GUIDANCE ON THE DEFINITION AND USE OF THE GLOBAL HEALTH AND CHILD SURVIVAL ACCOUNT

UPDATE

JANUARY 2009

The guidance contained within this document—including legal requirements, policy requirements, Congressional directives, and USAID guidance—is subject to change. Updates and revisions will be published as addenda.

Please make sure that the correct version of the guidance is being followed.

Questions should be directed to USAID's Bureau for Global Health, Office of Strategic Planning, Budgeting and Operations (GH/SPBO).

GUIDANCE ON THE DEFINITION AND USE OF THE GLOBAL HEALTH AND CHILD SURVIVAL (GH/CS) ACCOUNT

TABLE OF CONTENTS

APPENDICES

ACRONYMS

AAPD ..... Acquisition and Assistance Policy Directive
AB..... Abstinence, Be faithful
ABC ..... Abstinence, Be faithful, correct and consistent Condom use
ACI ..... Andean Counterdrug Initiative
ADS ..... Automated Directives System
AEEB ..... Assistance for Eastern Europe and the Baltics
AFR..... Bureau for Africa
AI ..... Avian Influenza
AIDS ..... Acquired Immunodeficiency Syndrome
AIMEBA. Avian Influenza Monitoring and Evaluation and Budget Analysis
AMR ..... Anti-Microbial Resistance
ANE ..... Bureau for Asia and the Near East
ARV..... Anti-retroviral
ART ..... Anti-retroviral Treatment
CASU ..... Cooperative Assistance Support Unit
CCM..... Country Coordinating Mechanism
CDC ..... Centers for Disease Control and Prevention
CF ..... Commodity Fund
CIB..... Contract Information Bulletin
COO..... Chief Operating Officer
COP ..... Country Operational Plan
CS ..... Child Survival
CSH..... Child Survival and Health Programs Fund
CTO ..... Cognizant Technical Officer
DA..... Development Assistance
DCHA ..... Bureau for Democracy, Conflict, and Humanitarian Assistance
DCOF..... Displaced Children and Orphans Fund
DOD ..... Department of Defense
DOTS ..... Directly Observed Therapy – Short Course
DP ..... Development Planning Office
E&E ..... Bureau for Europe & Eurasia
EGAT..... Bureau for Economic Growth, Agriculture, and Trade
ESF ..... Economic Support Fund
F..... Office of the Director of Foreign Assistance
FAA ..... Foreign Assistance Act
FACTS .... Foreign Assistance Coordination and Tracking System
FBO..... Faith-Based Organization
FDA ..... Food and Drug Administration
FFP..... Food for Peace
FGC ..... Female Genital Cutting
FNGO ..... Foreign Nongovernmental Organization
FP/RH ..... Family Planning / Reproductive Health
FSA ..... Freedom Support Act
FSL ..... Foreign Service Limited
FY ..... Fiscal Year
GC..... Office of the General Counsel
GFATM... Global Fund to Fight AIDS, Tuberculosis and Malaria
GH..... Bureau for Global Health
GHAI ..... Global HIV/AIDS Initiative
GH/CS..... Global Health and Child Survival
HIDN ..... Office of Health, Infectious Diseases and Nutrition
HIV ..... Human Immunodeficiency Virus
HHS ..... Department of Health and Human Services
IAVI ..... International AIDS Vaccine Initiative
IDFA ..... International Disaster and Famine Assistance
IDU..... Injecting Drug User
IEC ..... Information, Education, and Communication
IIP..... Investing in People
IPA ..... Inter-Agency Personnel Authority
IRS..... Indoor Residual Spraying
JSP ..... Joint Strategic Plan
LAC..... Bureau for Latin America and the Caribbean
M/HR ..... Bureau for Management/Office of Human Resources
MDR ..... Multi-drug Resistant
MH ..... Maternal Health
MOH ..... Ministry of Health
MVA ..... Manual Vacuum Aspiration
NCD ..... Non-Communicable Disease
NGO ..... Non-Governmental Organization
NTD..... Neglected Tropical Disease
NTP ..... National TB Program
OE ..... Operating Expenses
S/GAC .... Office of the Global AIDS Coordinator
OHA ..... Office of HIV/AIDS
OP..... Operational Plan
OPHT ..... Other Public Health Threats
ORS ..... Oral Rehydration Salts/Solution
OU..... Operating Unit
OVC ..... Orphans and Vulnerable Children
OVC ..... Other Vulnerable Children
PAPA..... Participating Agency Program Agreement
PASA..... Participating Agency Service Agreement
PD-3 ..... Policy Determination 3
PEPFAR .. Presidents Emergency Plan for AIDS Relief
PHN..... Population, Health, and Nutrition
PLWHA... People Living with HIV/AIDS
PMP..... Performance Management Plan
PMTCT ... Prevention of Mother-to-Child Transmission
PMI..... President's Malaria Initiative
PPC..... Bureau for Policy and Program Coordination
PPM..... Public Private Mix
PR..... Principal Recipient
PRH..... Office of Population and Reproductive Health
PSC..... Personal Service Contract
PSCMS .... Partnership for Supply Chain Management
PVO..... Private Voluntary Organization
Q&As ..... Questions and Answers
RFP ..... Request for Proposal
STI..... Sexually Transmitted Infections
SO ..... Strategic Objective
SPBO..... Office of Strategic Planning, Budgeting and Operations
TAACS .... Technical Advisors in AIDS and Child Survival
TB..... Tuberculosis
UNICEF United Nations Children's Fund
U.S..... United States
USAID..... United States Agency for International Development
USAID/W .USAID/Washington
USG..... United States Government
VCT..... Voluntary HIV Counseling and Testing
WCF ..... Working Capital Fund
WHO ..... World Health Organization
XDR ..... Extensively Drug Resistant

GUIDANCE ON THE DEFINITION AND USE OF THE GLOBAL HEALTH AND CHILD SURVIVAL ACCOUNT

I. SUMMARY

A. Purpose of the Guidance

The purpose of the Guidance on the Definition and Use of the Global Health and Child Survival Account ("Guidance") is to (1) provide comprehensive guidance to USAID operating units on the definition and use of the Global Health and Child Survival Account ("GH/CS Account," formerly the Child Survival and Health (CSH) Programs Fund and the Global HIV/AIDS Initiative (GHAI) Account); (2) provide reference documents to management, technical, program, and budget officers; and (3) delineate special considerations for programming the GH/CS Account.

Unless otherwise noted, the legislative and policy requirements contained in this guidance apply to the GH/CS Account. As a policy matter, if funds from other accounts (e.g., Economic Support Fund (ESF), Freedom Support Act (FSA), Assistance for Eastern Europe and the Baltics (AEEB), and Andean Counterdrug Initiative (ACI)) are used by USAID for health activities, then such use of those funds should also comply with this guidance.

Managers and technical and financial officers must do careful planning, monitoring, and reporting (see Automated Directives System (ADS) Series 200 for detailed guidance), follow parameters set forth by the Office of the Director of U.S. Foreign Assistance (F) and (for HIV/AIDS assistance) the Office of the U.S. Global AIDS Coordinator (S/GAC), and adhere to Congressional earmarks and, as appropriate, directives and other Agency guidelines.

To ensure that legislative and policy guidelines are followed, the Director of Foreign Assistance (F) is responsible for the appropriate allocation and tracking of GH/CS Account funds. The Bureau for Global Health, in collaboration with regional bureaus, the Office of the General Counsel, the Bureau for Legislative and Public Affairs, and F, takes the lead in: (1) communicating issues on the GH/CS Account to the appropriate parties; and (2) responding to external inquiries from Congress and others on the planning, implementing, and monitoring of the GH/CS Account funds assigned to USAID.

Scope, Definitions, Authorities, and Prohibitions

Funds must be used within the parameters set by Congress, the Department of State and Agency for International Development (USAID, or the Agency) Strategic Plan for Fiscal Years 2007 to 2012, S/GAC (for HIV/AIDS assistance), and this Guidance, and then applied to global, regional, and country needs. The Agency places considerable emphasis on local ownership and participation in planning and implementing programs, because these are important to

effectiveness and achieving lasting results. While USAID's management structure allows the flexibility to build strong local ownership and allows front-line managers to respond to local opportunities and circumstances, these responses must remain within the bounds of the GH/CS budget categories and sub-categories.

Operating units should explicitly communicate this Guidance to partners implementing activities with GH/CS Account funds, particularly as this Guidance affects their planning, implementation, monitoring and evaluation. Contractors, recipients, and grantees should be given documentation requirements (i.e., workplan requirements, program reports) in the scope of work and program description for acquisition and assistance instruments. Operating units should ensure that scopes of work and program descriptions for new awards reflect this Guidance on the definitions and appropriate use of funds for activities covered by GH/CS Account funds.

Operating units are required to implement activities that comply with the guidance for their discrete funding allocations and to report accordingly. Managers as well as technical and financial officers must ensure that GH/CS funds are used for the purpose for which they are appropriated by following the parameters set forth by F, and adhering to this Guidance for Congressional earmarks and directives and corresponding budget categories.

B. Modifications to the 2004 Guidance and Highlights of the Guidance

- This Guidance expands and clarifies previous guidance. This Guidance supersedes the July 22, 2004 Guidance on the Definition and Use of the Child Survival and Health Programs Fund and the Global HIV/AIDS Initiative Account ("2004 Guidance").

- The text incorporates the changes made to the GH/CS Account (formerly the CSH Programs Fund and the GHAI Account) in the FY 2005 Foreign Operations, Export Financing and Related Programs Appropriations Act ("FY 2005 Appropriations Act"), the FY 2006 Foreign Operations, Export Financing and Related Programs Appropriations Act ("FY 2006 Appropriations Act"), the FY 2007 Continuing Appropriations Resolution, and the FY 2008 Department of State, Foreign Operations, and Related Programs Appropriations Act ("FY 2008 Appropriations Act").

- The text is primarily organized by program elements under the Foreign Assistance Standardized Program Structure and Definitions (SPS) rather than Congressional budget category.

- Within each element, there is a distinction between "legal requirements and Congressional directives" and "USAID guidance."

- In Chapter I.A (Purpose of the Guidance) and III.1.B (Allowable Uses of Funds for Agency Programming Purposes: General: USAID Guidance), there is clarification of what accounts are covered by the Guidance.

- The 2004 Guidance Chapter II (Preserving the Integrity of the Child Survival and Health Programs Fund and the Global HIV/AIDS Initiative Account) has been eliminated.

- Chapter I.A (Summary: Purpose of the Guidance) clarifies the purpose of the Guidance and the responsibilities of the Office of the Director of U.S. Foreign Assistance. References to the Bureau for Policy Planning and Coordination (PPC) in the 2004 Guidance have been deleted.

- Chapter II (Element Relationship to Budget Categories) was added to detail the relationship between the health elements and the Congressional budget categories, replacing the 2004 Guidance Chapter III (Relationship of the Budget Categories to the State/USAID Strategic Plan). References to goals and objectives from the SPS have been included.

- In Chapter III.1.B (Uses of Funds for Agency Programming Purposes: General: USAID Guidance), there is updated language on the two key justifications for using GH/CS funds: "direct impact" and "optimal use of funds."

- In Chapter III.2.A (Allowable Uses of Funds for Agency Programming Purposes: HIV/AIDS: Legal Requirements and Congressional Directives) there is:
    - information on the "Prostitution and Sex Trafficking" requirement to reflect language regarding the application of provisions in Acquisition and Assistance Policy Directive (AAPD) 05-04 to U.S. organizations; and
    - guidance on the circumstances under which HIV/AIDS assistance can be provided to the military, police, prisons or other law agencies, and the procedures for relying on notwithstanding authority.

- In Chapter III.2.B (Allowable Uses of Funds for Agency Programming Purposes: HIV/AIDS: USAID Guidance) there is:
    - guidance regarding USAID support for Abstinence, Be faithful, correct and consistent Condom use ("ABC") programs, including a new Appendix: "*Guidance for USG In-Country Staff and Implementing Partners Applying the ABC Approach to Prevention of Sexually Transmitted HIV Infections Within the President's Emergency Plan for HIV/AIDS Relief*";
    - guidance on "HIV/AIDS Prevention Programs for Injecting Drug Users (IDU)," including updated examples of permissible activities targeting IDU and HIV/AIDS prevention, and a new Appendix: "The U.S. President's Emergency Plan for AIDS Relief HIV Prevention among Drug Users Guidance #1: Injection Heroin Use (March 2006);"
    - guidance on the provision of palliative care for people living with HIV/AIDS and their families, including the addition of a new Appendix: "*HIV/AIDS Palliative Care Guidance #1 For the United States Government in-Country Staff And Implementing Partners*";
    - a section on the use of GH/CS funds for Human Capacity Development;
    - guidance on Prevention of Mother-to-Child HIV Transmission (PMTCT);
    - guidance on orphans and vulnerable children affected by HIV/AIDS, and updates relating to the legislative provision requiring that 10 percent of GH/CS funds appropriated to the Department of State for HIV/AIDS be spent on assistance for orphans and vulnerable children affected by HIV/AIDS;

- guidance on procedures related to the use of the Commodity Fund, including the availability of female condoms;
- a section on the use of GH/CS funds for Supply Chain Management;
- a section on the use of GH/CS funds for the HIV/AIDS Working Capital Fund;
- guidance on TB/HIV co-infection, outlining the uses of HIV/AIDS funds for TB/HIV activities;
- guidance on the provision of antiretroviral treatment, including essential elements for pediatric treatment;
- guidance on injection safety, including a list of sample activities to reduce the spread of HIV in health care settings by making medical injections safe;
- guidance on the use of HIV/AIDS funds to support specific health system strengthening interventions, including the major components of health systems and sample interventions;
- guidance on the role of gender in HIV prevention, care, and treatment; and
- language on providing support to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

- In Chapter III.3.A (Allowable Uses of Funds for Agency Programming Purposes: Tuberculosis: USAID Guidance), there is a new background section and guidance on allowable uses of funds for TB programs.

- In Chapter III.4.A (Allowable Uses of Funds for Agency Programming Purposes: Malaria: USAID Guidance), there is:
  - updated guidance on the allowable uses of GH/CS funds appropriated to USAID for malaria, both for programs that are directly part of the President's Malaria Initiative (PMI) and malaria programs outside of the PMI, including a new appendix: the December 23, 2005 Executive Message on the President's Malaria Initiative.

- In Chapter III.5.A (Allowable Uses of Funds for Agency Programming Purposes: Avian Influenza: USAID Guidance), there is:
  - guidance on the allowable uses of GH/CS funds appropriated to USAID for avian influenza, including two appendices: the September 26, 2005 Executive Message "USAID's Response to Avian Influenza" and the November 3, 2005 Executive Message "Providing Interim Budgetary Guidance for Reprogramming of Funds for Urgent Avian Influenza Related Activities."

- **In Chapter III.6 (**Allowable Uses of Funds for Agency Programming Purposes: Other Public Health Threats), there is
  - information on the Congressional earmark for neglected diseases; and
  - updates to allowable uses of GH/CS funds under the Other Public Health Threats element, including neglected tropical diseases, antimicrobial resistance containment, and surveillance.

- In Chapter III.7.B (Allowable Uses of Funds for Agency Programming Purposes: Maternal and Child Health: USAID Guidance), there is guidance on allowable uses of funds for maternal health and allowable uses of funds for child health.

- In Chapter III.7.B.a (Allowable Uses of Funds for Agency Programming Purposes: Maternal and Child Health: USAID Guidance: Allowable Uses of Funds for Maternal Health) and Chapter III.8.B.c (Allowable Uses of Funds for Agency Programming Purposes: Family Planning and Reproductive Health: USAID Guidance: Allowable Uses of Family Planning/Reproductive Health Funds for Integrated Family Planning Activities), there is language on integrating gender, including gender-based violence and male involvement, into maternal health and FP/RH programs.

- In Chapter III.7.B.i (Allowable Uses of Funds for Agency Programming Purposes: Maternal and Child Health: USAID Guidance: Allowable Uses of Funds for Maternal Health) and Chapter III.8.B.c (Allowable Uses of Funds for Agency Programming Purposes: Family Planning and Reproductive Health: USAID Guidance: Allowable Uses of Family Planning/Reproductive Health Funds for Integrated Family Planning Activities), there is language on prevention and repair of fistula.

- Chapter III.8 (Allowable Uses of Funds for Agency Programming Purposes: Family Planning and Reproductive Health) now contains a reorganized/merged version of Chapter IV.E (Family Planning/Reproductive Health) and Appendix IV (Guidance on the Definition and Use of Family Planning and Reproductive Health (FP/RH) Funds) of the 2004 Guidance, eliminating redundancies.

- In Chapter III.8.A (Allowable Uses of Funds for Agency Programming Purposes: Family Planning and Reproductive Health: Legal Requirements, Policy Requirements, and Congressional Directives), there is guidance providing a complete listing of legislative and policy requirements, including a new appendix: USAID Family Planning Requirements—Statutory and Policy.

- In Chapter III.8.A (Allowable Uses of Funds for Agency Programming Purposes: Family Planning and Reproductive Health: Legal Requirements, Policy Requirements, and Congressional Directives), there is language on the application of legislative and policy requirements to integrated programs which include both family planning and HIV/AIDS activities.

- In Chapter III.9 (Allowable Uses of Funds for Agency Programming Purposes: Water Supply, Sanitation, and Hygiene), there is guidance on the use of GH/CS funds appropriated to USAID in water programs.

- Language in Chapter III.10 (Allowable Uses of Funds for Agency Programming Purposes: Vulnerable Children) has been reduced and simplified. It also contacts information on the "Assistance for Orphans and Other Vulnerable Children in Developing Countries Act."

- In Chapter III.11.A.a (Allowable Uses of Funds for Agency Programming Purposes: Other: Construction), there is new guidance on when GH/CS funds can be used for construction, including a threshold amount as well as a clarification on the distinction between construction and improvements (additions/renovations).

- There is a section on the use of GH/CS funds appropriated to USAID in Rebuilding Countries. See chapter III.12 (Allowable Uses of Funds for Agency Programming Purposes: Rebuilding Countries).

- In Chapter III.14 (Allowable Uses of Funds for Agency Programming Purposes: Co-Programming), language was added to clarify that operating units should consult with health staff and/or core team leaders when GH/CS funds are used for integrated activities or programmed with funds from other sectors.

- In Chapter IV (Additional Guidance: Procedures for Deviations from the Guidance), the procedures for deviating from the guidance contained within this document have been modified to include a two-phase approach. The first phase involves a technical consultation; the second phase involves approval from the Administrator of USAID and is only required if consensus is not reached during the first phase. A sample template for documenting technical consultations has been added as an appendix.

- APPENDIX III of the 2004 Guidance (Operational Guidelines on the Use of CSH Programs Funds in the Context of Multi-sectoral Programs for HIV/AIDS Activities (includes Annex I, II, and III)) has been removed.

- Emphasis area coding information previously included in Acronyms, Chapter IV.G, and Appendix V in the 2004 Guidance has been removed.

C. Structure of the Guidance

This document consists of four chapters and ten appendices.

- Chapter I defines the purpose and structure of the Guidance and indicates the most significant modifications to the 2004 Guidance.
- Chapter II describes how the budget categories of the GH/CS Account relate to the health elements under the Foreign Assistance Standardized Program Structure, and how the health elements contribute to the goals of the Foreign Assistance Framework.
- Chapter III discusses allowable uses of GH/CS funds within each of the health elements, distinguishing between legal requirements/Congressional directives and USAID guidance. This chapter also addresses areas of special concern, including health systems, health programming in rebuilding countries, administrative/management costs, and co-programming for health activities funded by other non- GH/CS accounts.
- Chapter IV outlines procedures for operating units who wish to deviate from the Guidance.

D. Points of Contact

Direct general questions concerning the overall guidance to the Director of the Bureau for Global Health's (GH's) Strategic Planning, Budgeting, and Operations Office.

II. RELATIONSHIP BETWEEN PROGRAM ELEMENTS AND BUDGET CATEGORIES

A. Appropriate Elements under the Foreign Assistance Framework

The Health Program Area goal: "to contribute to improvements in the health of people, especially women, children, and other vulnerable populations in countries of the developing world, through expansion of basic health services, including family planning; strengthening national health systems, and addressing global issues and special concerns such as HIV/AIDS and other infectious diseases" is primarily supported by activities funded with GH/CS Account funds. Operating Units develop Operational Plans specific to local conditions. Such Operational Plans include activities which are grouped into program elements used for summarizing and reporting on programs. The program elements specific to the health program area are:

3.1.1 HIV/AIDS
3.1.2 Tuberculosis
3.1.3 Malaria
3.1.4 Avian Influenza
3.1.5 Other Public Health Threats
3.1.6 Maternal and Child Health
3.1.7 Family Planning and Reproductive Health
3.1.8 Water Supply and Sanitation

The GH/CS account also includes funding for vulnerable children, which may be programmed in the following elements of the Social Services and Protection for Especially Vulnerable Populations program area:

3.2.1 Vulnerable Children
3.2.5 Host Country Strategic Information Capacity
3.2.6 Program Design and Learning
3.2.7 Administration and Oversight

Program elements are subject to adjustment annually, and are included in the Foreign Assistance Standardized Program Structure and Definitions, available at http://www.state.gov/documents/organization/93447.pdf. The SPS can also be found at: http://inside.usaid.gov/A/F/docs/plan/guidance/s_FAStandardizedProgramStructureandDefinitions-UpdatedforFY2008.pdf.

B. Budget Categories

The FY 2002 House Appropriations Committee Report clearly defined a set of five budget categories within the CSH Programs Fund (now the GH/CS Account) and specifically outlined how CSH funds were to be allocated. The GH/CS Account structure reflects certain directives and expectations of funding levels for specific parts of USAID's health programs. This category structure has been retained annually in Appropriations Acts, including that for 2008. As a matter of policy, the Agency utilizes these categories for all health programs regardless of funding

source. The relationship, or crosswalk, among the elements in the Foreign Assistance Framework and the five budget categories set forth in the FY 2008 Appropriations Act is as follows:

Budget Categories:

- ***Child Survival and Maternal Health,*** which includes the following activities identified by Congress: Primary Causes of Mortality and Morbidity, Polio, Micronutrients, and the Vaccine Fund (associated with GAVI).
  Associated Program Element:
    - **3.1.6 Maternal and Child Health**

- ***Vulnerable Children,*** which includes the following line items: Displaced Children and Orphans Fund (DCOF), Blind Children, and Other Vulnerable Children. Funds are used to support a set of programs designed to address critical needs of children at risk and needs of children in crisis, including orphans, though orphans affected by HIV/AIDS are part of the HIV/AIDS budget category.
  Associated Program Element:
    - **3.3.2 Social Services**

  Associated Program Sub-Elements:
    - **3.3.2.1 Vulnerable Children**
    - **3.3.2.5 Host Country Strategic Information Capacity**
    - **3.3.2.6 Program Design and Learning**
    - **3.3.2.7 Administration and Oversight**

- ***HIV/AIDS.*** The Agency may be required to meet directives for microbicides and the International AIDS Vaccine Initiative (IAVI). The 2006 Conference Report explained that the funds in the Global HIV/AIDS Initiative Account would be used for programs in the 15 AIDS Initiative "focus" countries, and that the funds in the CSH Programs Fund were not appropriated for HIV/AIDS country programs in the focus countries. Rather, the CSH Programs Fund would be used for HIV/AIDS programs in other bilateral countries, regional programs, and central programs.[1] The Conference Report also strongly encouraged the Office of the Global AIDS Coordinator (S/GAC) to "continue its policy of providing additional funding to 'non-focus' countries."
  Associated Program Element:
    - **3.1.1 HIV/AIDS**

- ***Infectious Diseases***, which includes the following activities identified by Congress: tuberculosis, malaria, other infectious diseases, including neglected diseases (e.g., intestinal parasites, schistosomiasis, lymphatic filariasis, onchocerciasis, trachoma, and leprosy), avian influenza, and anti-microbial resistance and surveillance.

[1]The FY 2008 Conference Report reiterates that: "The Appropriations Committees intend this [GH/CS] account to clarify overall United States Federal government spending on global health programs, and in no way is the consolidated health account intended to change the authorities or implementation of global health programs."

Associated Program Elements:

- **3.1.2 Tuberculosis**
- **3.1.3 Malaria**
- **3.1.4 Avian Influenza**
- **3.1.5 Other Public Health Threats**

- ***Family Planning/Reproductive Health*.** There are no specific activities identified by Congress within this budget category. The Agency is encouraged to undertake and implement reproductive health and family planning programs, including in areas where population growth threatens biodiversity and endangered species. Family planning represents the core reproductive health intervention of USAID's FP/RH program and the primary use of FP/RH funds. The Agency is reminded that all USAID-supported family planning programs must be free from coercion of any kind and should offer assistance appropriate to low resource settings to help people in these countries attain their desired family size.

  Associated Program Element:

  - **3.1.7 Family Planning and Reproductive Health**

III. ALLOWABLE USES OF FUNDS FOR AGENCY PROGRAMMING PURPOSES

This chapter describes both legal requirements and Congressional directives, as well as USAID requirements.

All legal requirements are mandatory. Congressional directives in the health sector are also treated as mandatory.

USAID guidance is issued to ensure effective, evidence-based programming, and to increase consistency and predictability of operations. This guidance has been determined based on decades of experience in health programming and represents the best understanding of leading technical experts. Although Operating Units (OUs) should generally follow these practices, there are situations where an OU may wish to deviate from them or adapt them to particular situations, especially when such deviations correspond to the guiding principles of direct impact and optimal use. Please see Chapter IV on the procedures for deviating from USAID requirements.

1. General

A. LEGAL REQUIREMENTS AND CONGRESSIONAL DIRECTIVES

a. Statutory Authorities

Statutory authorities for use of the GH/CS Account are as follows:

- **Authorization Authority:** The GH/CS Account (formerly the CSH Programs Fund and the GHAI Account) is authorized by the Foreign Assistance Act of 1961, as amended, the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (the "PEPFAR Authorization") and the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008 (the "PEPFAR Reauthorization"), including amendments made in the 2000 Global AIDS and Tuberculosis Relief Act and the PEPFAR Authorization. Relevant excerpts are included in Appendix I.

  Appropriation Authority: Funds from the GH/CS Account are appropriated in the annual Appropriations Act for the Department of State, Foreign Operations, and Related Programs. In terms of the scope of the legislation, the FY 2006 Appropriations Act authorized CSH activities by providing "for necessary expenses…for child survival, health, and family planning/reproductive health activities…." The FY 2006 Appropriations Act appropriated the CSH Programs Fund to remain available for obligation until September 30, 2007. Pursuant to Section 511 of the FY 2006 Appropriation Act, Child Survival and Health Programs Funds that were obligated during the initial period of availability may

be de-obligated and re-obligated, without USAID losing the funds, until September 2011.

The 2006 Appropriations Act funded Global HIV/AIDS Initiative activities by providing "for necessary expenses to carry out the provisions of the Foreign Assistance Act of 1961 for the prevention, treatment, and control of, and research on, HIV/AIDS." The FY 2006 Appropriations Act appropriated Global HIV/AIDS Initiative funds to remain available until expended and consequently can be deobligated and reobligated.

In 2007, a Continuing Appropriations Resolution extended full-year continuing appropriations under the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 2006, which made appropriations available through September 30, 2008 under the terms and conditions of the FY 2006 Appropriations Act.

The FY 2008 Appropriations Act created a new account, the Global Health and Child Survival Account, which combines the CSH Programs Fund and the GHAI Account. The FY 2008 Appropriations Act authorizes funding by providing "for necessary expenses…for global health activities…." The Conference Report states that "in no way is the consolidated health account intended to change the authorities or implementation of global health programs." These appropriations are available for obligation through September 30, 2009. The same deobligation/reobligation authority that existed in the FY 2006 Appropriations Act is contained in sec. 611 of the FY 2008 Act.

See Appendix I for excerpts from the FY 2006 Appropriations Act, the FY 2007 Continuing Resolution, the FY 2008 Appropriations Act, the PEPFAR Authorization, the PEPFAR Reauthorization, and relevant Report language for definitions and further elaboration. To ensure compliance, USAID staff should consult the applicable authorization and appropriation legislation each fiscal year as changes may occur.

- **Notwithstanding Authority:** The "notwithstanding" authority in Section 622 of the 2008 Appropriations Act allows USAID to use funds for "child survival activities or disease programs including activities relating to research on, and the prevention, treatment, and control of HIV/AIDS…*notwithstanding any other provisions of law except for the provisions under the heading 'Global Health and Child Survival' and the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003"* as amended. In other words, when required for program efficiency, USAID may carry out activities regardless of country prohibitions or certain procurement regulations, personnel regulations, competitive process standards, or other restrictions that would otherwise prohibit or restrict programming. Please note that utilizing the notwithstanding authority to provide GH/CS Account assistance applies specifically to provisions of law or regulation relevant to that program. The notwithstanding authority, however,

does *not* extend to FP/RH activities. If operating units have questions about certain provisions of law related to activities funded under the GH/CS, they must consult with the regional legal advisor or the Office of the General Counsel (GC) before providing such assistance.

A decision to rely on notwithstanding authority provides USAID legal flexibility, but must be carefully coordinated with appropriate offices in accordance with Agency policy and PEPFAR policy. Operating units must request approval from their relevant Regional Bureau Assistant Administrator, and obtain clearances from the Assistant Administrator of the Bureau for Global Health, the Assistant General Counsel for their Regional Bureau, the F IIP lead, and S/GAC (for HIV/AIDS activities only). F is responsible for tracking operating units that make use of the "notwithstanding" authority

b. Nonproject Assistance

The FY 2008 Appropriations Act directs that "…none of the [GH/CS] funds appropriated under this paragraph [which includes USAID Child Survival and Maternal Health, USAID Vulnerable Children, USAID Infectious Diseases, USAID Family Planning/Reproductive Health and USAID HIV/AIDS] may be made available for nonproject assistance, except that funds may be made available for such assistance for ongoing health activities." One example of such prohibited non-project assistance would be monetary payments to host country governments as part of sector reform efforts without reference to specific activities or results.

B. USAID GUIDANCE

GH/CS funds shall be used only where their direct impact on health objectives and their optimal use provide adequate justification.

- **"Direct impact"** means that the results (outcome/impact) of an activity can be linked and measured (using health elements and health indicators) against the purposes for which the funds supporting the activity were appropriated, as defined in the FY 2008 Appropriations Act and the relevant House, Senate, and Conference Reports and under the health element goal: "To contribute to improvements in the health of people, especially women, children, and other vulnerable populations in countries of the developing world, through expansion of basic health services, including family planning; strengthening national health systems, and addressing global issues and special concerns such as HIV/AIDS and other infectious diseases." Thus, the goal of the activity must include a specific and measurable health impact.

  In addition, the justification for use of GH/CS funds rests solely on the expected health impact of the activity. The impact of an activity on other goals, even those as valuable to development as poverty reduction, economic growth or education, is not relevant in justifying the use of GH/CS funds. While activities in other

sectors are likely to have positive impact on health, the selection of GH/CS-funded activities cannot take into account any impact outside of health.

- **"Optimal use of funds"** refers to the prioritization of the funding of an activity in terms of its effectiveness and efficiency. Activities that produce the greatest impact on the objective should be funded with the GH/CS Account over those that will show a lesser impact. This requires comparing the expected result of a planned activity with the best alternative and should be accompanied by monitoring and reporting on the achievement of those results. Effectiveness implies that there has been some analysis to determine that the proposed use of funds will likely achieve the greatest possible impact with the funding made available. Indicators and measurements exist for the different child survival and health interventions that have been legitimized by the peer reviewed literature, including The Lancet. Efficiency implies that the proposed activity can be implemented in a way that maximizes results relative to inputs. Country factors such as the severity and magnitude of the problem, overall developmental needs, program stage or maturity, relative cost- and program-efficiency of the intervention, and host country and other donor resources help determine optimal use.

The types of activities which are generally funded under the GH/CS Account include, but are not limited to:

- *Direct service delivery*
- *System strengthening in both public and private sectors*
- *Community participation and mobilization*
- *Development of management capacity*
- *Policy analysis and dialogue*
- *Training, quality assurance, and supervision*
- *Information, education, and communication (IEC) activities*
- *Data collection and analysis*
- *Pilot projects and applied research including the development, testing and introduction of new or improved interventions and delivery approaches*
- *Efforts to secure a stable and diversified resource base*
- *Rational management and use of essential drugs/commodities and commodity procurement*
- *Strong, ongoing monitoring and evaluation mechanisms to encourage continuous improvement of the management and quality of programs and systems*

The following sections further define allowable uses of funds in each specific category. If an operating unit needs clarification or has a question about whether an activity falls within these parameters, it may contact the Office Director of GH/SPBO, its Regional Bureau technical officer for health, S/GAC, GC's Regional Legal Advisor, or the IIP lead in F, as appropriate. See Chapter IV for further details and procedures for deviations from the USAID requirements.

2. HIV/AIDS

This budget category corresponds to the element 3.1.1 HIV/AIDS.

Background:
During his 2003 State of the Union Address, President Bush announced the creation of the President's Emergency Plan for AIDS Relief (PEPFAR), a five-year, $15-billion initiative to combat the global HIV/AIDS pandemic. In May 2003, President Bush signed into law the "United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003" (P.L. 108-25, the "PEPFAR Authorization") which authorizes the activities of the Emergency Plan, including efforts in prevention, treatment, and care (including care for orphans and vulnerable children). Under the PEPFAR Authorization and PEPFAR Reauthorization, the U.S. Global AIDS Coordinator has authority to provide "oversight and coordination of all resources and international activities of the United States Government to combat the HIV/AIDS pandemic." During its first five years, the Emergency Plan set goals to support antiretroviral treatment (ART) for two million HIV-infected individuals, prevention of seven million HIV infections, and care for 10 million people infected or affected by HIV/AIDS, including orphans and vulnerable children.

The law was reauthorized by the "Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008" (P.L. 110-293, the "PEPFAR Reauthorization.") President Bush has announced new goals to support ART for at least 3 million people, prevent 12 million HIV infections, and care for 12 million people infected or affected by HIV/AIDS, including 5 million orphans and vulnerable children.

S/GAC provides guidance for HIV/AIDS activities worldwide through guidance documents, including the annual Country Operational Plan (COP) and Mini-COP Guidance, which inform planning by interagency teams at the country level. Key policy documents are available in the appendices to this Guidance. For other questions, please contact the Office Director of GH/OHA.

Allowable activities for HIV/AIDS are those that contribute directly to prevention, care (including care for infected individuals and affected orphans and vulnerable children), and treatment of HIV/AIDS. These goals require a comprehensive, locally tailored approach that engages sufficient community, government, NGO, and donor resources in a consistent and complementary manner. The strategies should reflect the stage of the epidemic and focus efforts on "those most likely to contract or transmit" HIV.

The following guidance is directed to all programs providing HIV/AIDS assistance worldwide.

A. LEGAL REQUIREMENTS AND CONGRESSIONAL DIRECTIVES

a. Prostitution and Sex Trafficking

Section 301 of the PEPFAR Authorization entitled "Assistance to Combat HIV/AIDS" includes certain restrictions on the use of HIV/AIDS funds relating to prostitution and sex trafficking.[2] This provision was left unchanged in the PEPFAR Reauthorization. Specifically, Section 301 (e) prohibits the use of U.S. Government funds for HIV/AIDS activities to promote or advocate the legalization or practice of prostitution or sex trafficking. Section 301 (f) requires non-governmental organizations and certain Public International Organizations[3] receiving U.S. Government funds for HIV/AIDS activities to have a policy explicitly opposing prostitution and sex trafficking.[4] USAID's Acquisition and Assistance Policy Directive (AAPD) 05-04 implements these provisions. Prime recipients of assistance agreements (grants and cooperative agreements) for HIV/AIDS activities must provide a certification before receiving funds that they are in compliance with the applicable standard provisions included in AAPD 05-04. See AAPD 05-04: http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd05_04.pdf. USAID is currently enjoined from enforcing this requirement against certain organizations. You must check with the Office of the General Counsel or the Regional Legal Advisor to obtain current guidance on this policy requirement. AAPDs are revised from time to time. Please make sure that the correct AAPD that implements the provision is being followed, and that the proper clauses are included in all relevant awards for HIV/AIDS activities.

USAID and its implementing partners may work with high-risk groups, such as people engaged in prostitution, as long as PEPFAR funds are not used to "promote or advocate the legalization or practice of prostitution and sex trafficking." The following HIV/AIDS prevention, care, and treatment activities are specifically permitted by the PEPFAR

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[2] Section 301 includes the following provisions:

(e) LIMITATION. – No funds made available to carry out this Act, or any amendment made by this Act, may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and when proven effective, microbicides.

(f) LIMITATION. – No funds made available to carry out this Act, or any amendment made by this Act, may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking.

[3] The FY 04 Appropriations Act amends Section 301(f) of the AIDS Authorization by exempting the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, the International AIDS Vaccine Initiative and any "United Nations agency" from that section. The Statement of Managers states that the conferees "intend that for purposes of this provision, the World Health Organization includes its six regional offices: The Americas (PAHO); South-East Asia (SEARO); Africa (AFRO); Eastern Mediterranean (EMRO); Europe (EURO); and Western Pacific (WPRO)."

[4] This requirement is the subject of ongoing litigation. USAID is enjoined from enforcing this requirement against certain organizations. Please contact your cognizant RLA or GC/EGAT&GH if you have any questions regarding application of this requirement.

Authorization: "provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms and, when proven effective, microbicides." The Agency also supports the provision of other HIV/AIDS prevention activities, such as behavior change communication, to people engaged in prostitution.

b. Condoms

Within the GH/CS Account, HIV/AIDS funds may be used appropriately for purchasing condoms for HIV/AIDS prevention (see Commodity Fund, Chapter III.2.B.j).

The FY 2008 Appropriations Act provides that "information provided about the use of condoms as part of projects or activities that are funded from amounts appropriated by this Act shall be medically accurate and shall include the public health benefits and failure rates of such use." Such information should be consistent with USAID's fact sheet entitled, "USAID: HIV/STI Prevention and Condoms," available at: http://www.usaid.gov/our_work/global_health/aids/TechAreas/prevention/condomfactsheet.html.

c. Conscience Clause

The PEPFAR Authorization permits recipients of HIV/AIDS funds not to endorse, utilize or participate in a prevention method or treatment program to which the organization has a religious or moral objection.

Under section 301(h) of the PEPFAR Reauthorization, "an organization, including a faith-based organization, that is otherwise eligible to receive assistance shall not be required, as a condition of receiving such assistance to endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements… for refusing to meet any [such] requirement."

Clauses implementing these provisions must be included in HIV/AIDS assistance awards and contracts. See Acquisition and Assistance Policy Directive (AAPD) 05-04: http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd05_04.pdf

d. Military, Police, Prisons or other Law Enforcement Agencies

In many HIV high-prevalence countries, military and police populations are known to be high-risk groups that have a direct influence on the HIV transmission dynamics in the general civilian population. With HIV prevalence in some militaries estimated at 40-60 percent, their potential to infect others is enormous. In other countries where that prevalence is not yet high, it is essential to head off such an extreme situation before it occurs. In both cases, failure to include such groups in HIV/AIDS activities will pose a severe threat to the health of the public at large and diminish the likelihood that any HIV/AIDS prevention and mitigation program could succeed. Funds from the GH/CS Account may be used to address HIV/AIDS in military, police, prisons or other law

enforcement agencies, subject to the following guidance. Where possible, U.S. Department of Defense (DoD) HIV/AIDS experts should be consulted and engaged in programs addressing these groups.

1. Assistance to foreign military or to police, prison or other law enforcement personnel that is part of a larger public health initiative. Section 531(e) of the Foreign Assistance Act of 1961, as amended (FAA), and general principles of appropriation law prohibit the use of economic assistance funds for military purposes. In addition, Section 660 of the FAA prohibits training or advice or financial support for police, prisons, or other foreign law enforcement forces. However, GC has determined that these prohibitions will not apply to assistance used only for the prevention, treatment, care and control of, and research on HIV/AIDS in the military or police, prison or other law enforcement personnel, if the following conditions are met:

a) The programs or activities in which the military or police, prison or other law enforcement personnel would participate are part of a larger public health initiative to combat HIV/AIDS, and exclusion of such group would impair the achievement of the initiative's public health objectives;

b) The program for the military or police, prison or other law enforcement personnel must be similar to that received by other population groups similarly situated, in terms of HIV/AIDS transmission risk and prevention; and

c) Neither the program or activities, nor any commodities transferred under the program, can be readily adaptable for military or police, prison or other law enforcement personnel purposes.

GC has emphasized that the requirement for similar programs (b above) means similar in subject content, e.g., how HIV/AIDS is acquired, how it is transmitted, and how transmission can be avoided. As long as the training and materials are designed to deal with such acceptable subjects, they meet the test. It is not required that there be one uniform set of training materials appropriate for use by military and also by the other groups in society, such as younger school children. Clearly the language, content, and method of delivery could and should vary depending on the audience.

The Office of the General Counsel has also advised that it would be appropriate to have particular activities that are directed only toward the military or police, prison or other law enforcement personnel as long as they are designed only to support HIV prevention and combat its transmission. A conference or design workshop attended only by military personnel may be funded for the frank discussion of HIV/AIDS among the military and how to combat it (e.g., an officer's responsibility to see that his subordinates are fully informed and are discouraged from engaging in high-risk behavior or from frequenting known high-risk establishments). Under the same HIV/AIDS country or regional program, a conference for village health workers on avoiding mother-to-child transmission may well exclude military personnel as not being relevant to them. Both, however, are in pursuit of the broader goal and thus appropriate for USAID funding.

Therefore, it is appropriate and legally permissible to include the military, police, prison or other law enforcement personnel in comprehensive HIV/AIDS programs in conformance with the three legal criteria outlined above. Indeed, including those groups may well be critically important to the success of the programs. In the design and implementation of HIV/AIDS programs, it is also appropriate to have training sessions or materials focused specifically on individual groups as long as the activities are in pursuit of the overall program goal. Where possible, DoD HIV/AIDS experts should be consulted and engaged in programs addressing these groups, and in certain contexts with foreign militaries, it may be appropriate for DoD to implement these activities.

2. Notwithstanding authority for assistance to police, prison, or other law enforcement personnel. For HIV/AIDS programs, Section 622 of the FY 2008 Appropriations Act also provides USAID, when required for program efficiency, with "notwithstanding" authority to overcome the prohibition found in Section 660 of the FAA.

In relying on "notwithstanding" authority for this purpose, operating units need to carefully review the facts of any proposed activity to ensure that the activity falls only within the scope of HIV/AIDS activities permitted by this guidance. In addition, for programs with foreign militaries, consideration should be given to the possibility of implementation by DoD. If an operating unit decides to rely on "notwithstanding" authority, the clearance procedures described below must be followed.

Moreover, operating units should be aware that certain activities involving prisoners, as opposed to prison personnel, may not fall within the prohibition of Section 660 at all, and therefore would not require the reliance on "notwithstanding" authority to fund. If in doubt about the applicability of Section 660, contact your Regional Legal Advisor or GC for assistance.

3. Clearances. From a legal standpoint, use of GH/CS Account funds to provide HIV/AIDS assistance that is part of a larger public health initiative to the military or to police, prison or other law enforcement personnel does not require a specific, written request or formal approval if this guidance is followed. However, operating units should be aware that as a policy matter, the approval of Bureaus or Offices in USAID/W might be required before such HIV/AIDS assistance is provided to the military or police, prison or other law enforcement personnel; therefore, Missions are asked to confirm procedures with their Bureaus. Regardless of whether or not formal Bureau or Office clearance is required, operating units must document the decision to include military, police, prison or other law enforcement personnel in HIV/AIDS activities that are part of a larger public health initiative; such documentation should show how the legal criteria discussed above have been applied and how any bureau approval procedures have been followed. If it is a close question, or if there is confusion about applying the three criteria above to determine whether inclusion of the military or police, prison or other law enforcement personnel as part of a larger overall HIV/AIDS program is appropriate or authorized, please contact your regional legal advisor or GC advisors.

Because relying on "notwithstanding" authority to provide assistance to prisons, police, or other law enforcement personnel may raise sensitive policy issues, operating units must request approval from their relevant Regional Bureau Assistant Administrator, and obtain clearances from the Assistant Administrator of the Bureau for Global Health, the Assistant General Counsel for their Regional Bureau and the F IIP lead. F is responsible for tracking operating units that make use of the "notwithstanding" authority.

e. Earmarks and Directives

The FY 2008 Appropriations Act requires that $550 million in GH/CS Account funds appropriated to the Department of State be used for the Global Fund to Fight AIDS, Tuberculosis and Malaria. There are also Congressional directives in the FY 2008 Appropriations Act and the accompanying Conference Report for microbicides.

Under the PEPFAR Reauthorization, of the amounts appropriated for HIV/AIDS assistance, for fiscal years 2009 through 2013, for each fiscal year:

- More than half shall be expended for—
    - antiretroviral treatment for HIV/AIDS;
    - clinical monitoring of HIV-seropositive people not in need of antiretroviral treatment;
    - care for associated opportunistic infections;
    - nutrition and food support for people living with HIV/AIDS; and
    - other essential HIV/AIDS-related medical care for people living with HIV/AIDS; and
- Not less than 10 percent shall be expended for assistance for orphans and other children affected by, or vulnerable to, HIV/AIDS, of which such amount at least 50 percent shall be provided through non-profit, nongovernmental organizations, including faith-based organizations, that implement programs on the community level.

The law requires the Coordinator to "provide balanced funding for sexual transmission prevention activities for sexual transmission of HIV/AIDS," and to "ensure that activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction are implemented and funded in a meaningful and equitable way in the strategy for each host country based on objective epidemiological evidence as to the source of infections and in consultation with the government of each host country involved in HIV/AIDS prevention activities."

The Coordinator is to establish a sexual transmission prevention strategy in each country with a generalized epidemic. If the strategy provides less than 50 percent of funds for "activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction," the Coordinator is required, not later than 30 days after the issuance of this strategy, to report to Congress on the justification for this decision.

Programs or activities that implement or purchase new prevention technologies or modalities, such as medical male circumcision, blood safety, promoting universal precautions, investigating suspected nosocomial infections, pre-exposure pharmaceutical prophylaxis to prevent transmission of HIV, or microbicides and programs and activities

that provide counseling and testing or PMTCT interventions, shall not be included in determining compliance with this requirement.

For further guidance on how countries should expend resources for treatment, care (including orphans and vulnerable children programs), and prevention, see Chapter III.2.B.

B. USAID GUIDANCE

a. Prevention of Sexual Transmission

PEPFAR has adopted interagency guidance on implementation of programs to prevent sexual transmission through the ABC[5] approach in the policy document, "Guidance for USG In-Country Staff and Implementing Partners Applying the ABC Approach to Prevention of Sexually Transmitted HIV Infections Within the President's Emergency Plan for HIV/AIDS Relief," available at: http://www.state.gov/documents/organization/57241.pdf and attached as Appendix II. Like all PEPFAR guidance, the guidance applies to all funding used for HIV activities, including GH/CS (formerly CSH and GHAI), ESF, FSA, AEEB, ACI, or Title II funding.

Sexual Prevention activities supported by PEPFAR include promotion of abstinence, including delay of sexual activity or secondary abstinence, fidelity (including partner reduction, and related social and community norms), the purchase and promotion of condoms, STI management (outside of palliative care settings/context), and messages/programs to reduce risks of persons engaged in high-risk behaviors.

Section 403 of the PEPFAR Reauthorization requires the Coordinator to "provide balanced funding for sexual transmission prevention activities for sexual transmission of HIV/AIDS," and to "ensure that activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction are implemented and funded in a meaningful and equitable way in the strategy for each host country based on objective epidemiological evidence as to the source of infections and in consultation with the government of each host country involved in HIV/AIDS prevention activities."

The Coordinator is to establish a sexual transmission prevention strategy in each country with a generalized epidemic. If the strategy provides less than 50 percent of funds for "activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction," the Coordinator is required, not later than 30 days after the issuance of this strategy, to report to Congress on the justification for this decision.

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[5] The ABC Approach encompasses a range of risk-reduction behaviors, focusing on:

-- Abstinence until marriage, including delay of sexual debut among youth, and "secondary abstinence;"

-- Being faithful within marriage relationships and partner reduction outside of marriage; and

-- Condom use, correct and consistent use for at-risk/non-regular partners and sexually active sero-discordant couples.

For more information, please see the current COP or Mini-COP Guidance.

b. Biomedical Prevention

Biomedical prevention includes activities for blood safety, safe injection, injecting and non-injecting drug users and male circumcision. Programs or activities that implement or purchase new prevention technologies or modalities, such as medical male circumcision, blood safety, promoting universal precautions, investigating suspected nosocomial infections, pre-exposure pharmaceutical prophylaxis to prevent transmission of HIV, or microbicides and programs and activities that provide counseling and testing or PMTCT interventions, shall not be included in determining compliance with the 50% requirement for generalized epidemics cited above.

For more information, please see the current COP or Mini-COP Guidance.

Injecting Drug Users (IDUs)

USAID is committed to supporting effective strategies to prevent the spread of the HIV/AIDS pandemic among IDUs. Consistent with U.S. Government policy, Emergency Plan funding (funds for HIV/AIDS activities, including GH/CS (formerly CSH and GHAI), ESF, FSA, AEEB, and ACI) may not be used to support needle or syringe exchange programs.

Funds for HIV/AIDS activities may support the following:

- Policy activities that encourage countries to remove barriers to medication-assisted treatment for heroin users as an important component of their national HIV/AIDS treatment and prevention plans;

- Formative research and assessments of the contribution of substance use to the HIV epidemic globally;

- Confidential, routine HIV counseling and testing in substance abuse programs;

- Community-based outreach for drug users that addresses HIV prevention, risk reduction, and substance use with links to appropriate care services;

- Prevention education on the risks of injecting drugs and sharing syringes, and education and counseling on how to reduce or stop injecting drugs;

- Programs for prevention of sexual transmission of HIV among IDUs;

- Education of health professionals and policymakers regarding best practices for HIV prevention strategies for substance users;

- HIV treatment or referral to treatment for the HIV-infected IDU in the context of a comprehensive prevention program; and

- Substance abuse treatment programs for HIV-infected individuals, including medication-assisted treatment with methadone, buprenorphine and naltrexone. For those who are HIV-negative, the Emergency Plan can only support these programs on a pilot basis. All medication-assisted substance abuse therapy programs will require prior S/GAC approval.

For further guidance, please see Appendix III: The U.S. President's Emergency Plan for AIDS Relief HIV Prevention among Drug Users Guidance #1: Injection Heroin Use (March 2006). For help with questions, please contact GH/OHA.

Male Circumcision
According to the FY 09 COP and Mini-COP guidance:

> PEPFAR guidance is consistent with the March 2007 WHO/UNAIDS recommendations on male circumcision for HIV prevention. Under the leadership of host country governments, and consistent with local policies and norms, HIV/AIDS funds can now be utilized to support the implementation of safe male circumcision services. In FY 2009, there is no funding limit per country for safe male circumcision services or other safe male circumcision activities. It is critical to ensure appropriate follow-up and treatment of any complications of male circumcision procedures, while continuing to emphasize the importance of comprehensive prevention messages focusing on an ABC approach. Recognizing that male circumcision is not 100 percent protective, it is essential for countries that are incorporating male circumcision service delivery to place it within a comprehensive HIV prevention package. The Male Circumcision task force is available to provide additional support and information as you consider the introduction of this important but challenging prevention intervention.
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> Male circumcision (MC) activities include: feasibility studies and needs assessment activities; communication, training, service delivery and monitoring and evaluation. MC services must be delivered within a comprehensive package of prevention services focusing on an ABC approach, which include provider-initiated and -delivered HIV counseling and testing; active exclusion of symptomatic STIs and syndromic treatment where required; provisional promotion of correct and consistent use of condoms; and counseling on behavior change, including a gender component that addresses male norms and behaviors and sexual violence. Currently MC is NOT recommended for men who are HIV-positive. All male circumcision service delivery sites must include HIV counseling and testing for all patients (the USG follows the WHO MC for HIV prevention recommendations and therefore strongly encourages but does not mandate HIV testing). All MC sites should include links or referrals to HIV care and treatment for HIV-positive men. For countries that are planning MC service

delivery, S/GAC requires a letter from the Minister of Health requesting USG assistance for such work.

For more information, please see the current COP or Mini-COP Guidance.

c. Prevention of Mother-to-Child HIV Transmission (PMTCT)

The 2008 PEPFAR Reauthorization sets a goal of providing access to prevention of mother-to-child transmission interventions to 80 percent of pregnant women in heavily affected countries. In the PEPFAR Reauthorization, Congress has not specified a target amount of funding for PMTCT. Nevertheless, in areas where prevalence is high (exceeding five percent in pregnant women), PMTCT programs are an important gateway to HIV/AIDS and other maternal/child health services. Missions are strongly encouraged to develop PMTCT activities. In order to use GH/CS funds to improve services for pregnant and postpartum women, Missions should be able to demonstrate a direct contribution to increased access to PMTCT services.

PMTCT funds should be used to increase focus on providing access to PMTCT interventions, supporting ART provision for treatment-eligible HIV-positive pregnant women, and collecting and reporting data on the numbers of HIV-positive pregnant women initiating ART while pregnant, which is a required PEPFAR indicator. Ensuring this sub-group of HIV-infected women are appropriately screened and treated will dramatically reduce the risk of HIV transmission to their infants and improve overall maternal health and child survival.

For more information, please see the current COP, Mini-COP, and Technical Consideration Guidance.

d. Orphans and Vulnerable Children Affected by HIV/AIDS

Caring for orphans and vulnerable children is a critical part of PEPFAR's efforts to mitigate the impact of AIDS. In FY 2007, PEPFAR supported over 2.7 million children directly or indirectly, the majority through USAID programs. While this is a substantial number, it still represents just a small portion of the millions more in need. To underline the importance of expanding coverage, the PEPFAR Authorization for FY 06-FY08 (as well as the PEPFAR Reauthorization), stipulate that at least 10% of funds authorized to be appropriated be programmed for OVC. All countries/regions preparing a COP or Mini-COP are required to meet this earmark.

USAID programs with GH/CS funding for OVCs affected by HIV/AIDS may be directed to: (1) community-based efforts that impact on the protection and well-being of orphans and other children and adolescents affected by HIV/AIDS; (2) increasing capacity and systems at local and national levels for program design, implementation, monitoring and evaluation, and for sustaining effective efforts; (3) operations research to identify program models that are effective, efficient and sustainable; and (4) sharing lessons learned with local, national, and global partners.

Pediatric care and treatment are also priorities and should have their own dedicated funds. Funding for pediatric care and pediatric treatment will not be counted towards meeting the OVC budgetary requirement. Programs that have depended on pediatric HIV care activities to help fulfill the10% OVC earmark in the past will need to plan for a reasonable transition in budgeting to ensure care for HIV infected children is not disrupted. In such cases a budget justification should be submitted (a justification template is available on PEPFAR.net). Other justifications, where they make sense, for example where extensive national coverage of OVC services with other donor or host country resources already exist, may also be acceptable. For more information on programming for OVC, please refer to the current COP or Mini-COP guidance, as well as the "Orphans and Other Vulnerable Children Programming Guidance," available at http://www.pepfar.gov/pepfar/guidance/78161.htm.

e. HIV/TB

Tuberculosis (TB) is the leading cause of death among people living with HIV/AIDS. In some countries, up to 80 percent of people living with HIV/AIDS (PLWHA) are co-infected with the organism that causes TB, *Mycobacterium tuberculosis*, and up to 60 percent of people infected with HIV living in sub-Saharan Africa will develop active TB disease. HIV/AIDS is the strongest risk factor for developing active TB, as an HIV-infected individual has a 10 percent chance of developing active TB each year (compared to a 10 percent lifetime risk of developing TB in a non-HIV-infected individual). Diagnosis and treatment of active TB disease and latent TB infection using proven, effective strategies dramatically reduces the morbidity and mortality associated with TB/HIV and are among the most important medical interventions that can be offered to HIV-infected individuals living in high TB-prevalence areas. Individuals co-infected with HIV and TB fall under the Emergency Plan goals to provide care and support for people living with HIV/AIDS.

In countries or areas with a high burden of HIV/AIDS, the prevalence of HIV infection among patients in TB clinical settings is high, and thus patients in TB clinical settings are "high yield" for identification and referral for HIV prevention, care and treatment. TB increases mortality in PLWHA and complicates management of treatment for HIV. With the additional specter of extensively-drug resistant TB emerging among PLWHA both in communities and care settings, TB/HIV activities must be urgently scaled up.

Since TB is the leading infectious killer in people with AIDS, and TB, with proper therapy, is both preventable and curable for most individuals regardless of HIV status, addressing TB among HIV-infected persons is a high priority for HIV/AIDS care programs and may be supported using HIV/AIDS funds. Activities that may be supported include (but are not limited to):

- Screening of HIV-infected individuals (including individuals in PMTCT programs) for symptoms of active TB;
- Support for developing and refining referral systems for HIV-infected individuals to ensure that TB suspects have access to both diagnosis and treatment facilities and that they continue to access HIV care;

- Provision of HIV counseling and testing of all those with active or suspected TB -- either within TB clinics or through referral mechanisms;
- Implementation of the "Three I's" at HIV entry points as priority activities in TB/HIV (isoniazid preventive therapy, intensified TB case-finding, and TB infection control);
- Development of systems to manage HIV/TB co-infected individuals in either integrated treatment and care programs or across multiple health care programs, including reporting systems to monitor the provision of TB/HIV services, TB-program effectiveness and multi-drug resistant TB in HIV-infected individuals;
- Coordinated planning, training and monitoring and evaluation of TB/HIV collaborative activities; and
- Surveillance to measure the rate of TB and HIV co-infection.

TB/HIV collaborative activities are an important component of national level plans for both TB and for HIV/AIDS. Assistance can be provided to help develop these plans and PEPFAR resources for TB/HIV should also support the priorities outlined in these plans.

To maximize the impact USG investments and to avoid duplication, resources and support for TB/HIV activities should be coordinated with programs and funding from other sources including GH/CS funds appropriated to USAID and grants from the Global Fund to Fight AIDS, TB and Malaria. The formation of interagency technical working groups and joint monitoring and technical assistance visits can help to facilitate this coordination.

For further information or guidance, please contact GH/OHA or see the current COP or Mini-COP guidance for PEPFAR.

f. Counseling and Testing

HIV testing is a critical intervention that serves as a linchpin connecting prevention to treatment and care. Knowledge of HIV status is a vital tool for helping individuals learn to avoid behaviors that place them at risk of HIV infection, leading people to protect themselves and others from HIV infection. An emerging priority is the scale up of counseling and testing services that are strategically located to maintain a strong focus on prevention, while also identifying and reaching those individuals most likely to be in need of care and treatment services. In particular, the USG and its partners are supporting the provision of routinely-offered, provider-initiated counseling and testing in clinical and other settings such as STI and TB treatment programs; increasing access to confidential testing and counseling by expanding the range of settings in which services are offered; and encouraging the adoption of policies that prevent stigma, utilize appropriate HIV testing technology, and support the uptake and availability of counseling and testing services. Programs that support HIV testing and counseling should simultaneously consider strategies for the care, support, and treatment of HIV-positive persons identified through these testing activities, by establishing functional referral systems, and the prevention needs of HIV-negative persons so identified.

According to the FY 09 COP and Mini-COP guidance, "Counseling and testing includes activities in which both HIV counseling and testing are provided for those who seek to

know their HIV status (as in traditional VCT) or provider initiated counseling and testing." For more information, please see the current COP or Mini-COP Guidance.

g. Human Resources for Health

Human resources for health (HRH) are critical for a functioning health system. Effective health systems depend on a trained and motivated health workforce that can carry out the tasks and build the systems needed to achieve PEPFAR goals. These tasks include: HRH strategy development and workforce planning; human resource information systems; pre-service and in-service training and training for task-shifting; performance assessments; retention strategies; twinning and volunteers; management and leadership development; and support for salaries.

Questions often arise regarding support for long-term training and the use of USG funds to pay salaries of staff in government facilities, or to pay salary supplements. The following guidance is pursuant to S/GAC's "Support for Host Government Staffing: PEPFAR Guidance (8/16/06)" and the FY 2009 Country Operational Plan Guidance.

<u>Long-term training</u>

PEPFAR funds may be used to support long-term training of health professionals such as medical doctors, nurses, pharmacists, medical social workers; auxiliary workers or "associate professionals" such as clinical officers, assistant or general nurses, and laboratory and pharmacy technicians; advanced degrees in disciplines such as public health, public administration, epidemiology, and pharmacology.

Long-term training may be supported within certain parameters:

- For each PEPFAR country operational plan, other bilateral program, or operating unit, no more than 3.0 percent of annual HIV/AIDS budget levels or $6,000,000 per year (whichever is less) may be used to support long-term training;

- The types of personnel eligible for long-term training are only those who are directly involved in HIV/AIDS service delivery or program management support;

- All personnel should have a requirement to serve in areas of need and to deliver HIV/AIDS services upon completion of their program; and

- A strong monitoring and evaluation component should be included in order demonstrate the linkage to improved access to quality HIV/AIDS services.

Countries are encouraged to look at innovative approaches that leverage other resources from different donors, e.g., support the proportion of training that is HIV/AIDS-specific and ask other donors to support the remainder.

Salaries

USAID *shall not* pay for salaries of permanent civil service employees on public health institution payrolls. However, HIV/AIDS funds may be used by USG program contractors or grantees to pay for time-limited contractors to carry out activities essential to HIV/AIDS program goals. In addition, NGOs may hire personnel to be placed in the Ministry or other government health facilities or in their own organizations. USAID, through its contractors, already pays for staff seconded to the Ministry of Health (MOH). USG teams and their implementing partners are urged to be cautious about paying salaries or other benefits that attract staff away from their current positions in local public and private agencies. In all cases, countries should develop a transition plan to ensure that contract staff can eventually be absorbed through sustainable long-term approaches using non-USG resources.

Payment of salary supplements, or "top-ups", to host government employees is not permitted. However, it is permissible to pay bonuses or incentives to personnel (public or private sector) that meet performance-based criteria that are directly linked to achieving HIV/AIDS goals, e.g., working overtime to increase patient access or achieving quality performance targets above and beyond routine job requirements. Any performance-based financing scheme should first be implemented on a pilot basis and include monitoring and evaluation and reporting of results achieved as well as any broader impacts on service delivery. Successful models of performance-based health programs that can be applied to HIV/AIDS service delivery already exist in a number of countries.

In addition, there are a number of ways to motivate health care providers to stay on their jobs that do not involve financial-incentive schemes. HIV/AIDS funds may be used to support a number of these including:

- ART for health care providers and their families;
- housing support in rural areas;
- Providing basic infection-prevention supplies to reduce fear of HIV infection;
- Improving morale and empowerment through continuing education courses, supportive supervision, and in-house support groups;
- Placing a human resource professional at service facilities to plan for ART scale-up, ensure a workplace prevention program, develop a training plan, and rework job descriptions to reflect current responsibilities for HIV/AIDS service providers; and
- Establishing better linkages with community groups that provide care for HIV/AIDS patients at home.

For further information or guidance, please contact GH/OHA or see the current COP or Mini-COP guidance for PEPFAR.

h. Microbicide Research and Development for HIV/AIDS Prevention

In the Conference Report accompanying the FY 2008 Appropriations Act, Congress directed that $45 million in GH/CS funds appropriated to USAID shall be used for

microbicides. USAID/W anticipates funding microbicide efforts through central agreements. Examples of activities include the following:

- Supporting the discovery, development, and preclinical evaluation of topical microbicides (alone and/or in combination with each other or with condoms);
- Developing and assessing acceptable formulations and modes of delivery for microbicides; bridging knowledge and applications from the chemical, pharmaceutical, physical, bioengineering, and social sciences;
- Conducting clinical studies of candidate microbicides to assess safety, effectiveness, and acceptability in reducing sexual transmission of HIV and/or other STIs in diverse populations in international and domestic settings;
- Conducting basic and applied behavioral and social science research to enhance microbicide development, testing, acceptability, and use domestically and internationally; and
- Establishing and maintaining the appropriate infrastructure (including training) needed to conduct microbicide research domestically and internationally.

Missions may be asked for advice by USAID/W on local policies (such as HIV-testing policies) and assistance in coordinating HIV/AIDS prevention, care, and treatment program activities with clinical trial activities.

i. Vaccine Research for HIV/AIDS

USAID/W funds vaccine research efforts through IAVI. USAID/W will fund research and development, including clinical trials, through central agreements. Examples of activities include: vaccine research and development including clinical trials; training of personnel in good clinical practices; preparing communities for vaccine trials; training for developing country journalists; policy efforts to encourage national governments to establish practical and effective public policies for accelerating HIV/AIDS vaccine development and testing; and policy efforts to ensure that once a vaccine is developed it is widely accessible in as short a time as possible.

Missions may be asked for advice by USAID/W on local policies and assistance in coordinating HIV/AIDS program activities with clinical trial activities.

j. Commodity Fund (CF)

Condom availability and use in most countries is inadequate, especially for those most at risk. The Commodity Fund (CF) helps fill this important gap. The fund will centrally fund condoms for HIV prevention and ensure their expedited delivery to countries. The fund is intended to increase condom availability and use by making condoms for HIV prevention free of charge to other bilateral programs, subject to resource availability and program need, as elaborated below. It is expected that these condoms will be additive to country programs in an effort to expand HIV/AIDS activities and that Missions will not swap condom provision responsibilities with other donors such that availability and use remain unchanged.

Missions in other bilateral programs can request male and female condoms for free from the CF.

Focus countries will need to budget and pay for the male and female condoms they need and will not be eligible to obtain them free of charge from the CF. Countries that submit COPs or mini-COPs are required to include male and female condoms as an activity/budget line item in their COPs. Focus countries are expected to use USAID's centralized procurement mechanism (Central Contraceptive Procurement Project, 936-3057) for all condom procurement.

If a Mission has an insufficient CF level or funding constraints and limited options for obtaining needed condoms, please consult GH/PRH/CSL. There may be some flexibility on a country-by-country basis to assist in a limited way, on an emergency basis. For focus countries, these expenses must be reimbursed to USAID/GH with GH/CS funds appropriated to the State Department.[6] Missions should not reduce orders based on funding constraints without first corresponding GH/PRH/CSL about program needs and possible assistance.

Both focus countries and missions in other bilateral programs should follow the same ordering procedures as in prior years. Detailed ordering guidance has been sent separately to Missions.

For clarification on condoms, the HIV/AIDS budget category shall not be used for the purchase of contraceptives *for family planning only* nor used to make up for shortfalls in the FP/RH category activities or in any other program. However, within the GH/CS Account, HIV/AIDS budget category funds may be appropriately used for purchasing condoms *for HIV/AIDS prevention*.

k. Commodities

HIV/AIDS commodities (condoms, HIV test kits, and drugs) are critical for prevention, diagnosis, and treatment of opportunistic and sexually transmitted infections, including HIV/AIDS. The GH/CS Account may be used for commodity procurement for HIV/AIDS. Operating units are encouraged, if possible, to use GH/CS funds and other USAID resources to *leverage and mobilize* other donor/local resources in order to help meet the enormous needs worldwide.

[6] This is based on language from the FY 2006 Conference Report, which specifies that, "[a]gain this year, no funding for HIV/AIDS programs in the 15 Emergency Plan for AIDS Relief 'focus' countries is appropriated in [this CSH] account. Funding for the 'focus' countries is appropriated under the heading 'Global HIV/AIDS Initiative,'" as well as language in the FY 2008 Conference Report which reiterates that: "The Appropriations Committees intend this [GH/CS] account to clarify overall United States Federal government spending on global health programs, and in no way is the consolidated health account intended to change the authorities or implementation of global health programs."

Please consult the most recent annual Country Operational Plan Guidance issued by S/GAC for information about the use of HIV/AIDS funds for family planning commodities.

l. Partnership for Supply Chain Management System (SCMS)

Funded by the PEPFAR, SCMS brings together 16 private sector, nongovernmental, and faith-based organizations under one contract to procure essential medicines and supplies at affordable prices; help strengthen and build reliable, secure and sustainable supply chain systems; and foster coordination of key stakeholders. The contract with the Partnership for Supply Chain Management (PSCMS) is unique, because PSCMS services and expertise are available to USG agencies, foreign governments, USG-financed contractors, grantees, and other organizations doing HIV/AIDS work. Country teams are encouraged to use PSCMS because of the efficiency of centralized procurement and its expertise in supply chain management.

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

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

If you have questions, please contact the USAID Supply Chain Management team, More information about PSCMS is available at http://scms.pfscm.org/scms. Please also see the current COP or Mini-COP guidance for PEPFAR.

m. Working Capital Fund

The HIV/AIDS Working Capital Fund (WCF) is a Congressionally-authorized account that facilitates the procurement of HIV/AIDS commodities. Funds deposited into the WCF become no-year funds and are co-mingled with other funds. This gives the agency the flexibility to shift funds within the WCF to respond to changes in country needs to ensure protection against stock-outs and to meet a other program needs.
GH/OHA/SCMS manages the WCF and it is primarily used to fund the Supply Chain Management System project and its principal contractor, the Partnership for Supply Chain Management. While the WCF is principally funded through the COP process,

field support and MARRD funds can also be deposited into the WCF. The WCF can also accept funds from other agencies and other public and private entities.

n. Adult and Pediatric Care and Treatment

According to the FY09 COP and Mini-COP Guidance:

Adult Care and Treatment comprises all facility-based and home/community-based activities for HIV-infected adults and their families (HIV-affected individuals) aimed at extending and optimizing quality of life for HIV-infected individuals from the time of diagnosis throughout the continuum of illness, through provision of clinical, psychological, social, spiritual, and prevention services. Clinical services should include antiretroviral therapy, prevention and treatment of opportunistic infections (OIs) (excluding TB), a preventative care package 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. Psychological and spiritual support may include group and individual counseling and culturally-appropriate end-of-life care and bereavement services. Social support may include vocational training, income-generating activities, social and legal protection, and training and support of caregivers. Prevention services may include "prevention for positives," behavioral counseling, and counseling and testing of family members. Adult Care and Treatment also includes the purchase, distribution, and management of OI drugs, excluding TB drugs.

The Office of the Global AIDS Coordinator has issued guidance on palliative care called, "HIV/AIDS Palliative Care Guidance #1 for the United States Government in Country Staff and Implementing Partners," attached as Appendix IV.

Pediatric care and treatment programs should address linkages with PMTCT, efforts to rapidly scale up early infant diagnosis through dry-blood spot/DNA PCR laboratory networks, training of healthcare workers in the provision of pediatric care and treatment, and other key aspects of pediatric care and treatment. Pediatric care and treatment programs comprise all health facility-based activities for HIV exposed and HIV-infected children (<2 years and 2-14 years) and their families (HIV-affected individuals) aimed at extending and optimizing quality of life for HIV-infected children from the time of diagnosis throughout the continuum of illness, through provision of clinical, psychological, social, spiritual and prevention services. Clinical services should include early infant diagnosis, appropriate counseling and testing for at-risk children and adolescents, antiretroviral therapy, prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide treated nets, safe water interventions and related laboratory services), pain and symptom relief, and nutritional assessment and support. A key component of clinical services is provision of the Preventive Care Package for children. Other services – psychological, social, spiritual and prevention services – should be provided as appropriate. These services are provided within programs for orphans and vulnerable children (OVC) and clinic based partners should make linkages to OVC services and service providers to ensure the continuum of care for

these children. Pediatric Care and Treatment also includes the purchase, distribution, and management of OI drugs, excluding TB drugs. Readers are referred to Appendix IV, HIV/AIDS Preventive Care Guidance, which includes two sections, one regarding programming for adults, and the other regarding programming for children ages 0-14.

For more information, please also see the current COP or Mini-COP Guidance.

o. Injection Safety

HIV transmission in the health care setting can occur through unsafe injection practices that put both patients and providers at risk. Congress has strongly recommended that HIV/AIDS funds be used to support initiatives in the focus countries to reduce the spread of HIV in health care settings by making medical injections safe. S/GAC assigned this activity to be implemented by both the Centers for Disease Control and Prevention (CDC) and USAID. Beginning in FY 2004, through HIV/AIDS funds approved by S/GAC, USAID/W has provided central funding for medical injection safety activities. Activities include rapid assessments of current injection practices; training programs and systems to improve provider skills; improved commodity security; procurement and management of safe-injection supplies and equipment; better treatment guidelines that emphasize oral medications where appropriate; strengthened health care waste management systems, especially for sharps; improved knowledge about injection safety and advocacy to reduce inappropriate demand for injections; and the development and implementation of national injection-safety plans and policies. Where needed, Missions should consider safe-injection program elements along these lines.

p. Health Systems Strengthening

Health systems strengthening is an important foundation for ensuring sustainability of service provision and other HIV/AIDS services and interventions. HIV/AIDS programs need to be supported by systems that develop and implement sound policies, provide pharmaceuticals and laboratory services, finance health services, assure quality and efficiency of care, manage the health workforce, and provide the required information to operate effectively.

- To address weaknesses in host-country leadership and management that make HIV/AIDS services less effective and waste resources, funds may be used for broad policy reform and system wide approaches and for making management processes more transparent and accountable. Examples include improving donor coordination and strengthening local partner organizations, particularly in financial and program management, policy development and leadership.

- Where financial systems are not adequate to reveal funding deficiencies for HIV/AIDS programs, funds may be used to improve planning-unit approaches to the allocation of resources. Examples include conducting focused expenditure reviews for HIV/AIDS in order to provide policymakers with a clearer understanding of the current strengths and weaknesses of financial arrangements for priority areas.

- Where weaknesses in pharmaceutical management limit access to treatment, funds may be used to support strengthening the capacity of host government institutions to develop policies and plan, manage and implement HIV programs, including national procurement, logistics, and pharmacovigilance systems to ensure the quality, safety and rational use of medicines such that desired therapeutic outcomes are achieved.

- Where weaknesses in information limit the availability and use of reliable and timely information for evidence-based HIV/AIDS policy making and program management, funds may be used to support the collection, analysis, dissemination, and use of reliable and timely information. Examples include support to the development and use of harmonized core indicators for program planning, monitoring and evaluation; strengthening the quality of data sources, such as service records; addressing constraints to the use of information for program management; and implementing evaluations to assess the impact of program interventions.

- Where there is an inadequate number of HIV/AIDS human resources, funds may be used to support innovative recruitment and retention schemes. Examples include assessing health worker productivity and motivation.

Interventions in the following areas may also be supported with health systems strengthening funds:

- Strengthening leadership and the policy environment to reduce stigma and discrimination including addressing key gender issues;
- Support for construction and renovation, subject to the guidance contained in Chapter III.11 on Health Systems and Capacity Strengthening.
- Strengthening leadership and policy environment to expand access to HIV care and treatment services for children and documenting any positive outcomes from previous years' investments in this area (e.g., new policy or guidelines, new legislation, etc.);
- Strengthening the GFATM management structure.

For more information, please refer to the most current COP or Mini-COP guidance. Please also see Chapter III.11 on Health Systems and Capacity Strengthening.

q. Gender

PEPFAR recognizes that gender norms and inequalities help fuel the epidemic and its impact, and need to be considered in a successful response. The issues around gender and HIV/AIDS are complex, and can vary from one country to another; however, addressing these challenges successfully is critical to the achievement of PEPFAR's prevention, treatment, and care goals.

PEPFAR employs a two-pronged approach: 1) gender mainstreaming into all prevention, care, and treatment programs, and 2) programming to address five cross-cutting gender

strategic areas: Increasing gender equity in HIV/AIDS activities and services; Reducing violence and coercion; Addressing male norms and behaviors; Increasing women's legal protection; and Increasing women's access to income and productive resources.

Illustrative activities include (but are not limited to) interventions to:

- work with communities, men and women to transform traditional gender norms that perpetuate gender-based violence, sanction cross-generational and transactional sex, and promote multiple sex partners;
- address barriers to women's and men's access to quality PMTCT, counseling and testing, and care and treatment services, including adherence to treatment;
- increase couple communication and men's constructive involvement as supportive partners;
- provide counseling that considers fear of negative outcomes, such as violence, on disclosure of HIV status, and as a deterrent to testing and to accessing services;
- support family-centered care where appropriate;
- promote non-stigmatizing support networks for women infected and affected by HIV/AIDS;
- address the unequal burden of care on mothers/wives and other female household members; and
- ensure inheritance and property rights for women and access to productive resources, e.g., linking income-generation and microfinance as "wraparound" interventions with care and support activities.

Activities should include collection of sex-disaggregated data and/or build the capacity of data systems to enable collection of sex-disaggregated data. For additional guidance on activities per program area and five gender strategic areas, please see the most current COP and Mini-COP guidance. Please contact PEPFAR gender technical working group members in OHA for further information and assistance.

r. Support to the Global Fund to Fight AIDS, Tuberculosis and Malaria

The FY 2008 Appropriations Act requires that $545.545 million in GH/CS Account funds appropriated to the Department of State be used for the Global Fund to Fight AIDS, Tuberculosis and Malaria. The U.S. Government is the largest bilateral donor to the Global Fund with more than $3.3 billion in contributions to date. Over seven grant rounds, the Global Fund Board has approved $10.8 billion for more than 550 grants in 136 countries. In order to ensure the most successful implementation of these grants, Mission staff should participate in Country Coordinating Mechanisms (CCMs) and work closely with Global Fund Principal Recipients (PRs) and sub-recipients (SRs) where possible. In August 2007, GH/OHA awarded a Global Fund technical assistance contract – later named Grant Management Solutions (GMS) – to Management Sciences for Health (MSH) and partners. Global Fund PRs and CCMs in almost all countries are eligible to apply for technical assistance in organizational development, program and financial management, procurement and supply management, and monitoring and evaluation. Missions also are encouraged to use their GH/CS funds to support technical assistance to Global Fund grants where appropriate. The USAID Global Fund Liaison and S/GAC's Multilateral Diplomacy staff can answer questions about Global Fund policies and

procedures as well as USAID and U.S. Government policies and procedures regarding the Global Fund.

s. Integrated Family Planning and HIV/AIDS Activities

S/GAC has issued guidance on the use of HIV/AIDS funds in integrated family planning and HIV/AIDS activities. Please consult the most recent annual Country Operational Plan Guidance issued by S/GAC for information about this subject.

3. Tuberculosis

This budget category corresponds to the element 3.1.2 Tuberculosis.

Background:

Globally, TB is one of the leading causes of death due to infectious diseases, and kills about 1.6 million people each year, primarily in the developing world. TB is a major cause of morbidity, is economically devastating to families and communities worldwide, and remains the leading cause of death among people living with HIV/AIDS in sub-Saharan Africa. USAID plays an essential global leadership role in international TB control. USAID's programs support implementation of the STOP TB strategy, building on directly observed therapy, short-course (DOTS) as the key set of interventions to reduce transmission of TB and slow the emergence of drug resistant TB.

USAID's goal is to detect at least 70 percent of estimated TB cases and to successfully treat at least 85 percent of those detected cases in USAID focus countries by 2011. By 2015, USAID's goal is to reduce by 50 percent the number of deaths due to TB in USAID focus countries. These goals are fully consistent with the STOP TB Partnership's Global Plan to STOP TB 2006 – 2015.

Allowable activities are those that contribute directly to improving the rates of case detection and treatment success. These include DOTS expansion and enhancement; engagement of all public and private providers in DOTS; improvement in the management of TB/HIV co-infection; diagnosis and treatment of multi-drug resistant (MDR) TB and extensively drug resistant (XDR) TB; care and support for people with TB (such as community participation in TB care and engagement of persons affected by TB); development of new tools; operations research to improve program performance and assess impact; monitoring and evaluation; health systems components; support for GFATM grants addressing TB; human resource development; drug and laboratory commodity management strengthening; advocacy, communication and social mobilization; and engagement of civil society in TB activities.

A. LEGAL REQUIREMENTS AND CONGRESSIONAL DIRECTIVES

a. TB in Prisons

1. Assistance that is part of a larger public health initiative.

Section 660 of the FAA prohibits training or advice or financial support for police, prisons, or other foreign law enforcement forces. However, GC has determined that these prohibitions will not apply to assistance used only for DOTS anti-tuberculosis programs in prisons for law enforcement forces, if the following conditions are met:

a) The programs or activities in which the law enforcement personnel would participate are part of a larger public health initiative to combat tuberculosis, and exclusion of such group would impair the achievement of the initiative's public health objectives;
b) The program for the law enforcement personnel must be similar to that received by other population groups similarly situated, in terms of tuberculosis transmission risk and prevention; and
c) Neither the program or activities, nor any commodities transferred under the program, can be readily adaptable for law enforcement personnel purposes.

GC has emphasized that the requirement for similar programs (b above) means similar in subject content, e.g., how tuberculosis is acquired, how it is transmitted, and how transmission can be avoided. As long as the training and materials are designed to deal with such acceptable subjects, they meet the test. It is not required that there be one uniform set of training materials appropriate for use by law enforcement personnel and also by the other groups in society, such as younger school children. Clearly the language, content, and method of delivery could and should vary depending on the audience.

The Office of the General Counsel has also advised that it would be appropriate to have particular activities that are directed only toward the law enforcement personnel as long as they are designed only to support TB prevention and combat its transmission. A conference or design workshop attended only by law enforcement personnel may be funded for the frank discussion of TB among the law enforcement personnel and how to combat it (e.g., an officer's responsibility to see that his subordinates are fully informed). Under the same anti-tuberculosis country or regional program, a conference for village health workers may well exclude law enforcement personnel as not being relevant to them. Both, however, are in pursuit of the broader goal and thus appropriate for USAID funding.

Therefore, it is appropriate and legally permissible to include law enforcement personnel in comprehensive DOTS anti-tuberculosis programs in conformance with the three legal criteria outlined above. Indeed, including those groups may well be critically important to the success of the programs. In the design and implementation of DOTS anti-

tuberculosis programs, it is also appropriate to have training sessions or materials focused specifically on individual groups as long as the activities are in pursuit of the overall program goal.

2. Notwithstanding authority.

Section 622 of the FY 2008 Appropriations Act provides USAID, when required for program efficiency, with "notwithstanding" authority for disease programs to overcome the prohibition on providing training or advice or financial support for police, prisons, or other foreign law enforcement forces found in Section 660 of the Foreign Assistance Act of 1961, as amended (FAA).

In relying on "notwithstanding" authority for DOTS anti-tuberculosis programs in prisons for law enforcement forces, operating units need to carefully review the facts of any proposed activity to ensure that the activity falls only within the scope of TB activities permitted by this guidance. If an operating unit decides to rely on "notwithstanding" authority, the clearance procedures described below must be followed.

3. Clearances.

From a legal standpoint, use of GH/CS Account funds to fund DOTS anti-tuberculosis programs in prisons for law enforcement forces that is part of a larger public health initiative does not require a specific, written request or formal approval if this guidance is followed. However, operating units should be aware that as a policy matter, the approval of Bureaus or Offices in USAID/W might be required before such TB assistance is provided to the law enforcement personnel; therefore, Missions are asked to confirm procedures with their Bureaus. Regardless of whether or not formal Bureau or Office clearance is required, operating units must document the decision to include law enforcement personnel in TB activities that are part of a larger public health initiative; such documentation should show how the legal criteria discussed above have been applied and how any bureau approval procedures have been followed. If it is a close question, please contact your regional legal advisor or GC advisors.

Because relying on "notwithstanding" authority to provide assistance for a DOTS program in prisons for law enforcement forces may raise sensitive policy or legal issues, operating units must request approval from their relevant Regional Bureau Assistant Administrator, and obtain clearances from the Assistant Administrator of the Bureau for Global Health, the Assistant General Counsel for their Regional Bureau and the F IIP lead. F is responsible for tracking operating units that make use of the "notwithstanding" authority.

B. USAID GUIDANCE

Missions may use funding in the TB element to support activities in any or all of the areas described below. Missions may also support activities that strengthen TB and DOTS implementation within overall health system strengthening. USAID's strategy

also emphasizes expanding the involvement of private providers and PVOs/NGOs in DOTS implementation.

Link to five-year plans of National TB Programs (NTPs) – NTP five-year plans that are consistent with the STOP TB Partnership Global Plan to STOP TB 2006 – 2015 and with the STOP TB Strategy should serve as the basis for planning for USAID assistance. USAID can help to develop these plans, and USAID assistance should support the priorities outlined in these plans. In implementing TB programs, it is critically important that Missions coordinate with the National TB Program in-country to identify the most important role for USAID.

Technical interventions of the STOP TB strategy – USAID programs support implementation of the STOP TB Strategy. The six key elements of the STOP TB Strategy are summarized below and are also available at the following web site:
http://www.stoptb.org/resource_center/assets/documents/The_Stop_TB_Strategy_Final.pdf

1) Pursue high-quality DOTS expansion and enhancement:
    i) Political commitment with increased and sustained financing: linked to long-term strategic plans prepared by NTPs which include technical and financial requirements, promote accountability, and where appropriate, are backed up by national legislation.
    ii) Case detection through quality-assured bacteriology:
        (1) expansion of sputum smear microscopy;
        (2) expansion of capacity for culture and drug susceptibility testing;
        (3) internal and external quality assurance for laboratories;
        (4) strengthening the performance of the laboratory network through regular training, supervision, monitoring and evaluation;
        (5) national laboratory guidelines and standard operating procedures aligned with international guidelines, including biosafety measures;
        (6) decentralization of diagnostic services;
        (7) organization and management of the laboratory network, including laboratory commodities.
    iii) Standardized treatment, with supervision and patient support:
        (1) for all adult and pediatric TB cases (including sputum smear positive, negative, and extra-pulmonary cases);
        (2) treatment support may be based in health facility, workplace, community, or at home;
        (3) measures to identify and address barriers to accessing TB treatment services, such as expanded treatment outlets in poor rural and poor urban settings, addressing of gender issues, and improvement of staff attitudes;
        (4) adherence counseling and use of enablers to promote patient adherence.
    iv) Effective drug supply and management system:
        (1) drug selection, product quality assurance, procurement, and distribution;
        (2) use of fixed dose combinations, and packaging, such as patient kits to improve logistics, drug administration, and adherence.
    v) Monitoring and evaluation systems, and impact measurement:
        (1) standardized recording of patient data;

(2) training staff in the analysis and interpretation of data, as well as the use of electronic recording systems, to improve data quality and data sharing between peripheral and central TB levels.

2) Address TB/HIV, MDR-TB, XDR-TB, and other challenges:
   i) Implement collaborative TB/HIV activities, such as:
      (1) creation of national joint TB/HIV coordinating body
      (2) development and implementation of a joint national plan, policies and guidelines
      (3) HIV testing of TB patients
      (4) HIV surveillance among TB patients
      (5) monitoring and evaluation of TB/HIV activities
      (6) referral system between HIV and TB services
      (7) infection control measures in health care and congregate settings
      (8) provision of co-trimoxazole preventive therapy to TB patients with HIV infection
   ii) Prevent and control multi-drug resistant TB (MDR) and extensively resistant (XDR) TB:
      (1) needs assessment to determine capacity of TB program to manage drug-resistant TB
      (2) assurance of quality-assured first- and/or second-line anti-TB drugs
      (3) measures to promote adherence to treatment by patients and to its proper provision by health care providers
      (4) infection control measures in health care and congregate settings
      (5) expanded culture and drug sensitivity testing
      (6) drug resistance surveys
      (7) development and implementation of MDR and XDR guidelines, treatment regimens, and policies
   iii) Address prisoners, refugees, and other high-risk groups and special situations, including:
      (1) Identifying risk groups, such as displaced people, orphaned and homeless, ethnic minorities, marginalized groups, substance abuse victims, victims of unexpected population movements due to political unrest, war, natural disasters
      (2) Assessing problems faced and defining strategies to ensure access to high–quality TB services

3) Contribute to health system strengthening
   i) efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems
   ii) human resource development for TB control – pre-service and in-service training; curriculum development and training materials; and human resource information to track deployment, rotation, and trained staff; and institutional capacity building to strengthen national or sub-regional training institutions
   iii) application of innovations that strengthen TB control, including the Practical Approach to Lung Health
   iv) adaptation of innovations from other fields (e.g., primary care outreach in MCH programs, social mobilization, use of regulatory actions, financing initiatives to reach the poorest, cooperation with broader information platforms and surveys)

4) Engage all care providers (including informal and formal providers, including public sector health providers outside of the MOH, nongovernmental and private providers such as village doctors, drug sellers, private medical providers, health insurance organizations, general and private hospitals):
    i) piloting and scaling up approaches based on public-public and public-private mix (PPM)
    ii) support for implementation of the International Standards of TB Care to enhance support for TB control efforts, including among professional medical and nursing organizations and academic institutions

5) Empower people with TB and affected communities:
    i) advocacy, communication and social mobilization to increase support and demand for TB services
    ii) community participation in TB care
    iii) patient's charter for TB care

6) Enable and promote research:
    i) operational research to assess and/or improve program performance and delivery of TB services
    ii) development and dissemination of tools (such as improved laboratory techniques or improved treatment regimens)
    iii) development of new drugs, diagnostics, and vaccines

In addition to supporting implementation of the STOP TB Strategy described above, funding in the TB element may be used to provide technical assistance to ensure the success of Global Fund to Fight AIDS, TB and Malaria (GFATM) TB grants, including:

- development of quality proposals to the GFATM;
- building technical, administrative and organizational capacity of Country Coordinating Mechanisms and Principal Recipients; and
- development of implementation, procurement, supply management, and monitoring and evaluation plans for GFATM grants.

4. Malaria

This budget category corresponds to the element 3.1.3 Malaria.

A. USAID GUIDANCE

USAID's malaria prevention program is designed to improve malaria prevention, control, and treatment.

The December 23, 2005 executive message from the Administrator on the President's Malaria Initiative defined the rules and requirements for all allocations and for the use of all USAID malaria funding – for programs that are directly part of the President's Malaria Initiative (PMI) as well as those outside of the PMI. These rules and requirements are significantly different from those in the past. This notice in its entirety

is included in Appendix VI. The notice has been incorporated into the ADS and the provisions continue to apply to FY 2008 funds for malaria. The following summarizes the elements in the notice related to budgeting and funding:

1. The Agency's Malaria Coordinator will:
- Approve all malaria allocations and malaria staffing
- Approve all malaria-related acquisition and assistance plans

2. In FY 2006, 40 percent of USAID's non-directed malaria funding was designated for commodities, and 25 percent was designated for indoor residual spraying (IRS). The FY 2006 allocations for malaria for each Mission and operating unit included directives for commodities and IRS. Missions and other operating units are required to meet these marks.

3. Budgets were set centrally by F following recommendations of the Malaria Coordinator. Approval from the Malaria Coordinator is required for any change in budgets or to shift funding between sub-elements.

4. No country malaria program or regionally-managed country program will be funded at less than $1.5 million annually. This has been addressed in the FY 2006 country and regional program allocation.

5. All operating units are required to submit reports as requested to the new malaria data management system. To meet Congressional reporting requirements for FY 2006, Missions will also be required to respond to queries every 90 days on allocations of FY 2006 malaria funding.

6. For PMI countries, the PMI website, www.fightingmalaria.gov, will include all procurement documents funded under the PMI. GH is responsible for managing this process, but PMI countries are required to submit all procurement documents (after redaction by the contractor/grantee).

7. No Agency malaria funds are allowed to fund non-malaria activities, including cross-cutting programs or initiatives, "taxes" to cover non-malaria costs or common costs, or any other mechanism, regardless of past practice, without the express consent of the Malaria Coordinator.[7]

8. In substance, interventions that malaria funds may be used for include:
- Prevention of malaria including increased access to and use of insecticide-treated bednets and indoor residual spraying;

[7] This would not preclude the use of malaria funds for common costs or cross-cutting programs allowable under Objective 6 (See Section III. 13).

- Improved use of effective drugs for treatment of malaria, reduction of the emergence and spread of drug resistant strains, and improved recognition, diagnosis and treatment of malaria;
- Improved prevention and management of malaria in pregnancy through the scale-up of intermittent preventive treatment; and
- Some limited research and development of new approaches/technologies for preventing, diagnosing and treating malaria.

5. Avian Influenza

This budget category corresponds to the element 3.1.4 Avian Influenza.

A. USAID GUIDANCE

In an Executive Message dated September 26, 2005, attached as Appendix VII, the USAID Administrator announced that crafting an effective response to avian influenza (AI) was a priority for all Missions and posts worldwide, given the health and development ramifications of H5N1 AI outbreaks and its potential to spark a human influenza pandemic. USAID is an essential partner in a cross-USG effort to combat AI. A multi-sector AI Unit, housed in GH, coordinates all USAID AI planning, budgeting, and programming. The AI Unit serves as USAID's central coordinating body for all USAID supported activities and as the primary management unit coordinating all operational field activities with those of other USG departments and agencies as outlined in the U.S. *National Strategy for Pandemic Influenza: Implementation Plan*. In addressing AI, USAID operating units are asked to be flexible and prepared to respond to sudden priority shifts within countries if/when outbreaks occur in either animal or human populations. Operating units are also asked to work within existing central mechanisms to respond to dynamic and highly fluid circumstances that surround the spread of AI as much as possible. USAID's primary programmatic focus for AI is to limit the potential for the emergence of a human influenza pandemic by containing the virus in animals, limiting human exposure to infected animals, minimizing the number of human AI cases, and ensuring adequate and appropriate response to a pandemic should it occur. To accomplish these objectives USAID's AI activities focus on five key areas: planning and preparedness, animal and human surveillance, animal and human response, behavior change communication and messaging for increased public awareness, and stockpiling of essential commodities.

The following summarizes the elements in the Agency notice dated November 3, 2005, attached as Appendix VIII, related to budgeting and funding. This notice has been incorporated into the ADS and applies to FY 2008 funding as well:

1. All AI allocations and all AI-related implementation plans must be reviewed and approved by the Deputy Director of the AI Unit.

2. In the FY 2006 Supplemental Appropriations Act, $161 million was appropriated for AI: $75.3 million of CSH funds for programmatic activities, and $56 million of

international disaster and famine assistance (IDFA) funds designated for international and regional stockpiling of essential commodities (personal protective equipment, disinfectant, sprayers, etc). The FY 2007 Supplemental Appropriations Act included $161 million in CSH funds for AI. The FY 2008 Appropriation included $115 million for AI. All funding is notified by GH/HIDN-AI.

3. The use of Agency funds to purchase antivirals or human influenza vaccines (including Tamiflu, the brand name, FDA-approved antiviral medication produced by Roche) is prohibited, pursuant to the General Notice issued by the Administrator, "Interim Budgetary Guidance for Reprogramming of Funds for Urgent Avian Influenza Related Activities," dated November 3, 2005, and attached as Appendix VIII.

4. Missions are allowed and encouraged to be creative and to consider existing platforms, including central mechanisms as much as possible, for AI efforts. Missions are allowed to reprogram funds for AI related activities, but this should only be done after careful discussions with the Regional Bureau and the AI Unit[8]. Reprogramming efforts (the funding of AI activities with non-CD/AI funds) must first be approved by the AI Unit for technical merit as well as budgetary compliance. Missions should submit requests to the AI Unit through regional bureau AI points of contact. The AI Unit will consider the request and make a 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. Final approval for reprogramming rests with the Director of Foreign Assistance, within the approved reprogramming guidelines. Missions and regions will not be reimbursed for reprogrammed funds.

5. 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. The data collection will be conducted 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.

6. No Agency AI funds are allowed to fund non-AI activities, including cross-cutting programs or initiatives, "taxes" to cover non-AI costs or common costs, or any other mechanism, regardless of past practice, without consent of the AI Unit.[9]

7. In substance, AI interventions include:
- Planning and Preparedness, including establishing and strengthening in-country working groups, and designing/updating and testing national multi-sector AI and pandemic plans;
- Animal and Human Surveillance, including enhancing in-country laboratory capacity, linking animal and human surveillance activities, strengthening regular

[8] For FY 07 and FY 08, F clearance is required to move funds into or out of any health or education element.

[9] This would not preclude the use of AI funds for common costs or cross-cutting programs allowable under Objective 6 (See Section III. 13).

monitoring for AI and reporting of suspected outbreaks/cases, strengthening information channels and reporting pathways, supporting early-warning networks, tracking the movement of AI in birds, and identifying key risk factors for disease transmission*;*

- Animal and Human Response, including establishing, training and supporting rapid response teams for animal and human outbreaks; providing support for collection and transport of samples to laboratories; increasing access to appropriate diagnostic capacity; assisting with implementation of appropriate containment measures during outbreaks; promoting safe culling and disposal procedures and improved bio-security practices in outbreak settings; and deploying and distributing essential commodities;
- Communications and messaging, including mobilizing communication networks, designing AI-specific communication strategies, conducting research on key populations and practices for improved and targeted outreach, broadcasting AI awareness and behavior change messages, and ensuring quality and coordinated messages are being released; and
- Stockpiling of essential commodities, including determining and procuring essential commodities, deployment strategies, establishing release triggers for mobilizing deployment of stockpiled commodities, and stockpile replenishment.

On May 3, 2006, the Administrator approved an Action Memorandum entitled "Expedited Acquisition and Assistance Procedures for Activities and Programs Related to USAID's Avian Influenza Pandemic Emergency Preparedness and Response Efforts," dated April 27, 2006. The Action Memorandum was extended for 12 months until May 3, 2008. M/OAA has promulgated AAPD 06-06 to disseminate and implement the Action Memorandum.

The original approved recommendations and associated determinations and findings related to this AAPD provided for:

1) One-year Authorization to Initiate Activities prior to Completion and Approval of a Strategic Plan. The waiver of the (ADS 201.3.4.5) requirement that obligations always be covered by an existing approved strategic objective is no longer required because all of AI's strategic objectives are already in place under the Foreign Assistance Strategic Framework.
2) Grants and Cooperative Agreements—Authorization for Other than Fully Competitive Procedures. This was included in the extension.
3) Procurement of Goods and Services—Authorization for Other Than Full and Open Competition. This was included in the extension.
4) Source, Origin, and Nationality Blanket Waiver for Goods and Services, including Vehicles and Pharmaceuticals. This was included in the extension.

6. Other Public Health Threats

This budget category corresponds to the element 3.1.5 Other Public Health Threats (OPHT).

A. LEGAL REQUIREMENTS AND CONGRESSIONAL DIRECTIVES

Earmarks and Directives: The FY 2008 Appropriations Act contains a $15-million earmark for neglected tropical diseases (NTDs). This funding has been centrally allocated within the Global Health Bureau budget. The earmark for NTDs mandates an integrated approach to the management of NTDs that can be controlled through mass drug administration. Missions with overlapping NTD disease burdens (i.e., at least 3 diseases) that want to support the integration of mass drug administration may buy into the NTD control project managed by Research Triangle Institute. Otherwise, funds to support the control of any NTDs are appropriately planned under this element but will not count toward the congressional earmark.

B. USAID GUIDANCE

The Other Public Health Threats (OPHT) element provides an umbrella for activities targeting several key areas in the prevention and management of infectious diseases. Specifically, this element supports activities that address neglected tropical diseases (NTDs) and other infectious diseases that are not captured elsewhere in the framework (e.g., dengue, cholera, Japanese encephalitis, leprosy). This element also supports critical cross-cutting work related to the containment of anti-microbial resistance (AMR), surveillance, and epidemiology. This element is not designed to absorb entire budgets for health systems strengthening activities. Funding for health systems strengthening activities should be attributed across the elements, including but not exclusively OPHT.

Other Public Health Threats funding may be used to support the following areas of work:

a. Neglected tropical diseases and other infectious diseases of major public health importance

Missions may use OPHT funds to address other infectious disease issues, provided they are of significant public health importance for the country, and there is a clear role for USAID. This includes activities that control and reduce the burden of neglected tropical diseases (e.g., onchocerciasis, schistosomiasis, soil-transmitted helminthes, lymphatic filariasis, trachoma, etc.) and other infectious diseases of public health importance (e.g., Japanese encephalitis, dengue hemorrhagic fever, etc.), including effective and wide-scale drug treatment and other proven interventions. On February 20, 2008, President Bush announced a five-year, $350 million initiative to provide integrated treatment to control and eliminate the burden of neglected tropical diseases in Africa, Asia, and Latin America. The Presidential Initiative will target the following seven neglected tropical diseases through mass drug administration: lymphatic filariasis (elephantiasis); schistosomiasis (snail fever); trachoma (eye infection); onchocerciasis (river blindness); and three soil-transmitted helminthes (hookworm, roundworm, and whipworm).

b. Antimicrobial Resistance (AMR) Containment

Activities funded under the directive for reducing antimicrobial resistance, may include (but are not limited to):

- interventions designed to "preserve the effectiveness of currently available antimicrobials," including educational activities such as formal and continuing

education (pre- and in-service training, seminars and workshops for health professionals);
- curricular development involving concepts of AMR and rational use of antimicrobials;
- development of printed and other media-based materials (clinical literature, newsletters, radio and TV spots, flyers, videos) and face-to-face approaches for practitioner and public awareness on appropriate treatment-seeking behavior, self-medication and adherence to recommended therapy;
- other behavior change and communication strategies;
- establishment of drug information centers to provide accurate, up-to-date and unbiased drug information/materials;
- support for global and regional AMR advocacy and containment networks and country-level approaches;
- managerial activities involving the design and implementation of standard tools to promote rational medicine selection, procurement and use such as formularies, pharmacoeconomics, limited procurement lists, standard diagnostic and treatment guidelines, and drug utilization reviews;
- promotion of proven approaches to facilitate effective uptake of new treatment technologies and practices;
- Drugs and Therapeutics Committees;
- infection control programs;
- efforts to develop pharmaceutical management capacity and appropriate financing and incentive schemes for improved access to and use of medicines; and
- regulatory activities such as strengthening regulatory authority capacity, quality control laboratories and quality assurance mechanisms such as drug registration and surveillance systems to detect counterfeit and substandard medicines.

AMR containment activities specific to disease control areas highlighted elsewhere in the framework (e.g., TB, malaria, avian influenza, HIV/AIDS) should be included in their respective elements, not within the OPHT element.

c. Surveillance

Surveillance and Collection and use of health information to respond to endemic and epidemic infectious diseases:

Activities funding under the directive for surveillance and response may include (but are not limited to):
- Strengthening epidemiological surveillance and response capacity by improving collaborating partnerships;
- Improve the use of surveillance and health data to respond to disease threats and improve programs;
- Expanding capacity building including training and improved laboratory capacity, including performance in diagnostic techniques for new and re-emerging pathogens; and

- Development and use of improved tools, including rapid diagnostics, policy tools, data gathering tools, and strengthened field epidemiology capacity and the understanding of disease patterns and trends.

Surveillance activities need not be limited to antimicrobial resistance, tuberculosis, or malaria, and are encouraged to cover a wider range of infectious disease or public health surveillance issues. However, surveillance activities specific to disease control areas highlighted elsewhere in the framework (e.g., TB, malaria, avian influenza, HIV/AIDS) should be included in their respective elements, not within the OPHT element.

d. Non-communicable public health threats

GH/CS funds may not be used for non-communicable public health threats.

7. Maternal and Child Health

This budget category corresponds to the element 3.1.6 Maternal and Child Health.

A. LEGAL REQUIREMENTS AND CONGRESSIONAL DIRECTIVES

Earmarks and Directives: In the FY 2008 Appropriations Act and the accompanying Conference, House, and Senate Reports, Congress has established specific funding levels for the GAVI Fund, polio, micronutrients, and iodine deficiency disorder. For further guidance on recommended uses of the funds within each of these directives, please see Chapter III.7.B immediately below.

B. USAID GUIDANCE

a. Allowable Uses of Funds for Maternal Health

Allowable activities using funds for maternal health include those that contribute directly to the element 3.1.6 Maternal and Child Health. Specifically, maternal health and survival activities are primarily directed to adolescent girls and women of reproductive age and are centered on eight related areas:

- *Increasing access to and use of quality maternal and reproductive health interventions at community, family, and individual levels,* through educational preparation for childbearing; encouraging healthy behaviors and access to related health services; and modification of services to become more available, culturally appropriate, and effective.

- *Improving maternal nutritional status throughout the reproductive life-cycle* through nutrition education and appropriate micronutrient interventions, including iron folate and vitamin A supplementation, and other communications interventions to improve variety and amount of food consumption.

- *Strengthening preparation for birth,* including antenatal care; planning for a clean and safe delivery attended by a skilled, professional attendant; preventing, detecting, and treating infections including tetanus, intestinal parasites, syphilis, malaria,

HIV/sexually transmitted infections (STIs), and others; recognition and treatment of complications; and planning for transport.

- *Promoting safe delivery and postpartum care*, including use of the partogram, clean delivery, active management of the third stage of labor, and elimination of harmful practices; recognition, referral, and treatment of maternal and newborn complications; postpartum and neonatal care that includes identification and treatment of complications; and postpartum and neonatal preventive care, including counseling on proper rest, nutrition, breastfeeding, hygiene, and child spacing. (Child spacing is limited, as in the past, to those activities in which child spacing efforts are conducted as a part of a larger maternal health and child survival effort with the objective of improving maternal health and reducing infant and child mortality; no contraceptives may be purchased with MCH funds—see below).

- *Improving management and treatment of life-threatening obstetrical complications* including providing information to family and community members on complications of pregnancy and provision of obstetric first aid; communication and emergency transport; and timely, high quality care for obstetric and newborn complications by skilled, professional providers.

- *Providing care for women who suffer from long term disability as a result of pregnancy and birth*, including repair and rehabilitation of obstetric fistula and treatment of anemia. Activities for preventing and repairing fistula may include: 1) repair, 2) prevention, 3) reintegration, and 4) monitoring and evaluation and research. The fistula program should be funded with a combination of funds from both the MCH and FP elements. A typical distribution of funds within a comprehensive fistula program would include 70 percent of funding from the 3.1.6 Maternal and Child Health element and 30 percent of funding from the 3.1.7 Family Planning and Reproductive Health element. FP funds should be focused on community-based prevention and post-repair counseling, while MCH funds should focus on obstetric prevention and repairs. Activities to prevent the occurrence of fistula may include supporting family planning to prevent unintended pregnancies, delaying marriage and first birth, and increasing community awareness of danger signs in pregnancy and delivery.

- *Improving long-term capacity and systems of local institutions to provide quality maternal health care*, including diagnostic assessments; improved health policies; standard treatment guidelines; use of data for decision-making processes; quantification, costing, and rational management of commodities and services; sustainable maternal health financing arrangements such as prepayment schemes, franchising, insurance and targeted subsidies; improved capacity and use of health sector personnel and financial resources; and enhanced monitoring, evaluation, and quality improvement systems.

- *Improving Gender Relationships*: Interventions to transform traditional gender norms that limit women and men's access to maternal health information and services,

including community mobilization and behavior-change interventions seeking to improve couple communication and increase constructive male involvement in maternal health counseling and decision-making, and to prevent or mitigate gender-based violence as related to maternal health and to give women a greater role in care and care-seeking for themselves and their newborns.

b. Allowable Uses of Funds for Child Survival

Allowable activities for this category are those that make a direct impact on improving infant/child health and nutrition and reducing infant/child mortality. Specific interventions include the following:

Expanding access to and use of key child health interventions that primarily focus on the prevention, treatment, and control of primary childhood diseases, such as diarrhea, acute respiratory disease, malnutrition, malaria (in general, malaria-related activities are supported with malaria funding), vaccine-preventable diseases, and diseases and conditions affecting the newborn. Interventions directed toward these areas are the core of USAID's child survival program.

Enhancing the quality, availability, and sustainability of key child health interventions through activities that improve planning, organization, and management of health systems and services; increase promotion and delivery of key interventions by communities; build in-country capacity; promote private sector service delivery; improve the use of health sector financial resources; enhance the availability and appropriate use of health commodities; and promote positive health policies.

Addressing child malnutrition and improving nutritional status through promotion of general child nutrition via nutrition policy improvement; support and promotion of breastfeeding; growth monitoring and promotion; young child nutrition; community therapeutic care; and prevention of nutritional deficiencies in children, especially through delivery of micronutrients.

Developing, testing, and replicating priority environmental health interventions to prevent the spread of childhood disease due to environmental factors, such as improving household-level water supply and sanitation, promoting good hygiene behavior, and controlling vector-borne diseases that represent important threats to children's survival, health, or nutrition.

c. Special Considerations for Maternal and Child Health: Other Funding Considerations

i. Polio Eradication Activities

In the Conference Report accompanying the FY 2008 Appropriations Act, Congress recommended that $32 million in USAID Child Survival and Maternal Health funds be used for polio; the 653(a) agreement reflects this recommendation. USAID has joined

forces with other international, bilateral, and national efforts to eradicate polio. Intensive efforts are underway to interrupt virus transmission in endemic countries, maintain immunity in polio-free areas, and establish or maintain certification-standard surveillance in all countries. Polio directive funds must be used to directly support polio eradication activities, the primary purpose of the funding. In addition, a governing principle of USAID's polio strategy is to contribute to the eradication of polio in a way that strengthens health systems, particularly for the delivery of polio vaccines. Accordingly, polio directive funds may be used to support the following polio eradication interventions:

- Developing effective partnerships to support polio eradication and vaccination (e.g., interagency coordinating committees; nongovernmental organization (NGO) participation);
- Strengthening immunization delivery systems as a secondary impact of investments in polio eradication (e.g., cold chain, communications, supervision);
- Improving timely planning, implementation and monitoring of supplemental polio immunizations (e.g. micro-planning, training, independent monitors);
- Improving acute flaccid paralysis surveillance and response (e.g., facility and community-based surveillance and laboratory diagnosis, Expert Review Committees);
- Supporting certification, containment, and post-certification policy development; and
- Improving timely dissemination and use of information to continuously improve the quality of polio eradication activities.

Missions should contact the USAID Polio Eradication Coordinator to jointly determine how best to program polio funds to assure specific activities are allowable under the directive and to maximize the impact of these funds towards achieving the polio eradication goals.

ii. Micronutrient Activities

In the House and Senate Reports accompanying the FY 2008 Appropriations Act, Congress recommends that $30 million in USAID Child Survival and Maternal Health funds be used for micronutrients. The Conference Report provides $20 million for vitamin A deficiency. Reducing child and maternal morbidity and mortality can be achieved through improved micronutrient status. Interventions that may be funded with the micronutrient directive funds include food supplementation, fortification, and dietary improvement. Expanded delivery of vitamin A is central to USAID's micronutrient strategy because of its demonstrated cost effectiveness, relative to other proven child survival interventions, to reduce illness and deaths due to measles, diarrhea, and other common childhood infections. In countries or regional areas where vitamin A deficiency is prevalent, operating units are strongly encouraged to incorporate vitamin A capsule delivery as a key element of their child survival programs. Other important micronutrient interventions are those that address iron, zinc, and iodine deficiencies. Micronutrient activities may be linked to and integrated within other nutrition, health, and agricultural activities, but the focus should be on *direct measurable (and reportable) impact* on specific micronutrient deficiencies. Micronutrient funds may be used for breastfeeding and similar child nutrition activities to the extent that the impact of these activities on

reducing micronutrient deficiencies is clear. Generally, no more than 20 percent of these integrated programs should be supported from micronutrient funds.

iii. GAVI

In the FY 2008 Appropriations Act, Congress directed that $72.5 million in USAID Child Survival and Maternal Health funds should be used for the GAVI Fund. Funds for GAVI are managed by the Bureau of Global Health through a pooled funding mechanism which purchases vaccines and provides funding to countries to support immunization and health system strengthening.

iv. Prohibition on Purchase of Contraceptives

USAID Child Survival and Maternal Health funds should not be used for the purchase of contraceptives, including condoms, nor used to make up for shortfalls in FP/RH funding or in any other program. Child spacing activities are limited to those education and service activities in which child spacing efforts are conducted as part of a larger maternal health and child survival effort with the objective of improving maternal health and reducing infant and child mortality. Programs designed to provide contraceptives for integrated Child Survival / Family Planning / Reproductive Health programs should use FP/RH funds for those appropriate portions of their programs. Language from the FY 2002 House Report clearly defines the parameters of use for CS/MH funds and FP/RH funds (see Appendix I).

v. Child Survival Grant Program

Allowable uses of Child Survival/Maternal Health directive funds include the Child Survival Grants Program, which is intended to enhance the participation of private voluntary organizations (PVOs) in implementing programs related to all of the health-related elements and to strengthen their organizational, managerial, and technical competencies in these areas. Though centrally administered, Missions have the opportunity for input during the review of all U.S. PVO applications submitted to GH for funding. GH is responsible for programming and reporting these activities.

8. Family Planning and Reproductive Health (FP/RH)

This budget category corresponds to the element 3.1.7 Family Planning and Reproductive Health.

Background

USAID is a leader among international donors in creating and sustaining the conditions necessary for individuals to access safe, voluntary, and high quality family planning information and services. Consensus-based agreements negotiated at international conferences have highlighted the strong linkages among women's position in society, small family size, and women and children's health and well-being. As these agreements reaffirmed, family planning is a key component of reproductive health care.

Family planning represents the core of USAID's FP/RH program and the primary use of FP/RH funds. A family planning program should serve the objective of creating the necessary conditions for women and men to have the number and spacing of children that they desire. Such a program must be free of coercion of any kind and should offer assistance appropriate to low resource settings to help individuals and couples attain their ideal family size.

Key family planning and reproductive health outcomes for FP/RH funds include, but are not limited to: correct, voluntary use of contraceptive methods; healthy spacing of births; reduction of unmet need and total fertility rate; increased age at sexual debut and age at birth of first child; and prevention of abortion as a method of fertility regulation.

Allowable activities for this category are those that make a direct measurable impact in the reduction of unintended pregnancies and contribute to the optimal use of funds. Direct impact means the activity directly reduces unplanned pregnancies and other risks to reproductive health, while maintaining family planning as the core focus. Optimal use of funds means the activity is the most effective, cost- and program-efficient way to reach significant, critical populations with FP/RH information and services and reflects USAID's comparative advantages within the local context. Programs in family planning and reproductive health will: expand access to high-quality, voluntary, family planning services and information; expand access to reproductive health care to reduce unintended pregnancy; promote healthy reproductive behaviors of men and women; reduce abortion; and reduce maternal and child mortality and morbidity, as noted in the Joint State/USAID Strategic Plan. Operating units are strongly encouraged to review applicable legislation and Agency guidelines before programming this program element.

Innovations to promote family planning information and services as part of a broader package of reproductive health care are crucial to fulfilling USAID's continuing commitment to reproductive health, and are encouraged. However, due to the integrated nature of some FP/RH programs, questions often arise about the requirements of joint funding from other program elements within the health program area or from other program areas or accounts. Please see Chapter III.14 on Co-Programming.

A. LEGAL REQUIREMENTS, POLICY REQUIREMENTS, AND CONGRESSIONAL DIRECTIVES

a. Authority

USAID's FP/RH Program is authorized by the Foreign Assistance Act (FAA) of 1961, as amended.[10] Restrictions on the use of FP/RH funds for FP/RH-related activities are clearly outlined in current legislation and policy, and continue to govern programming within the family planning/reproductive health element.

b. Legislative Requirements on the Use of FP/RH Funds

USAID supports the freedom of individuals to choose voluntarily the number and spacing of their children through family planning. Since its inception, USAID's FP/RH program has helped effect the conditions that make it possible for individuals to exercise this fundamental freedom. USAID places highest priority on ensuring that its FP/RH activities adhere to the principles of free choice in deciding whether and how to practice family planning (*"voluntarism")* and *informed choice*. The Agency considers an individual's decision to use a specific method of family planning or to use any method of family planning as being *voluntary* if it is based upon the exercise of free choice and is not obtained by any special inducements or any element of force, fraud, deceit, duress or other forms of coercion or misrepresentation. USAID defines *informed choice* to include effective access to information on family planning choices and to the counseling, services, and supplies needed to help individuals choose to obtain or decline services, to seek, obtain, and follow up on a referral, or simply to consider the matter further.

Through legislated requirements, presidential policy, and its own policies and practices, USAID has taken special measures to protect individuals against potential abuses and coercion in family planning programs. References to each of these legislative and policy requirements are included in a chart entitled: "USAID Family Planning Requirements," attached as Appendix IX. The following legislative and policy requirements are also generally reflected in the standard provisions of USAID awards for family planning. See ADS 303 for the latest provisions for assistance awards and CIB 99-06 for the latest provisions for contracts.

- *Tiahrt*: The principles of voluntarism and informed choice are codified in the Tiahrt Amendment, which requires that USAID-assisted family planning projects meet certain standards of voluntarism. The Tiahrt Amendment was first included in the FY 1999 Appropriations Act, and has been included each year thereafter. Under the Tiahrt Amendment, voluntary family planning projects receiving

[10] Section 104 (b) of the FAA of 1961, as amended, states that "In order to increase the opportunities and motivation for family planning and to reduce the rate of population growth, the President is authorized to furnish assistance, on such terms and conditions as he may determine, for voluntary population planning. In addition to the provision of family planning information and services, including also information and services which relate to and support natural family planning methods, and the conduct of directly relevant demographic research, population planning programs shall emphasize motivation for small families."

family planning assistance from USAID (including in the form of funds, commodities, technical assistance, or training) must meet five requirements:

- Service providers or referral agents in the project must not implement or be subject to targets or quotas of number of births, number family planning "acceptors," or "acceptors" of specific family planning methods.
- The project must not pay incentives, bribes, gratuities, or financial rewards to (1) individuals in exchange for becoming a family planning "acceptor," or (2) program personnel for achieving family planning targets.
- The project must not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, because an individual decides not to accept family planning services.
- Projects must provide comprehensible information to "acceptors" about the health benefits and risks, inadvisabilities, and adverse side effects of the family planning method chosen.
- Experimental contraceptives can only be provided in the context of a scientific study in which participants are advised of potential risks and benefits.

- *DeConcini Amendment*: Family planning funds may only be available to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services.

- *Livingston-Obey Amendment*: In awarding grants for natural family planning under section 104 of the Foreign Assistance Act of 1961 no applicant shall be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning, and all applicants must comply with the aforementioned DeConcini Amendment and Tiahrt Amendment.

- *Helms Amendment:* USAID funds may not be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions. Under the Leahy Amendment, the term "motivate," as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.

- *Biden Amendment*: USAID funds may not be used to pay for any biomedical research that relates in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning. Epidemiological or descriptive research to assess the incidence, extent or consequences of abortions is not covered by the amendment and is therefore permitted.

- *Kemp-Kasten Amendment*: USAID funds may not be made available to any organization or program that, as determined by the President of the United States,[11] supports or participates in the management of a program of coercive abortion or involuntary sterilization. The FY 2008 Appropriations Act provides that a determination made under the Kemp-Kasten Amendment must be made no later than six months after the date of enactment of the Appropriations Act, and must be accompanied by a comprehensive analysis as well as the complete evidence and criteria utilized to make the determination.

- *Siljander Amendment*: USAID funds may not be used to lobby for or against abortion.

- *Additional provision relating to voluntary sterilization*: USAID funds may not be used to pay for the performance of involuntary sterilizations as a method of family planning, or to coerce or provide any financial incentive to any person to undergo sterilization.

c. Policy Requirements on the Use of FP/RH Funds

- *Post-abortion Care:* USAID FP/RH funds may be used to support post-abortion care activities, regardless of whether the abortion was legally or illegally obtained. However, no USAID funds may be used to purchase or distribute manual vacuum aspiration (MVA) kits for any purpose. Foreign NGOs may also perform and promote post-abortion care without affecting their eligibility to receive USAID assistance for family planning/reproductive health.

- *Policy Determination-3* (PD-3): In 1982, USAID issued a policy paper on population assistance, which clearly states its commitment to voluntarism in the provision of family planning services. The Population Policy of 1982, in Annex PD-3, includes specific requirements for USAID-supported programs that include voluntary sterilization. These requirements cover informed consent, ready access to other methods, and guidelines on incentive payments, which affect payments to acceptors, providers, or referral agents. The requirements of PD-3 are implemented in conjunction with the Tiahrt requirements. Further requirements that apply to voluntary sterilization include documentation of informed consent.

B. USAID GUIDANCE

Allowable Uses of Funds for Family Planning/Reproductive Health

a. Allowable Uses of FP/RH Funds for Family Planning Activities

The vast majority of FP/RH-designated funds should be used to support family planning activities, primarily through family planning information and services, including

[11] This authority has been delegated to the Secretary of State and the USAID Administrator.

integration into other reproductive health or general health activities. USAID's approach to family planning includes the following allowable activities:

- *Expanding access to and use of family planning information and services,* including partnerships with the commercial sector (taking care to avoid the appearance of USG favoring one recipient over another) and faith- and community-based organizations; policy development to encourage a favorable environment for providing family planning information and services; support for mass media and other kinds of public information initiatives; and initiatives focused on underserved populations and in areas where population growth threatens biodiversity or endangered species.

- *Supporting the purchase and supply of contraceptives and related materials*, including the purchase of contraceptive commodities and related equipment, and commodity and logistics support. In the case of condom procurement, one must consider the purpose for which the condoms are to be used (HIV/AIDS or STI prevention versus pregnancy prevention) in determining the proper source of funds for their purchase (HIV/AIDS and/or FP/RH funds).

- *Enhancing quality of family planning information and services,* including interpersonal communications: training and human resource management; quality assurance; incorporation of a gender approach into family planning programs, for example, by training providers to identify signs of gender-based violence that should be addressed as part of family planning counseling; record-keeping; and monitoring and evaluation.

- *Increasing awareness of family planning information and services*, including behavior change communications, encompassing interpersonal communications, mass media, and promotion of community involvement with special attention to raising awareness about family planning information and services and social marketing of contraceptive products.

- *Expanding options for fertility regulation and the organization of family planning information and services*, including research to develop and introduce new options for expanding contraceptive choice; and social science research to improve the organization and quality of family planning information and services. Note that FP/RH funds may be used to pay for operations research activities that include broader health or non-health components or linkages provided that the objective of the study is to improve family planning and related reproductive health activities.

- *Integrating family planning information and services into other health activities,* including communications, awareness-raising, and training activities that weave family planning messages into related themes, such as responsible behavior, limiting sexual partners, abstinence, delay of marriage, child spacing, well-baby care, parenting skills, and breastfeeding. Integrated activities can produce

economies of scale and synergistic benefits for both activities. The costs of adding family planning to another health program may be paid for with FP/RH-designated funds alone.

- *Assisting individuals and couples who are having difficulty conceiving children* by providing information and services appropriate for low resource settings. Appropriate activities for low resource settings include those aimed at increasing awareness and knowledge of the fertile period.

b. Allowable Uses of FP/RH Funds for FP/RH System Strengthening Activities

FP/RH system strengthening activities include the following:

- *Fostering the conditions necessary to expand and institutionalize family planning information and services,* including building national and local level support for family planning; strengthening of management systems, including information systems, human resources, supervision, training, and financial systems; and leadership training and development.

- *Contributing to the sustainability of family planning information and services,* including initiatives with the commercial sector and health and social insurance programs to leverage private resources for family planning; mobilization of public sector resources to finance family planning information and services; measures to ensure reliable supplies of contraceptives; and policy and program actions to maximize the positive effects of health reform on family planning services.

c. Allowable Uses of FP/RH Funds for Integrated Family Planning Activities

There are two categories of integrated family planning activities included in this guidance: i. Intra-sectoral Family Planning/Reproductive Health Activities, and ii. Multi-Sectoral Family Planning/Reproductive Health Activities. Intra-sectoral activities are integrated across various elements within the health program area. Multi-sectoral activities are integrated with funds from other accounts and/or program areas. Examples of each are included below. Integrated family planning activities support USAID family planning objectives, but are not considered stand alone family planning activities. Integrated family planning activities often strengthen or complement a family planning program, facilitate the achievement of family planning program objectives, or contribute to the results of a family planning activity. Integrated activities often have similar key audiences as family planning activities, are co-located, or require the skills of a single health services provider.

To help decide whether a non-family planning activity represents an appropriate use of FP/RH funds, the activity should satisfactorily addressing the criteria of:

- direct measurable impact in the reduction of unintended pregnancies and optimally used funds as described in the introduction to Chapter III.8 Family Planning/Reproductive Health, and
- programmatic linkage to existing family planning activities.

In the case of both intra-sectoral and multi-sectoral family planning/reproductive health activities, an integrated family planning activity funded by USAID requires joint funding of FP/RH-designated funds and non-FP/RH-designated funds. For example, the use of non-FP/RH-designated funds is required to help support integrated FP/HIV activities that also receive FP/RH-designated funds. Likewise, USAID funding for mentoring activities that are intended to keep girls in school by building their self-esteem while also modeling

positive reproductive health behaviors requires joint funding from FP/RH-designated and non-FP/RH-designated accounts.

i. Intra-sectoral Family Planning/Reproductive Health Activities

Reproductive health needs vary over the course of an individual's life. Therefore, FP/RH funds should be used to help countries provide women and men with the convenience of co-located or linked health services that respond to a broad set of reproductive health needs.

Research suggests that linking family planning with STI, including HIV, prevention efforts or perinatal services or broader youth development efforts is associated with improved client satisfaction, higher utilization rates and sustained and satisfied use of family planning and related health or other services. Further, support for strengthened linkages between family planning and other reproductive health areas is consistent with the objectives of the Programme of Action adopted by the USG at the 1994 International Conference on Population and Development, which called for, *inter alia*, universal access to a full range of safe and reliable family planning methods and related reproductive health care.
(See http://www.un.org/popin/icpd/conference/offeng/poa.html).

Illustrative examples of the allowable intra-sectoral family planning/reproductive health activities that may be supported with FP/RH-designated funds include, but are not limited to, the following:

- *Integrating family planning and antenatal, neonatal, and postpartum care.* Activities may include safe motherhood initiatives such as community education and awareness raising about delivery complications and increasing access to emergency obstetrical care.

- *Providing post-abortion care*, including emergency treatment for complications of induced or spontaneous abortion; post-abortion family planning counseling and services; linking women to family planning and other reproductive health care; and community awareness and support to help women get emergency treatment, recover and prevent future unplanned pregnancy. However, no USAID funds may be used to purchase manual vacuum aspiration (MVA) kits.

- *Integrating and coordinating family planning and HIV/AIDS and STI prevention* programs as well as, in some special instances, treatment programs. Illustrative activities include promotion of dual protection, encompassing condom promotion and other behavioral change efforts to reduce pregnancy and STI/HIV risk; development and introduction of microbicides; and integration of family planning counseling and services (or referral for services) into voluntary counseling and testing centers for women and men who wish to avoid future childbearing and into programs focused on preventing mother-to-child-transmission of HIV/AIDS. (See Family Planning/HIV Integration: Technical Guidance for USAID-

Supported Field Programs, September, 2003: http://www.usaid.gov/our_work/global_health/pop/publications/docs/fphiv.pdf).

S/GAC has issued guidance on the use of HIV/AIDS funds in integrated family planning and HIV/AIDS activities. Please consult the most recent annual Country Operational Plan Guidance issued by S/GAC for information about this subject.

- *Linking contraceptive information and services to broad-based youth development activities* that promote self-efficacy and responsibility by strengthening life-skills (e.g., programs such as *Better Life Options* and *It's Your Life*).

- *Preventing and repairing fistula*. Activities may include: 1) repair, 2) prevention, 3) reintegration, and 4) monitoring and evaluation and research. The fistula program should be funded with a combination of funds from both the MCH and FP elements. A typical distribution of funds within a comprehensive fistula program would include 70 percent of funding from the 3.1.6 Maternal and Child Health element and 30 percent of funding from the 3.1.7 Family Planning and Reproductive Health element. FP funds should be focused on community-based prevention and post-repair counseling, while MCH funds should focus on obstetric prevention and repairs. Activities to prevent the occurrence of fistula may include supporting family planning to prevent unintended pregnancies, delaying marriage and first birth, and increasing community awareness of danger signs in pregnancy and delivery.

- *Integrating gender into family planning programs*: Illustrative activities include interventions to transform traditional gender norms that perpetuate gender-based violence and limit women and men's access to FP/RH information and services. Community mobilization and behavior-change interventions seek to improve couple communication and increase constructive male involvement in FP/RH counseling and decision-making, and to prevent or mitigate gender-based violence as related to FP/RH.

ii. Multi-sectoral Family Planning/Reproductive Health Activities

Officers are encouraged to seek opportunities to develop mutually productive linkages with other health activities and development sectors such as education, democracy and governance, environment, micro-enterprise and income generation programs, and to those with specific gender objectives. Such linkages can serve multiple purposes. Often, they expand the entry points for introducing family planning information and services, particularly when coupled with HIV and child survival and maternal health (CS/MH) services.

While FP/RH-designated funds can be used to support the FP/RH components of multi-sectoral activities, funds from non-FP/RH sources must be used to support activities that do not directly affect FP/RH outcomes.

Within an integrated family planning activity, non-family planning/reproductive health and non-health activities must be supported with non-FP/RH funds in combination with FP/RH-designated funds. Illustrative examples include, but are not limited to, the following:

- *Non-Family Planning/Reproductive Health.* Addition of non-family planning products and promotion to a family planning social marketing campaign, for example, addition of oral rehydration salts (ORS) or impregnated bed nets can enhance a social marketing system that delivers and promotes family planning products. *Note:* FP/RH funds must not be used to pay for non-FP/RH products and their promotion. In this case, non-FP/RH-designated funds would pay for the non family planning products and their promotion.

- *Education.* Pregnancy and dropout among schoolgirls are sometimes precipitated by poor school performance. Mentoring programs that help adolescent girls succeed in school while also providing them with reproductive health information and counseling combine the two forces that are needed to reduce dropout due to pregnancy. *Note:* Basic education activities must be paid for with funds that are designated for that purpose. FP/RH funds may not be used to support basic education activities.

- *Democracy and Governance.* Education and awareness-raising about reproductive issues, such as voluntarism in family planning programs, can be supported as a component of broader awareness-raising and education about women's rights.

- *Environment.* Awareness-raising activities for environmental issues that look at a wide range of policy responses, including ones related to FP/RH. Also appropriate are national environmental planning activities that include consideration of demographic factors.

- *Microenterprise and Income Generation.* Linking family planning volunteers, including peer educators, to microenterprise and income generation activities. For example, FP/RH-designated funds may be used along with non-FP/RH designated funds to subsidize small loans, training or skills development activities that are directed to family planning volunteers, or peer educators as rewards for length or quality of service. Also, income-generating activities may help to generate resources for FP/RH activities, for example, microfinance activities to assist women to sell family planning and related health products.

- *Gender*. Linking family planning clients to sources of legal counsel about gender based violence, property, custody, and other rights of women. Additional best practice examples for integrating gender-based violence initiatives into health programs are included in the document, *Addressing Gender-based Violence Through USAID's Health Programs: A Guide for Health Sector Program*

Officers. The document is available at http://pdf.usaid.gov/pdf_docs/PNADH194.pdf.

9. Water Supply, Sanitation, and Hygiene

A. USAID GUIDANCE

This guidance applies to the use of GH/CS funds appropriated to USAID and included under Element 3.1.8, Water Supply and Sanitation, or under sub-Element 3.1.6.7, Household Level Water, Sanitation, Hygiene and Environment of Element 3.1.6 Maternal and Child Health. Operating units considering use of GH/CS funds to support water supply, sanitation, and hygiene activities as part of other Program Elements, including but not limited to those addressing environmental protection, democracy and governance, and humanitarian relief, should consult with USAID/W as described in Chapter IV, to help ensure that such programs maximize health impact and are consistent with any other programmatic guidance. Additional specific guidance on the use of HIV/AIDS funds for water, sanitation, and hygiene activities is found in Appendix IV, HIV/AIDS Preventive Care Guidance and should also be consulted.

Diarrheal diseases and related malnutrition account for virtually all of the deaths and nearly 90% of the overall disease burden associated with unsafe water supply, sanitation, and hygiene (WSH). For this reason, GH/CS funds shall be used for WSH components that have a primary goal of reducing the prevalence of diarrheal diseases in groups for which mortality from diarrhea is a significant public health concern, primarily children under five and people living with HIV/AIDS.

From the diarrheal disease prevention perspective, a comprehensive WSH program includes interventions in hardware (e.g., water supply through public utility, community, or household wells/taps; rainwater harvesting/water storage capacity; latrines and handwashing facilities; or household-level technologies and products); complementary hygiene promotion and behavior change activities (e.g., community mobilization for sustained management and repair of hardware; social marketing of products and behaviors; or schools and clinic programs in the public and private sector); and interventions to support an enabling environment (political leadership/sector reform; supportive national and state policies; community organizations; institutional capacity strengthening; and financing). Typically, GH/CS funds would be used to fund components of an operating unit's overall WSH activity in combination with DA or other funds, exploiting the comparative advantage of health activities as appropriate. For example, promotion of safe drinking water treatment and storage, effective sanitation, and hygiene improvement at the household level through community-based health workers can serve to build demand for and help sustain infrastructure investments.

Key health-focused WSH interventions are those that increase access to and effective use of improved drinking water supply and sanitation; increase water quantity per capita used for drinking and hygiene improvement; ensure microbiologically safe drinking water quality, measured at the household level; improve handwashing practices; or result in the

effective use of a sanitary means of excreta disposal. Each of these interventions has been shown to reduce diarrhea prevalence approximately 30-50%.

GH/CS funds should be used for WSH activities that are consistent with the "optimal use of funds" guidance of Chapter III.1.B. This includes efficiency not only amongst the various eligible WSH activities, but also in considering efficiency of WSH interventions with respect to other approaches to achieve an identified health objective, such as the reduction of child mortality.

WSH activities eligible for GH/CS funding include:

- **Increasing access to improved drinking water supply as defined by the Millennium Development Goals**, i.e., the availability of at least 20 liters per person per day from an "improved" source within one kilometer of the user's dwelling. An improved source is one that is likely to provide safe water, including household connections to a water supply distribution network, public standpipes (connected to networked systems, or from a community well or surface water source), boreholes, protected dug wells, protected springs, and rainwater collection. Access to improved sources can be rural or urban, and may be provided through utilities, community-based systems, self supply, and/or other long-term and permanent systems. Unprotected wells, unprotected springs, rivers or ponds, vendor-provided water, bottled water, and tanker truck water are not considered improved.
- **Increasing access to improved sanitation at the household level as defined by the Millennium Development Goals**. Sanitation facilities are considered improved if they are private and if they separate human excreta from human contact, including connection to a public sewer, connection to a septic system, pour-flush latrines, simple covered pit latrines, and ventilated improved pit latrines. Access provided can be rural or urban, and may be provided through community managed simplified systems, utility-managed central network systems, or self-supply.
- **Increasing access to public or shared improved sanitation facilities in communal or institutional settings** (e.g., health clinics, schools, public markets, etc.) if they adequately separate human excreta from human contact and have a sustainable management and maintenance system in place, as well as sufficient hygiene facilities.
- **Supporting availability of, access to, and use of products to treat and properly store drinking water at the household level or other point of use (POU), in order to ensure the safe microbiological quality of drinking water; facilitate effective handwashing; or ensure safe excreta management practices**.
- **Supporting behavior change through hygiene promotion, including household drinking water management, handwashing, and feces management (e.g. sanitation promotion and marketing)**.

There are also other WSH-related activities that are eligible for partial GH/CS funding, consistent with the guidance provided on Co-Programming in Chapter 1II.14 of this document. The appropriate fraction of GH/CS funding will be determined by the extent

to which the activity contributes to the health-focused WSH interventions described above. Operating units are encouraged to consult with USAID/W, as described in Chapter IV, to help determine the appropriate fraction of GH/CS funding. These include:

- **Improving the quality of existing drinking water supply or sanitation services**, including increasing the number of hours of water access per day or quantity of water available, improving the quality of water delivered, improving the maintenance of systems and reducing the number of days out of service, or increasing the number of household connections for people who already have access to a communal improved source.
- **Provision of multiple-use water services** that include both domestic drinking water supply and water supply for productive use needs of the community (e.g., small-scale agriculture/gardening/animal husbandry).
- **Protection of surface water and groundwater quality** of potable water supply system from direct contamination prior to distribution to users, including installation of barriers to prevent access to the water point by animals, people, or other contamination sources, or water quality protection activities where there is a credible, direct, and specific cause-effect linkage between the contaminating activity and the degradation of an otherwise high-quality drinking water source.
- **Institutional strengthening and reform** related to drinking water supply, sanitation and hygiene, including capacity building of government and other key actors and organizational development, water supply and wastewater utility governance/corporatization and utility reform.
- **Water and sanitation infrastructure financing**, including increased access to credit, strengthening of domestic private capital markets, and facilitating support from domestic financial institutions.
- **Small-scale community-managed wastewater collection and/or treatment infrastructure.**

The following categories of water-related activities are <u>not</u> eligible for GH/CS funding, because they are not directly associated with health-focused WSH outcomes described earlier in this section:

- **Water resources management**, including management of water and associated natural resources, analysis of hydrologic resources and ecosystems, developing allocation strategies among multiple competing human demands for water resources, and water resources management governance structures.
- **Water productivity**, including economic or productive uses of water in agriculture, industry, commerce, services, or energy resources.
- **Water security**, including the management of transboundary or shared water resources.

10. Vulnerable Children

A. LEGAL REQUIREMENTS AND CONGRESSIONAL DIRECTIVES

Earmarks and Directives: The FY 2008 Appropriations Act and Conference Report contain a directive for vulnerable children ($15 million), which includes $1.85 million for blind children. For further guidance on recommended uses of the funds within each of these directives, please see Chapter III.10.B.

Orphans and Vulnerable Children Act: In November, 2005 the "Assistance for Orphans and Other Vulnerable Children in Developing Countries Act" was signed into law (the "OVC Act"). This was authorizing legislation and no funds have been appropriated for this Act; thus, there are no specific requirements for how GH/CS funds may be used for OVC activities. However, the OVC Act calls for a comprehensive U.S. government-wide strategy for OVC programs and annual reporting on the status of USG-funded OVC programs. For more information, please contact the USAID OVC Special Advisor in GH.

B. USAID GUIDANCE

a. Vulnerable Children

The Vulnerable Children budget category includes the following line items: Displaced Children and Orphans Fund (DCOF), Blind Children, and Other Vulnerable Children. This budget category corresponds to the sub-element 3.3.2.1 Vulnerable Children.

The FY 2008 Appropriations Act includes $15 million for children displaced or orphaned by causes other than HIV/AIDS, and is programmed centrally in Washington.

Based on experience gained over the past 15 years, the Agency is pursuing a strategy whereby allowable uses for funds reserved for "vulnerable children" support a set of programs designed to address the critical *needs of children most at risk* as well as to *address disabilities, family separation,* and other problems that can put children at risk. Family reunification is a primary objective for children outside of family care. At the center of this strategy are programs that strengthen the capacity of families and communities to address the physical, social, educational, and emotional needs of children in crises. Children that have been identified as requiring special attention include: (1) children displaced, orphaned or otherwise severely affected by the consequences of complex emergencies, armed conflict (including child soldiers), and natural disasters; (2) separated children who are outside the care of their parents or normal guardians; and (3) children with disabilities. For more information on children affected by HIV/AIDS, please see Chapter III.2.B.g.

b. Displaced Children and Orphans

The Displaced Children and Orphans Fund (DCOF) directive within the Vulnerable Children budget category provides financial and technical assistance for the care and protection of orphans and other vulnerable children who are displaced or separated from their families, are at risk of losing family care and protection, or are faced with other sources of extreme duress.

The DCOF focuses primarily on children affected by war (including child soldiers), children with disabilities, and other disenfranchised or unaccompanied children, such as street children.

DCOF places strong emphasis on strengthening family and community capacity for identifying and responding to the special physical, social, educational, and emotional needs of these children. The definition of children includes adolescents.

Allowable activities include the following:

- *Documenting, tracing, and reuniting children* (including child soldiers) separated from their families and supporting their community reintegration;
- *Addressing psychological and emotional issues of* children affected by conflict or other emergencies*;*
- *Mobilizing communities and strengthening families to care for and protect their most* vulnerable children;
- *Working with host country governments* and others to develop and execute policy and programmatic reform regarding vulnerable children; and
- *Enhancing economic opportunities* for vulnerable children and their families.

c. Other Vulnerable Children Activities

In addition to the types of activities described above, operating units may use "Other Vulnerable Children" funds to: (a) finance a variety of activities in countries of "special need" where there are an unusually large number of, or especially disadvantaged, vulnerable children for whom increased accessibility to mainstream health services and/or other psychological or social services are critically needed; or (b) finance special opportunities which fall outside of mainstream USAID strategies, but which because of special circumstances or opportunity, are deemed to be of critical importance to at-risk children.

For more detailed guidance on the above activities, please contact the Displaced Children and Orphans Fund manager.

NOTE: Activities specifically targeting Children Affected by HIV/AIDS are *not* appropriate uses of Vulnerable Children funds. All activities specifically addressing Children Affected by HIV/AIDS must be funded by HIV/AIDS funds.

11. Other: Health Systems and Capacity Strengthening

A. USAID GUIDANCE

a. Construction

Construction of Facilities: USAID has legal authority to perform construction and renovation overseas, which, like the Department of State, is based on authorities under the Foreign Assistance Act. Construction refers specifically to new construction, as distinguished from improvements (renovation/alteration). New construction is defined as: "the erection of a building, structure or facility; including the installation of equipment, site preparation, landscaping, and associated roads, parking, environmental mitigation, and utilities, which provides area or cubage not heretofore available. It includes…additional wings or floors…and any other means to provide usable program space that did not previously exist.[12]" Improvement (renovation/alteration) is defined as "any betterment or change to an existing property to allow its continued or more efficient use within its designed purpose (renovation), or for the use of a different purpose or function (alteration). Improvements do not include the addition of wings, floors, or other increases to usable program area cubage; such projects constitute new construction. The only added areas or cubage which may be construed as a building improvement rather than new construction involves stairwells, elevator towers, pipe chases, etc., not providing useable program space….Such renovation activities cannot add to the size of the facility.[13]"

Although USAID has legal authority to perform both construction and improvements, USAID usually prefers to avoid using health funding for construction. This is based on the view that the construction of facilities is resource-intensive and does not ordinarily result in *optimal use* of GH/CS funds. Optimal use is defined throughout this guidance as those activities that are most effective and efficient in reaching significant, critical populations and/or providing *sustainable* community-based services. This requires balancing the use of funds for construction against other factors, such as the severity and magnitude of the problem, overall developmental needs, program stage or maturity, relative cost- and program-efficiency of the intervention, and host country and other donor resources.

To assist with this determination, USAID/Washington review is required when GH/CS funds exceeding $100,000 of an OU's portfolio (per year) are used for new construction. The following procedures should be followed:

a) If a construction project is funded exclusively with GH/CS funds appropriated to the Department of State, as in a PEPFAR focus country, the review can be incorporated into the County Operational Plan (COP) review process, and approval of the COP would equate with approval to construct with no further waivers required.

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[12] Definition from the Health and Human Services (HHS) Facilities Program Manual (Volume I).
[13] HHS Guidance.

b) If a construction project is funded exclusively with GH/CS funds appropriated to USAID, in any element, the Mission must follow the guidance for deviations from the guidance, as outlined in Chapter IV.
c) If a construction project is funded with both GH/CS funds appropriated to the Department of State and GH/CS funds appropriated to USAID, and the country is submitting a COP or mini-COP to S/GAC, then the review can be incorporated into the COP review process. In addition to approval of the COP, Missions must submit a copy of the documentation approving the funding (including the request, the rationale, and the response from S/GAC) to GH/SPBO, and GH/SPBO will share the documentation with the IIP lead in F and the appropriate Regional Bureau health team.
d) If a construction project is funded with both GH/CS funds appropriated to the Department of State and GH/CS funds appropriated to USAID, and the country is *not* submitting a COP or mini-COP to S/GAC, then the procedure set forth in paragraph b above should be followed for the GH/CS funds appropriated to USAID. For the GH/CS funds appropriated to the Department of State, prior approval must also be granted from S/GAC.

If GH/CS funds appropriated to USAID are used for improvements (renovation/alteration), USAID/W review is not required. If GH/CS funds appropriated to the Department of State are used for improvements (renovation/alteration), these activities should be included in the COP and the review can be incorporated into the County Operational Plan (COP) review process. Approval of the COP would equate with approval to renovate with no further waivers required.

All awards involving construction or renovation of structures, facilities, or buildings are required to comply with USAID's AAPD 05-07: "Supporting USAID's Standards for Accessibility for the Disabled in Contracts, Grants, and Cooperative Agreements."

b. Health Systems/Systems Strengthening

At this time, health systems activities may be allocated to any health program element. The rules for program elements may be updated annually in the Operational Plan Guidance; please be sure to follow current guidance. Please use the health sub-elements for systems work corresponding to the health elements such work supports. Results achieved should benefit programs in proportion to the funding category (family planning, maternal and child health, etc.) used. For sustainable progress toward achieving Agency goals, operating units must seek to foster an institutional environment that is favorable to development, working closely with partner and customer organizations. In the course of planning, implementing, and appraising programs, USAID managers often find that achievement of results is constrained by either an inappropriate institutional framework or a partner organization's lack of capacity. Increasing the capacity for institutional and organizational effectiveness promotes sustainability in all of the goal areas.

- *Support for the development of institutions* focuses on three areas: (1) formulation and coordination of policy (i.e., rules and norms in the policy making process); (2) rules and norms shaping efficient and effective delivery systems for

goods and services; and (3) development of motivated and effective staff for rulemaking and enforcement. These are largely, though not exclusively, public sector functions. They are frequently the focus of USAID's policy reform efforts. Assistance is also provided to ensure the sustainability of a policy-making process, as well as of incentive and sanction mechanisms (e.g., public budgeting and expenditure functions, transparency and accountability measures, adjudication systems, etc.).

- *Support to strengthen an organization's ability to provide quality and effective goods and services, while being viable as an organization*. This means supporting an organization to be: (1) programmatically sustainable (providing needed and effective information and services); (2) organizationally sustainable (with strong leadership and having necessary systems and procedures to manage by); and (3) assured that it has sufficient resources (human, financial, and material) that are utilized well.

Allowable Uses of Funds for Systems Strengthening

- **Funding Considerations**: At this point, there is no directive or special budget category for health systems development or capacity strengthening. Therefore, to the extent that the activity is part of any health program for the purpose of that program, it should be funded with monies from the FP/RH, Child and Maternal Health, Vulnerable Children, HIV/AIDS, and Infectious Diseases budget categories, using any of the eight health elements or the Social Services element.

Within each of the categories above, allowable activities for uses of GH/CS funds relate to the Agency's sustainability objective of assuring the long-term accessibility, efficiency, effectiveness, quality, equity, and sustainability of child health/survival, maternal health/survival, family planning/reproductive health, other infectious diseases, HIV/AIDS, water and sanitation, other public health threats, and vulnerable children's programs. Specifically, recommended activities geared towards building self-reliance include the following:

- *Improving appropriate health sector reforms* that support and protect policies related to health programs;

- *Assuring quality, effectiveness, and financial sustainability* of health programs in the context of decentralization and health sector reform, including reducing corruption;

- *Establishing fair, efficient, and equitable financing* to protect access by the poor to health programs by improving cost controls and rationalizing application of user fees, privatization, and health insurance programs;

- *Reorganizing health sectors,* including realignment of roles within the health sector, such as redefining which institutions deliver services, make policies, and set standards on financing services and supplies;

- *Strengthening health information systems and resources* to inform the making of better health policy, management decision-making, and monitoring and analysis of program activities;

- *Improving the quality of and capacity* to deliver health care services that are responsive to patient and community needs;

- *Strengthening human resources and management,* often with progressive decentralization and work at the community level;

- *Involving the private sector, including faith- and community-based organizations,* actively in the provision of health care;

- *Improving commodity management systems* for pharmaceuticals and improving drug quality, supplies, equipment, and facilities, to include use of the commercial sector more extensively for distribution of commodities; and

- *Developing new and improved technologies and approaches* to effectively plan and deliver quality child survival and health services.

12. Rebuilding Countries

A. USAID GUIDANCE

The goal of USAID's Fragile States Strategy is "to guide USAID's efforts in reversing decline in fragile states and advancing their recovery to a stage where transformational development progress is possible" (available at: http://inside.usaid.gov/DCHA/CMM/documents/USAID_FragileStatesStrategy.pdf). To support this goal, USAID staff will need to explore how health development assistance can address key risk factors associated with state fragility and determine how health programs can be implemented to make the greatest possible contribution to a country's stability, resilience, and recovery and at the same time achieve the purposes for which the funds were appropriated.

The guiding principles of using GH/CS funds to achieve "direct impact," and the Agency's responsibility to assure "optimal use" of GH/CS funds, still apply in fragile state environments (see below). Mission staff will therefore need to develop program approaches that deliver situation-appropriate health programs in ways that also contribute to reconstruction and stability objectives, while respecting existing earmarks and directives.

a. Allowable Uses of Funds for Fragile States

The guidance in this chapter on rebuilding countries applies to the use of GH/CS funds appropriated to USAID. In order to use GH/CS funding for these activities, the activities should meet two established criteria: "direct impact" and "optimal use of funds." "Direct impact" means that the results of the activity can be linked and measured directly (using the health elements and standard indicators) against the purposes for which they were appropriated, as defined in the FY 2008 Appropriations Act and the relevant House, Senate, and Conference Reports and under the health element goal: "To contribute to improvements in the health of people, especially women, children, and other vulnerable populations in countries of the developing world, through expansion of basic health services, including family planning; strengthening national health systems, and addressing global issues and special concerns such as HIV/AIDS and other infectious diseases." "Optimal use of funds" means ensuring that those activities that are most effective and efficient in reaching significant, critical populations and/or providing sustainable community-based services receive priority for funding. Under the direct impact and optimal use of funds criteria, activities undertaken with GH/CS funds in fragile environments and during stabilization and reconstruction actions should contribute to the effective use and delivery of the interventions for which those funds were appropriated, as referenced in Chapter III of this Guidance. Such activities should be linked to health outcomes as well as stabilization and reconstruction objectives.

In addition to what is outlined in Chapter III of this guidance on the recommended uses of GH/CS funds, the following areas have been identified as needing additional guidance.

<u>Health sector governance activities</u>
Rebuilding countries are characterized by weak governance and lack of capacity and/or willingness on the part of the government to work together with public and private providers and the community to deliver services. Strengthening the ability of national, local, and community institutions to manage a country's resources and affairs in a manner that is open, transparent, accountable, equitable, and responsive to the needs of the people is an important goal of programming in fragile environments.

The following activities may be funded when they directly impact the delivery and use of services for the directive and sub-directive areas for which the funds used were appropriated:

- Expanding and institutionalizing health services, including but not limited to:
    - Establishing or strengthening the delivery of services and the procurement of pharmaceuticals and medical supplies, including supply chain management;
    - Drafting national health policy and promoting legislation and regulation[14];
    - Improving infrastructure and institutional capacity to deliver services and manage health programs;
    - Strengthening corruption prevention;
    - Training, quality assurance and human resource development;

[14] The Siljander Amendment prohibits USAID funds being used to lobby for or against abortion.

    - Establishing fair, efficient, and equitable health sector financing; and
    - Strengthening national and local level management, information, financial systems, and leadership training/development.
- Reestablishing or strengthening basic health services with particular attention to previously underserved, socially marginalized, and vulnerable populations in ways that promote longer-term re-engagement with national governments and building capacities of national governments to use health resources effectively.
- Building the capacity of public sector institutions and strengthening the relationship between government institutions and non-government providers at all levels in the health sector by:
    - Assuring that non-government organizations in the health sector are aligned with the national government and contribute to building state capacity;
    - Strengthening the capacity of local NGOs to engage with and be accountable to government (where feasible) and to implement and report on health programs.
- Increasing the participation of civil society, local government, and community institutions in health activities by:
    - Increasing the role of communities in planning, decision-making, and resource management for health activities;
    - Strengthening organization and capacities of communities and local government;
    - Supporting the provision of health empowering information to families and communities;
    - Supporting the development of local mechanisms to monitor health status and plan effective responses; and
    - Increasing accountability and responsiveness of local health authorities.

<u>Multi-sectoral programming</u>

Many of the factors that drive state fragility are rooted in the political, security, economic, or social sectors. Development efforts to address grievances in these factors in rebuilding countries that have limited absorptive capacity presents a major challenge--particularly in post-conflict situations. USAID health officers are encouraged to seek opportunities to develop mutually productive linkages with other sectors such as education, democracy and governance, and economic development. For example, in a post-conflict situation both the agriculture and education sectors may be investing in strengthening district governments to provide services to vulnerable populations; GH/CS funds could be used to develop a consistent approach to strengthening health sector governance at the district level. Use of a common governance model would decrease duplication of effort among the sectors and contribute to aid efficiency and effectiveness.

While GH/CS funds should be used to support the GH/CS components of multi-sectoral activities, funds from non- GH/CS sources must be used to support activities that do not directly affect GH/CS outcomes. Examples of multi-sectoral activities that can be funded with GH/CS funds include the following:

- Support for the health component of a larger government-wide decentralization, corruption-prevention or management strengthening activity;

- Addition of child survival, maternal health, or family planning education component to employment, income generation, or agricultural programs;
- Support for food aid programs that increase the nutritional status of households; and
- Provision of field guidance and training in high impact child survival interventions in complex emergencies.

The relationship of health to stability

There is not extensive data on the degree to which health sector activities contribute to stabilization and reconstruction objectives, however improved governance, enhanced government effectiveness and credibility, and improved health service delivery are seen as a catalyst for broader transformations in national development. There is evidence that public security plays an important role in health outcomes. A nationwide study in the Democratic Republic of Congo showed that, even though violence was not a significant proximate cause of death, overall mortality rates and child mortality rates were significantly elevated in health zones where incidents of armed conflict were reported, compared to those in which peace reigned.

- GH/CS funds may be used to establish the evidence base for the impact of health sector activities on the fragile state objectives.

13. Administrative/Management Costs

A. USAID GUIDANCE

Agency regulations on the appropriate use of operating expense and program funds for administrative and management positions are found in ADS 601. ADS 601 is applicable to the use of GH/CS Account funds, and Missions must carefully review costs where there may be doubt about the proper source of funding. Regarding funding sources, E601.5.7 states:

> "In most instances the appropriate funding source will be clear, particularly viewed in conjunction with the examples provided in the Mandatory References to this policy. In cases where it is not clear which funding source is to be used, the cognizant technical office or other requesting office, after consultation with the cognizant GC or M/B, as appropriate, must document the funding source decision. Such documentation will be in the form of a statement that the requestor has reviewed the scope of work and determined that the appropriate source of funding is (identify funding source)."

Operating units should consult health officers, either in Missions or in USAID/Washington, when GH/CS funds are used for administrative and/or management costs. If any doubt remains as to whether a position should be funded by Operating Expenses (OE) or GH/CS Account funds, operating units are urged to err on the side of caution and to use OE funds for the position.

Use of Objective 6:

It is important for operating units to ensure that overhead costs allocated to specific positions (for example, office leases and utilities, building maintenance, warehouse costs,

etc.) are properly funded and that the GH/CS Account bears its fair share of these costs (see E601.5.8b). As with every Program Element, Operating Units must ensure that those costs that are considered cross-cutting truly do fall within this category and that all Program Elements within the portfolio are proportionately supporting the costs. Operating Units should clearly document the justified funding amounts. For additional guidance on the use of program funds for cross-cutting program support expenses, please see the Operational Plan Guidance and associated Annex, "Operating Unit Management Costs and Program Support," including any subsequent changes to the Foreign Assistance Standard Program Structure and Definitions.

For complete policy guidance on determining appropriate funding sources, see the following documents:

ADS 601: Funding Source Policy
(http://www.usaid.gov/policy/ads/600/601.pdf)
Mandatory Reference: Office of Federal Procurement Policy (OFPP) Policy Letter 92-1, Inherently Governmental Functions
(http://www.arnet.gov/Library/OFPP/PolicyLetters/Letters/PL92-1.html)
Mandatory Reference: Cost of Doing Business
(http://www.usaid.gov/policy/ads/600/601.pdf)

- **Program Funded Technical Expertise**: Under the Agency's allowable activities, operating units can use the GH/CS funds appropriated to USAID to obtain technical expertise through a variety of mechanisms such as Personal Services Contracts (PSCs), Intergovernmental Personnel Act Assignments (IPAs), Participant Agency Service Agreements (PASAs), Participating Agency Program Agreements (PAPAs), the Technical Advisors in AIDS and Child Survival Program (TAACS)[15], Cooperative Assistance Support Units (CASUs), and the Fellows Programs for the design, implementation, and evaluation of health programs. For additional information on the CASU or Fellows Programs, contact the appropriate Cognizant Technical Officer in the GH Bureau. Note that the FY 2008 Appropriations Act limits to 25 the number of PSCs that can be employed in USAID/W under this authority; no more than 10 can be assigned to any bureau or office. Allocations are made by the agency's human resources office (M/HR) and the Chief of Staff in USAID/W. Missions still have full PSC authority, which is not affected by this language. PSCs can also be hired with GH/CS funds under the "notwithstanding" authority in Section 622 of the FY 2008 Appropriations Act. See Appendix I, excerpt 2, Section 622.

  Program to Operating Expenses: Under the 2008 Appropriation Act, up to $6,000,000 may be transferred to and merged with funds appropriated by the Appropriation Act under the heading "Operating Expenses of the United States Agency for International Development" for costs directly related to global health.

[15] Current Agency policy is not to hire additional TAACSs.

Foreign Service Limited (FSL): The FY 2008 Appropriations Act includes a provision that funds may be made available to "hire and employ individuals in the United States and overseas on a limited appointment basis pursuant to the authority of sections 308 and 309 of the Foreign Service Act of 1980."

This provision requires that the number of limited Foreign Service hires shall not exceed 175 in any fiscal year. The authority to hire individuals expires on September 30, 2009, and may only be used to the extent that an equivalent number of positions that are filled by personal services contractors or other non-direct hire employees of USAID, who are compensated with funds appropriated to carry out part I of the Foreign Assistance Act of 1961, are eliminated.

14. Co-Programming

A. USAID GUIDANCE

Co-Programming
Intra-sectoral and multi-sectoral integrated activities are an increasing component of Agency sector portfolios. Intra-sector activities are co-programmed across various elements within the health program area. Multi-sectoral activities are co-programmed with GH/CS funds and with funds from other accounts and/or program areas. While such integrated activities are encouraged, careful attention must be given to ensure that GH/CS funds are used for their intended purposes. To this end, operating units must ensure that funding levels from the respective elements and/or other accounts are *proportionate* to the percentage breakdown of relevant activities within the larger project. Operating units must also clearly document how the percentage breakdown among the various types of funds was determined and how specific funds are being used. Operating units should consult health officers, either in Missions or in USAID/Washington, when GH/CS funds are used for integrated activities. Missions are encouraged to contact USAID/W for assistance where such a breakdown might be difficult to determine.

a. Intra-sectoral Programming: Co-Programming Across Various Elements Within the Health Program Area. Co-programming for a single intra-sectoral health program requires joint funding from the relevant elements across the health program area, funded by the GH/CS Account. For example, an antenatal clinic that also provides voluntary counseling and testing for HIV/AIDS must be proportionately funded through the maternal and child health element and the HIV/AIDS element. Roughly, if the clinic devotes approximately 75 percent of its resources to providing maternal and antenatal care and approximately 25 percent to voluntary counseling and testing (VCT), the amount of MCH and HIV/AIDS funds must be proportionate to their respective balance of activities in the clinic.

In an integrated program that includes both HIV/AIDS activities and voluntary family planning activities, any partner that receives U.S. Government funding for both purposes must comply with the respective requirements applicable to each activity. However, in an integrated program, different organizations may be responsible for different types of

activities, as not all organizations will necessarily do both voluntary family-planning and HIV/AIDS activities. Any partner that receives funds solely for HIV/AIDS activities is thus not subject to the requirements applicable to family planning activities.

b. Multi-sectoral Programming: Co-Programming of GH/CS **Funds with Other Program Areas and/or Accounts.** Under certain restrictions, GH/CS funds may be used with other account funds in a single integrated program. However, GH/CS funds must be used for the purposes intended by Congress as detailed in this guidance, and must be accounted for and reported separately. The above proportionality rule applies to multi-sectoral programming and operating units must clearly document how the percentage breakdown among the various types of funds was determined and how GH/CS funds are being used. Again, where such a breakdown might be difficult to determine, Missions are encouraged to contact USAID/W for assistance. Operating units will also be required to disaggregate GH/CS-funded and other activities in Congressional notifications and in annual reporting.

c. Co-Programming Using Food for Peace (FFP) -- P.L.. 480 Title II: GH/CS funds may be used in conjunction with P.L. 480 Title II food security resources to provide a more complete maternal/child health, nutrition, or HIV/AIDS activity. Operating units are encouraged to work with Agency partners to strategically program activities funded by GH/CS funds with those supported by Title II resources. In that effort, operating units are reminded that while the activity areas may overlap, each resource must be used within its specified activity area (either GH/CS or Title II). Title II resources are provided to cover the cost of commodity procurement, ocean transportation and, where applicable, inland transportation for all Title II activities. For emergency activities, Title II resources may be provided to cover costs associated with internal transport, storage, and handling costs. For Title II non-emergency (development) activities, operating units with FFP and GH/CS activities are encouraged to consider the integration of GH/CS activities with those from Title II where they would be mutually supportive. Where activities are integrated, the Title II component may also receive direct Title II support with either Section 202(e) or monetization resources when they are available. Both programs must be reported separately.

IV. PROCEDURES FOR DEVIATIONS FROM THE GUIDANCE

This document describes both legal requirements and Congressional directives, as well as USAID guidance.

All legal requirements are mandatory.

USAID guidance is issued to ensure effective, evidence-based programming, and to increase consistency and predictability of operations. This guidance is determined based on decades of experience in health programming and represents the best understanding of leading technical experts. If an Operating Unit seeks clarification or has a question about whether an activity falls within the parameters of the requirements, the OU should seek additional guidance by contacting the IIP lead in F or GH/SPBO, and GH/SPBO will coordinate a review and response with the Regional Bureau technical officer, GC/Washington, or the GC's Regional Legal Advisor, as appropriate.

Although Operating Units should generally follow these practices, there are situations where an OU may wish to deviate from them or adapt them to particular situations, especially when such deviations correspond to the guiding principles of direct impact and optimal use. There is a two-phase process for requesting a deviation from this Guidance.

Phase I: When an Operating Unit wishes to deviate from USAID guidance, the OU must hold a technical consultation, organized by the Office Director of GH/SPBO, which must include representatives from the relevant Regional Bureau, GH, the Bureau for Legislative and Public Affairs, GC/Washington or the Regional Legal Advisor, the Office of the Chief Operating Officer, and the Office of the Director of U.S. Foreign Assistance/Investing in People. The technical consultation should be documented in an Information Memorandum to the File from the OU. Ideally, the parties will reach a consensus on technical grounds. If all parties reach consensus, then the Information Memorandum will serve as documentation and the OU is free to proceed with the requested program. See Appendix X for a sample template for documenting technical consultations.

Phase II: If and only if a mutual agreement can not be reached, then an arbitration will be held. The AA of the relevant Regional Bureau should write a split decision Action Memo to the Administrator of USAID. This action memo should include a detailed description of the activity, how it directly contributes to the relevant health area and element objectives, and the expected results. It should outline the pros and cons of moving ahead with the proposed activity, and the relevant external considerations (including political, diplomatic, and programmatic considerations). The COO's office will convene an intra-agency committee with the appropriate policy, technical, program, and budget personnel to review the request and recommend approval or disapproval.