governance, health system financing, human resources, health system organization and management or pharmaceutical management. An example would be an activity which strengthens the leadership and team-building skills of the ministry of health and which can be directly tracked to improved service statistics in priority PHN services.

6. **Question:** How do you use a cross-cutting health system strengthening sub-element?
Answer: First, your operating unit should identify relevant health governance and finance sub-element results, with defined links to achieving and sustaining impact and coverage targets; this may include management, health information systems, healthcare financing, rational pharmaceutical management, quality improvement, and human resources development. Given the above, your operating unit may determine that it is important for USAID to support a Ministry of Health workforce analysis to improve the use of human resources in health and that this will contribute to better operation of all USAID's health elements. You have funds for work on TB, MCH, HIV and FP/RH. For each Health Element where you anticipate accruing benefits from the analysis, you charge the funding for this activity to TB, MCH, HIV and FP/RH based on your judgment of their relative shares of benefits.

7. **Question:** Where do you use a cross-cutting health strengthening sub-element?
Answer: In situations where a relatively small amount of money can have a large impact on health systems. This would be particularly relevant in countries nearing graduation.

8. **Question:** What do you mean by "using" the health systems sub-elements? Where do I include the narrative for my systems strengthening activities?
Answer: Within each element you will be asked to input information specific to implementing partners. For each implementing partner you are asked to enter the dollar amount that, that partner should spend on each sub-element. This is where you ascribe funding to health systems sub-elements. You can also describe health systems strengthening activities within the narrative sections; however the way you do this will depend on your particular country program. For example: to the extent it is relevant and/or feasible the "Work of other players", "Program element", and "implementing mechanism" narratives could all be used to describe parts of your health systems program. If you are unsure how to describe in narrative form health systems activities please consult with one of the people identified below.

9. **Question:** If the standard indicators do not track with your particular health systems strengthening activities, how can we best track performance?

Answer: Performance at outcome and impact levels will continue to be tracked through your PMP and other sources (DHS/RHS data). Output level information is tracked in the FACTS system as a way to identify what was obtained for a particular set of resources.

You have several options to select among and fit to the situation in your program. One way to follow your progress is to select a standard health element indicator that tracks with more effective system performance, such as "Number of counseling visits for FP/RH as a result of USG assistance." Additionally, the FACTS system includes a small set of Health Governance and Finance Indicators, which may be relevant for your programs. A final option is to insert a local indicator to track that health systems strengthening activity. When utilizing this option, we advise that you attempt to select an indicator which would be relevant for many countries (and not just your particular program).

10.

10. **Question:** What are examples of activities covered in Health Governance and Finance (HGF) for purposes of completing OP Sections 4, 5, and 6?

Answer: See Annex A, below

11. **Question:** What reference information can I consult in preparing my OP activities in HGF?

Answer: See the health systems section of the USAID website: www.usaid.gov/our_work/global_health/hs/.

12. **Question:** Who can I contact for additional help in preparing OP activities health systems strengthening and Health Governance and Financing (HGF)?

Answer: In GH, contact Bob Emrey, who can direct you to specialized assistance. In regional bureaus, the following individuals are working on Health Governance and Finance activities and are available to answer OP questions: AFR – Ishrat Husain, ANE – Gary Cook, E&E – Forest Duncan, and LAC – Kelly Saldana. We are available to discuss how best to plan and document health system strengthening activities going into your country OP by email or conference calls.

Annex A. Illustrative Examples of Application of Health Systems Sub-elements

a. Single Health System Strengthening Sub-element within a Single Element *(Refer to Columns 1 to 3 in Table 1)*

- The collection, analysis and dissemination of national health accounts sub-accounts to track resources for child health. [Coding -- **Element 1.6:** Maternal and Child Health**; SubElement 1.6.10:** Host Country Strategic Information Capacity]

- A workforce analysis to estimate available and required human resources to provide anti-retroviral treatment for AIDS [Coding -- **Element 1.1:** HIV/AIDS**; SubElement 1.1.13:** Other/Policy Analysis and System Strengthening]

b. Multiple Health System Strengthening Activities Captured by Multiple Sub-elements within a Single Element *(Refer to Column 4 in Table 1)*

- Support to the improvement of the quality of care through use of Improvement Collaboratives for assisted deliveries and sick child care [Coding -- **Element 1.6:** Maternal and Child Health; **Program SubElement 1.6.1:** Birth Preparedness and Maternity Services, and **Program SubElement 1.6.6:** Treatment of Child Illness]

- The strengthening of pharmaceutical management for treatment of obstetric complications and sick children [Coding -- **Element 1.6:** Maternal and Child Health; **SubElement 1.6.2:** Treatment of Obstetric Complications and Disabilities, and **SubElement 1.6.6:** Treatment of Child Illness]

c. Health Governance and Finance *(Refer to Column 5 in Table 1)*

- Support to the Ministry of Health to improve its capacity to develop, spend and track its annual budget by priority health program (for example, Family Planning and Reproductive Health, Maternal and Child Health) for the purpose of strengthening management and reducing waste in priority health programs supported by USG health investments [Coding -- **Element 1.6:** Maternal and Child Health; **SubElement 1.6.8:** Health Governance and Finance (MCH); and **Element 1.7:** Family Planning and Reproductive Health; **SubElement 1.7.4:** Health Governance and Finance (FP)]