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

FY 2012

Country Operational Plan (COP) Guidance

August 2nd, 2011

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1 Introduction – Historical Background

Launched in 2003 by President George W. Bush, PEPFAR holds a place in history as the largest effort by any nation to combat a single disease. In the first five years of the program, PEPFAR focused on establishing and scaling up prevention, care, and treatment programs. Country programs achieved great success in expanding access to HIV prevention, care, and treatment in low-resource settings. During its first phase, PEPFAR supported treatment to more than 2.4 million people, care to nearly 11 million people, including 3.6 million orphans and vulnerable children (OVC), and prevention of mother-to-child treatment activities for nearly 16 million pregnancies.

The global epidemic continues to require a comprehensive, multisectoral approach that expands access to prevention, care, and treatment. In December 2009, PEPFAR released its second Five-Year Strategy, which builds upon its success as programs transition from an emergency response to promoting sustainable country programs. For more information about PEPFAR's Five-Year Strategy, please visit http://pepfar.gov/strategy/.

On May 5, 2009, President Barack Obama and Secretary of State Hillary Rodham Clinton announced the U.S. government's Global Health Initiative (GHI); see press release at: http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/. PEPFAR is the cornerstone of GHI. GHI is designed to connect and build upon the impressive results and momentum of PEPFAR and other USG health programs. It is leveraging the full range of USG assets in supporting a long-term strategic approach to global health that enables partner countries to improve health in communities impacted by HIV and other diseases. As part of GHI, PEPFAR is supporting countries to provide more efficient, integrated and sustainable health programs and serves as the platform upon which to link and integrate systems of care. For more information about the GHI, please visit http://ghi.gov.

2 What is a Country Operational Plan?

The Country Operational Plan (COP) is the vehicle for documenting USG annual investments and anticipated results in HIV/AIDS and the basis for approval of annual USG bilateral HIV/AIDS funding in most countries. The COP also serves as the basis for Congressional notification, allocation, and tracking of budget and targets and as an annual work plan for the USG. For programs that have or are negotiating Partnership Frameworks, it serves as the annual work plan for the USG's contribution to the Partnership. Data from the COP is essential to PEPFAR's transparency and accountability to key stakeholders.

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

Several multi-country platforms are now developing Regional Operational Plans (ROPs). This guidance applies to those programs equally, whether they are explicitly referenced or not.

FY 2012 is the first year in a two-year cycle, and thus will include a level of narrative and budget reporting that will allow the Office of the Global AIDS Coordinator and agency headquarters to review and evaluate the strategic direction and program planning for a given country or region; we are in the process of ensuring that the content and timing of this more substantial submission to headquarters is well harmonized with other headquarters reporting processes for foreign assistance. Narratives will mostly address the activities and strategic approach for FY 2012 instead of attempting to describe two years' worth of activities. The exceptions to this are the Technical Area Narratives which should mention a broader two-year strategy for each of the four designated technical areas, and the M&O narratives.

3. COP Preparation

3.1 Which Programs Prepare a FY 2012 COP?

The following programs are required to complete a full FY 2012 COP: Angola, Botswana, Burundi, Cambodia, Cameroon, China, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Ghana, Guyana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Russia, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Thailand, Uganda, Ukraine, Vietnam, Zambia and Zimbabwe. Regional Operational Plans are required from the Caribbean, Central Asia, and Central America field teams.

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

countries/regions that do not prepare COPs will account for their resources through CDC Country or Regional Assistance Plans.

3.2 Coordination during COP Planning

3.2.1 Coordination among U.S. Government Agencies

A key focus of PEPFAR is the USG interagency response, in which all USG agencies working in a country or region[1] plan, implement, and monitor a unified country program as one USG team, in most cases with the coordination of a PEPFAR Coordinator. Thus, **it is essential that all USG agencies working on HIV/AIDS programs in a country be included in all levels of discussion regarding the COP.** In addition, dialogue with the interagency country support team at headquarters is encouraged to ensure a well vetted COP is reached prior to submission. Country programs may have several sources of HIV/AIDS funding; however, all HIV/AIDS programming decisions are to be made as an interagency USG Team. If any agency is not present in-country, the country program may still want to draw on the expertise of a non-presence agency to benefit the program and may use the COP process to solicit that agency's expertise.

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

3.2.2 Coordination with Country Governments and Donors

The USG is firmly committed to principles of alignment with national programs, including harmonization with other international partners, and the COP should be fully in keeping with the national strategy and the PEPFAR Partnership Framework. Sharing of information with government authorities, e.g., Ministry of Health, National AIDS Council, local multi-sectoral coordinating body, multilateral partners (e.g., Global Fund,

[1] While this guidance uses the term "country programs" in most contexts, the guidance also applies to regional platforms that work through a common operating plan.

UN agencies), or civil society is an essential aspect of effective planning, leveraging resources, and fostering sustainability of programs. Consultation with the partner government is essential to ensure buy-in, and approval of the strategic direction of the PEPFAR program by the partner government is required.

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

- Unredacted FY 2012 COPs should be shared on a "need to know" basis, as determined by the Ambassador or his/her designee. In the spirit of Partnership Frameworks and furthering country ownership, the USG team may share the entire FY 2012 COP with partner government officials that have responsibility for COP approval, subject to the following instructions:

    - Electronic copies of the unredacted COP should not be distributed to the government, in order to prevent inadvertent distribution beyond those with a legitimate "need to know" for planning and coordination purposes.

    - With Agency and Mission clearance, hard copies of the full COP may be shared with the partner government reviewers, but all copies should be retrieved following the review period. We understand that often the hard copies of the unapproved COP are not returned and teams should make every effort to exchange these with a hard copy of the approved COP.

    - Specific funding levels for any award which is "To Be Determined" (TBD) (whether at the prime or sub-partner level) should be redacted (deleted) from the hard copy of the COP to be reviewed by the partner government. However, aggregate dollar amounts for TBD award(s) within one program area (as opposed to by mechanism) may be summarized for the partner government, e.g., "In the PMTCT program area, we plan to add $2 million through new awards."

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

- Final redacted COPs from previous years are available online at www.pepfar.gov/countries/cop/. However, if the prior year COP continues to contain TBD awards, funding levels should be redacted as described above.

3.3 Important Resources for COP Preparation

Country Support Team Lead (CSTL) and team members, including the Strategic Information (SI) Advisor, and Technical Working Groups (TWGs) are important participants and can help support the COP process. The CSTL is your main point of contact at the Office of the U.S. Global AIDS Coordinator (S/GAC), and for the PEPFAR interagency team at HQ, and should be substantially involved. Engaging the SI Advisor early in the process to assist with target setting and with planning of Strategic Information activities is also essential. The Country Support Team members can help with strategic planning of activities and reviewing and finalizing the COP. If you would like assistance from the country support team or one of the TWGs, please contact the CSTL for your country. The *FY 2012 Technical Considerations*, drafted by the TWGs, is a companion document to be used in conjunction with this *FY 2012 COP Guidance*.

As in previous years, the guidance and its appendices contain critical information that informs program planning and will be posted on the FY 2012 COP Planning section of the PEPFAR Plan B SharePoint site, in the FACTS Info PEPFAR module, and subsequently on www.pepfar.gov .

Other channels of communication to strengthen COP planning, including work with CSTLs and weekly COP clarification calls, are important. Based on questions from the field, headquarters will develop "COP Clarifications" to answer issues in the COP guidance and disseminate "COP Clarifications" through News to the Field and by posting them on the PEPFAR Plan B SharePoint site on the FY 2012 COP Planning page.

3.4 Partner Performance, Pipeline and Financial Planning

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

It is critical to monitor and evaluate USG partner performance (i.e., utilizing funds and achieving program targets) regularly, both to ensure the success of PEPFAR programs and to remain accountable to Congress and the American people. Interagency, team-based partner performance reviews are a well-established management practice, informing (Operating Unit) OU teams' program planning, management, and oversight. The collection of performance data helps ensure consistency and allows teams to evaluate trends over time. These efforts also contribute to PEPFAR's commitment to performance-based budgeting and are required by the Office of Management and Budget (OMB) and implementing agencies. Interagency OU teams and headquarters personnel are thus required to monitor and evaluate partner performance on an

ongoing basis throughout the year, especially through the COP, APR, and SAPR processes.

Teams should monitor progress informally throughout the year and conduct formal interagency reviews of all partners **at least once a year**. Interagency partner performance reviews, no matter how frequently performed, should follow consistent templates to establish trends over time. PEPFAR teams should use a standard form to capture the outcomes of the review that can be shared throughout the USG country team. This information is central to decision-making and planning.

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

Pipeline analyses help country teams plan, manage, and oversee their programs and partners and ensure that financial data is shared interagency within each team. Although expenditure rates may not be captured in the pipeline report, program managers are encouraged to also monitor and evaluate partner expenditure rates ("burn rates").

In support of COP 2012, OU teams will develop an outlay estimate (obligation and outlay plan) to inform S/GAC of the timeline for the utilization of funds. Looking ahead, this can be used as a tool for the interagency team to monitor the utilization of each year's funds.

See Appendix 2 for additional information.

3.5 COP Timeline

All COPs/ROPs must be submitted by October 14th.

COP Guidance released	August 2nd, 2011
Country-specific target templates available to Operating Units	August 5th, 2011
FACTS Info – PEPFAR module training	Mid August to Mid September 2011
Early Funding Requests Due	September 2, 2011
FACTS Info – PEPFAR module deployed	September 22nd, 2011
COP/ROP Due	October 14, 2011
COP Cleaning	(approx) October 17 – December 2
COP Reviews	(approx) December 5 –16
COP Approval Memos Sent	(approx) January 30, 2012

3.6 COP Submission changes

All OUs will submit their COP 2012 using the FACTS Info – PEPFAR Module. This software system is the primary source for tracking and reporting of foreign assistance data and is jointly operated by the State Department and USAID. S/GAC has worked with the Office of the Director of U.S. Foreign Assistance at the Department of State (State/F) to ensure that PEPFAR-specific planning and reporting requirements are represented in the PEPFAR Module and that all PEPFAR implementing agencies have appropriate access to the system.

This Guidance is intended to describe "what" should be contained in your COP and will not describe "how" to use the FACTS Info – PEPFAR Module. Details on how to access and use FACTS Info will be described in the PEPFAR Module training and user support materials that will be provided separately.

COP/ROP submission may be done using PEPFAR Module templates that teams will upload directly into FACTS Info, or via data entry screens in the PEPFAR Module. The templates will be blank, however, Operating Units will have access to their previous FY data in the system, which can be updated for FY 2012. Please refer to the FACTS Info – PEPFAR Module training materials for further details.

The templates that were used in COP 2010 and COP 2011 **WILL NOT** be accepted by FACTS Info. If you plan to use templates for data entry, you must use the newly created FACTS Info – PEPFAR Module templates. Blank templates for each Operating

Unit can be found at PEPFARplanb.org. The table below gives a brief outline of which elements are required for the FY 2012 COP.

COP Elements	Required/ Optional
Operating Unit Overview Items	
Executive Summary	Required
Population and HIV Statistics	Optional
Partnership Framework/Strategy Goals and Objectives	Required for all OUs that have completed a PF
Global Fund/Multilateral Engagement	Required
Public-Private Partnerships	Required if OU has PPPs
Surveillance and Surveys	Required
Indicators	
National Level	Required
Technical Area Level	Required
Policy Tracking Table	Required for all OUs that have a completed PFIP
Technical Area Summary	
Governance and Systems	Required
Prevention	Required
Treatment	Required
Care	Required
Implementing Mechanisms	
Implementing Mechanism (IM) Narratives	Required
Budget Code Narratives by IM	Required
Management and Operations	
Narratives	Required
Agency Costs of Doing Business	Required
Staffing	Required
Supplemental Documents	
Ambassador's Letter	Required
Budgetary Requirements Justification	As Needed
Functional Staff Chart and Agency Management Charts	Required
Health Care Worker Salary Table	As Needed
Construction	As Needed
Obligation and Outlay Plan	Required
Central Initiative documents e.g. Updated GF collaboration work plan PMTCT acceleration plan LCI template	As Needed

4. FY 2012 Program Priorities and Approaches

Because of an aggressive global response, fewer people are being infected, an HIV diagnosis is no longer a death sentence and more people with HIV/AIDS are living long, vibrant lives. But as long as tens of millions of people live with this devastating disease, and so long as nearly two million people die from AIDS-related diseases every year, we must continue to fight the effects and growth of the HIV epidemic.

During COP planning, PEPFAR country teams should consider the following technical priorities and programming approaches to continue saving lives while ensuring sustainability and increased efficiencies.

4.1 Program Priorities

As it works to promote sustainable country programs and achieve program goals and targets, PEPFAR is focusing in FY 2012 on the following strategic areas, presented in non-hierarchical order. Although these priorities are highlighted for FY 2012, teams should not move away from country-specific and context-specific priorities that fall outside of the areas noted below.

1. Increase PMTCT coverage and effectiveness

Prevention of Mother to Child Transmission (PMTCT) is a smart investment for PEPFAR in generalized epidemics. In settings with high HIV prevalence, it is cost-effective and high-impact. Mother-to-child transmission is a significant cause of new HIV infections among children worldwide. Pregnant women in developing countries face a range of obstacles in getting health services they need, including support to protect their babies from HIV. Yet PMTCT interventions are extraordinarily effective. Without PMTCT, 25-40% of babies of HIV-positive mothers will be born infected; with PMTCT that number drops to below 5%. The benefits are vast. PMTCT has a triple life-saving benefit: saving the life of the mother, protecting her newborn from HIV infection, and protecting the family from orphanhood. We have shown that PMTCT works: the challenge is reaching all the women in need. In settings where access for women to HIV testing and ongoing care can be increased by heightened linkages with MCH or family planning programs, this approach should be utilized.

2. Improve and refine the country's approach to treatment

Supporting national treatment programs to increase access to those in need of treatment remains a central priority of the PEPFAR program. As programs mature, there must be increased attention to systematically ensuring adherence and retention on ART. This will maximize the beneficial effects for individuals receiving treatment, and to

ensure the broad and important contributions of ART to the prevention of vertical and sexual transmission of HIV infections are achieved. There must also be increased attention to a strengthened facility-based continuum of care that is appropriately linked to community-based care and support activities that foster conducive environments for service uptake, adherence and retention. Guidance regarding budget allocations to treatment is provided below in the section, "Investing Strategically." As in 2010 (prior to the COP 2011), S/GAC will again facilitate joint field team and headquarters discussions around treatment goals and targets during the consensus treatment targeting process, to be conducted prior to COP submission.

3. Programming for prevention impact

The PEPFAR Five-Year Strategy published in December 2009 endorses Combination Prevention (CP) for all PEPFAR Operating Units[2]. Updated guidance for the prevention of sexually transmitted HIV infections will be released later in FY 2011.

CP approaches HIV prevention using a suite of mutually reinforcing interventions to address transmission risk as thoroughly and strategically as possible. It is predicated on the idea that no single intervention is efficacious enough to bring an HIV epidemic under control, but that the optimal set of interventions implemented with quality and to scale can significantly reduce HIV incidence[3].CP recognizes three broad categories of interventions: biomedical, behavioral and structural.

In any country, three overall approaches are crucial to reducing new HIV infections:

(1) increasing knowledge of HIV status among people living with HIV and their partners;
(2) reducing risk of HIV transmission from people living with HIV; and
(3) reducing HIV acquisition among persons at high risk for infection.

In working with country partners to implement their national plans, and upcoming updated guidance on prevention of sexually transmitted HIV infections, PEPFAR teams should prioritize funding of programs that are:

(1) scientifically proven to reduce HIV infection and/or increase access to care;
(2) able to demonstrate sustained and long-standing outcomes that contribute to goals;
(3) scalable to produce outcomes at the community level; and
(4) cost-effective.

[2] (2009) U.S. President's Emergency Plan for AIDS Relief 5-year Strategy. In Office of the Global AIDS Coordinator, U.D.o.S. (ed), Washington, DC.
[3] Hankins, C.A. & de Zalduondo, B.O. Combination prevention: a deeper understanding of effective HIV prevention. *AIDS,* **24,** S70.

4. TB/HIV integration

Tuberculosis (TB) remains the most common cause of death among people living with HIV in sub-Saharan Africa. The PEPFAR Five Year Strategy identifies the urgent need to address the TB/HIV syndemic and commits to aggressively expand implementation of the treatment of co-infected persons and the Three Is:

- Intensified case finding,
- Isoniazid preventive therapy
- TB Infection Control Measures to prevent spread

Bringing TB/HIV activities to scale and providing basic care packages including cotrimoxazole, should be prioritized.

5. Testing and Counseling

Knowledge of HIV serostatus is fundamental for combination prevention and entry into evidence-based interventions that reduce HIV morbidity and mortality. These interventions include, but are not limited to: ART, TB screening, prevention, and treatment, cotrimoxazole preventive therapy, nutritional support, and prevention of diarrheal disease. Similarly, HTC is the entry point into evidence-based HIV prevention interventions: MC, ART and PMTCT. Despite the central importance of HTC, in many middle and low income countries only 30 to 40% of people have ever been tested for HIV, and less than 40% of people living with HIV know they are positive. Partner and family HTC programs are especially important for the identification of HIV serodiscordant couples, for whom HIV prevention benefits may be the greatest. Additional resources may be required for HTC to support identification of candidates for HIV care and treatment.

The overarching goals of HTC programs are to:

- Provide services for individuals, couples/partners, and families to learn their HIV status–with particular emphasis on identifying HIV-infected individuals and HIV sero-discordant couples – including appropriate pre-test information and post-test counseling based on serostatus to enhance the benefits of this services and reinforce linkages; and
- Implement strategies for ensuring that individuals, couples, and families are linked with appropriate follow up HIV treatment, care and support, and prevention services based on their sero-status

6. Training new healthcare providers

Severe shortages of heath care providers are a serious threat to countries' abilities to reduce morbidity and mortality due to HIV/AIDS. The lack of an adequate supply of qualified health care and social service providers is also a significant barrier to improve

country ownership and the sustainability of health system investments. As a result, PEPFAR's authorization includes Congressional direction to "help partner countries train and support retention of health care professionals and paraprofessionals, with the target of training and retaining at least 140,000 new health care professionals and paraprofessionals with an emphasis on training and in-country deployment of critically needed doctors and nurses and to strengthen capacities in developing countries, especially in Sub-Sahara Africa, to deliver primary care with the objective of helping countries achieve staffing levels of at least 2.3 doctors, nurses and midwives per 1,000 population…" Given this Congressional direction, all PEPFAR country teams are expected to contribute to the production of newly trained health care providers to support the overall continuum of comprehensive HIV/AIDS response in their countries. Target numbers should be based on the national estimate of persons, adults and children, living with HIV/AIDS and the WHO standard of 2.3 health workers per 1000 population. In addition to producing new providers, country teams need to simultaneously support a range of strategies to retain providers with particular focus on retaining providers in rural areas and under-served populations.

7. Capacity Building

One of the primary goals of the second phase of PEPFAR (2009-2013) is to build partner country capacity to respond to HIV/AIDS effectively and efficiently, and to build long-term sustainability of national HIV/AIDS programs. Capacity building, defined as "the ability of individuals and organizations or organizational units to perform functions effectively, efficiently and sustainably" (UNDP, 2004), is integral to the USG's efforts in fighting the global AIDS epidemic. **Capacity building** is an on-going evidence driven process of strengthening the abilities of individuals, organizations, and/or systems to perform core functions sustainably, and to continue to improve and develop over time.

An important objective of PEPFAR in all countries is to strengthen host country government, civil society and private sector capacity to respond to HIV/AIDS effectively and efficiently and to build sustainable national HIV/AIDS programs. Capacity building is an inherent part of initiatives and activities underway in PEPFAR, including program activities in all technical areas covering prevention, care and treatment, and cross-cutting areas of health system strengthening and integrated health services. Capacity building is particularly important for the transition to greater country ownership, local partner direct implementation and country led programs.

US government investment in capacity building through PEPFAR, within the context of national HIV/AIDS plans, should seek to assist host government efforts to know their epidemics and respond strategically to prevent new infections, care for and treat infected and affected populations, and mitigate the social and economic consequences. Effective capacity building efforts target government, local research and development institutions, nongovernmental organizations, networks, communities, academia and the private sector, with a goal toward enhancing the short and long term potential for these

institutions to support the local response and for host governments to lead, manage and monitor internal and external efforts to address HIV/AIDS in country. Part of this process includes a host country's ability to drive the process to identify, source and manage on-going capacity building efforts as a sustained government-led effort to target change.

PEPFAR endorses a capacity building framework that addresses three integrated and reinforcing components: individual/workforce, organizational, and systems within a country setting. The conceptual framework for capacity building stresses the interrelationship of the three components - the individual, organizational and systems – often requiring concurrent and sustained capacity strengthening over time. As PEPFAR and host country partners strive to increase the sustainability of HIV/AIDS programs and results, the relationship between capacity building and development outcomes and impact is increasingly important. Furthermore, it is of critical importance for the host country to be able to capture and measure change in HIV/AIDS program quality, efficiency and health outcomes over time.

Thus, all efforts in PEPFAR should explicitly consider the degree to which host country capacity to know and appropriately respond to their epidemic is improved as a result of those efforts, and all capacity building under PEPFAR should ultimately lead to improvements in HIV outcomes and impacts.

The COP submission should provide clear capacity building objectives for each of the main program areas of treatment, care, and prevention as well as across program areas and in cross-cutting areas based on current capacities. The COP should include a description of what is being done to ensure capacity is being built to achieve and sustain those objectives.

Each PEPFAR team should use the COP as an opportunity to look strategically at your portfolio and see how to maximize the effectiveness of the capacity building efforts to address existing gaps. Each of the three levels of capacity building should be considered. Capacity building efforts should be based on an understanding of the landscape of capacity building activities, both within and outside of USG funded efforts and be responsive to identified gaps. Capacity building activities should clearly spell out expected capacity outcomes and performance by technical and cross-cutting areas. Such activities should rely heavily on partnerships with local and national entities to support a country-owned capacity building strategy. While describing in-country PEPFAR capacity building plans, the COP should address transition plans for increasing the leadership and management role of local partners in implementing USG-funded activities over time as prime partners as capacity is demonstrated.

PEPFAR teams are encouraged to include plans for monitoring and evaluating capacity building efforts in terms of both performance and HIV/AIDS outcomes and impact.

Monitoring capacity building efforts provides an opportunity for USG country teams to demonstrate the transition of the PEPFAR program strategy from an emergency response focusing on direct service delivery to one that focuses on developing sustainable country capacity and ownership. It is equally important to describe how you will monitor the effects of this transition on HIV/AIDS service delivery outcomes and health impact.

As teams develop their COPs, they should consider and try to answer the following questions:

1. What are the overall capacity building objectives for your program and for each technical area? Does the approach integrate individual/workforce, organizational, and systems/policy needs?
2. Are priorities determined by their potential effect on expected HIV/AIDS outcomes and impact?
3. What current or new partnerships with national government, local organizations and other stakeholders will support capacity building?
4. What are the capacity building activities, outputs, and outcomes and what indicators will be used to measure these?
5. What measures are in place or will be developed to assure that quality standards remain as host countries take a greater role in leading and managing the response. What capacities will need to be enhanced to take on these roles? Are quality standards determined at the country level based on input from a collaborative process with host country and other stakeholders, including USG teams?
6. What are the benchmarks to measure change in the intended overall performance outcome(s) of all capacity building activities that will support the independent implementation of HIV programs and services by national governments and local partners?
7. How will change in capacity of national governments and local partners be measured over time?

The PEPFAR Capacity Building Framework will be provided as supplementary guidance to country teams with additional information on how to formulate and monitor effective capacity building plans.

4.2 Programming Approaches

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

approaches: integration, the continuum of the HIV response, attention to specific vulnerable populations, the Global Health Initiative, and country ownership.

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

2. Continuum of the HIV response – Focus on the program priorities should enhance the HIV continuum of care model, ensuring that programs:
   - Link to and between HIV prevention, care, and treatment opportunities within and between facilities and communities;
   - Link to and between HIV services to other health sector services; and
   - Link to and between HIV services to broader development opportunities.

Please see Appendix 3 for a description of the core principles for the Continuum of Response (CoR).

3. Attention to specific populations **-** Consider vulnerable populations when programming to the priorities.

   - **MARPs:** Most-at-risk populations – Especially vulnerable or MARPs populations [including Men Who Have Sex with Men (MSM), People Who Inject Drugs (PWIDs), Sex Workers (SWs) and prisoners] are affected by laws, regulations and policies because of their illegal behaviors. Stigmatized and marginalized populations whose practices affect the nature, scope and quality of programs.
   - **Focus on Women, Girls, and Gender Equality:** A core objective of GHI is to improve health outcomes among women and girls, both for their own sake and because of the centrality of women to the health of their families and communities.

4. Global Health Initiative

The Global Health Initiative (GHI) aims to maximize the sustainable health impact the United States achieves for every dollar invested, both by PEPFAR and other USG health programs. Through this Initiative, PEPFAR will take its achievements to the next level by further accelerating progress and investing in sustainable health delivery systems for the future. The GHI strategy is a high level document outlining a whole of government vision for working with and in partner countries around health investments. It is not intended to be an operational plan, nor is an associated implementation plan required. Existing programs and funding streams such as PEPFAR, PMI, and USG health programs will all continue to operate and deliver services as component elements of GHI. The COP continues to be the mechanism through which PEPFAR country teams plan and

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

If your country has done a GHI Strategy or is in the process of developing one, you should ensure that your COP reflects in the Executive Summary and the implementing mechanism overall narratives the linkages between the cross-cutting areas defined in the GHI Strategy and your PEPFAR work.

All PEPFAR countries are expected to work to incorporate the GHI Principles and model into their COP planning processes. If country teams have already completed a GHI Strategy, there should be a reflection of how PEPFAR will contribute to that strategy in the COP. Specifically; all implementing mechanisms (IMs) should include some discussion of the plans by Implementing Partners to incorporate relevant GHI principles into their work-plans. PEPFAR-funded activities under the 2-3 focus areas should also be highlighted in the overall IM narratives. If country teams are in the planning stage of a GHI Strategy, the team should reflect how they expect the activities in the COP to contribute to GHI over the next year.

In particular, teams should focus on the ways in which PEPFAR programs can reflect and incorporate the GHI principles into their programming, as summarized below:

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

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

GHI guidance is available to country teams at
www.ghi.gov/resources/guidance/index.htm.

5. Country ownership

Accelerating local ownership of HIV/AIDS programs supported by PEPFAR is a central goal of the second phase of PEPFAR. This new era shifts from the necessary emergency response which was the foundation of PEPFAR, to a phase emphasizing

sustainability. Country ownership is an iterative and evolving process. Some country teams have graduated programs to local organizations; assisted governments to build their own capabilities and developed cadres of technical experts. In certain countries, PEPFAR teams already work in an environment where the country has always been in the lead.

There is a need to accelerate the pace of country-level change to local institution leadership, joint conceptualization in program design and planning and clear measurements for this change over time.

With continuing consultation with other global collaborating and country partners, PEPFAR has prioritized a common approach to understanding country ownership. This approach identifies four dimensions to country ownership:

- Political ownership/ stewardship
- Institutional ownership
- Capabilities
- Accountability

Dimensions of country ownership form a definition and a way of describing the essential requirements for successful ownership. In the current assessment of country ownership, political ownership and institutional ownership alongside capabilities to implement programs and accountability for results and financial stewardship have been identified as the essential requirements.

Political ownership/stewardship: At the core of political ownership is ownership by the government of the vision for sector support. Here the government, with support from civil society, the private sector and other funding partners, clearly articulates its priorities and plans for program development, and has visibility into and oversight of the specific activities conducted by all stakeholders.

Institutional ownership: With high institutional ownership, local institutions (Governmental, NGOs, FBOs, etc) own the final decisions for each stage of program development and local institutions manage the funds and have responsibility for programs.

Capabilities: For programs to be sustained and quality retained, country leadership must have the technical and management capabilities to oversee programs and make adjustments and shifts over time. Planning must be deliberate to provide ample opportunities for local capacity to perform activities. These efforts could include outsourcing to capable entities as well as modifications to programs when new evidence emerges for program improvement.

Accountability: Meaningful ownership requires a strong sense and defined accountability between governing bodies and the citizens it serves, and mutual accountability between country leadership and donors for measurable results over time. Information and processes must be transparent with mechanisms for input and feedback from recipients of services including civil society. Explicit roles and responsibilities should be identified, with consequences for failure in performance.

Responsibilities within U.S. Government Country Teams:

Within PEPFAR OU teams, many good and emerging practices which advance the objectives of country ownership were seen during the Partnership Framework development process. To further accelerate country ownership, this guidance provides country teams with additional tools, including a mandate to change the way we do business to make country ownership successful. This mandate begins with providing teams with a common understanding and vision for country ownership and encouragement and incentives to aggressively transition programs to local implementers with concurrent support to organizational capacity development.

In order to succeed, PEPFAR teams will have to draw upon a mix of skill sets (capabilities) in both technical areas and management that can be deployed to enhance capabilities in partner country systems and personnel. These include a deliberate effort at greater mentoring and supportive supervision activities. PEPFAR processes and evaluations must support national plans and PEPFAR organizational structures and professional incentives must support the country ownership approach. Clear incentives and consequences for program performance should be delineated with partner countries and PEPFAR should model transparency in planning with country stakeholders.

Measurement of Success: The important component for country ownership metrics will be change over time. Discussion is still ongoing in the effort to look across the four dimensions of country ownership in each stage of program development and determine how best to 'score' country ownership to track change over time. Nonetheless, teams must provide a narrative during the reporting season of the progress over the past year by determining benchmarks that have been developed with host partners.

Examples: Country teams may consider developing benchmarks for each 'stage' defined for each dimension of country ownership. Benchmarks for political ownership may include the degree of government led planning or the level of country financial contribution to the HIV response. Institutional ownership may be the percentage of funds managed by local organizations or the degree of meaningful engagement of civil society in decision making. Capability may be measured by the use of local procurement and financial management systems and the degree to which services are managed by in-country technical personnel. And lastly, accountability may be measured by

publishing of results or the successful operating of a single integrated national M&E framework.

When considering the four dimensions of country ownership and responding to the assessment questions in the executive summary, teams should consider how change in these dimensions could be tracked over time in your country context. This will be addressed during the COP reviews so review teams can help country teams place themselves on a continuum of country ownership and start thinking of possible metrics for their programs tailored to their country context.

4.3 Tools for Portfolio Decision Making

1. Investing Strategically Across the Portfolio

There is increasing need to define priorities and make intentional resource allocation decisions to ensure the program more strategically, sustainably and efficiently meets its goals and puts partner countries in a leadership position. We are in a position in which investment choices must be made, and made strategically, in full knowledge of other donor and country level financial investments and plans.

While there are always new decisions to make due to emerging data and technical innovations, recommendations for changes in practice *within* a program area are typically made by subject matter experts, aided by normative guidance and are more straightforward than guidance on allocations across an entire program. For instance, when scaling-up HIV treatment programs, PEPFAR and WHO guidance recommend integration of routine screening for TB because it is highly effective and thus should be prioritized. PEPFAR has traditionally provided little direction on allocation decisions across program areas and has instead relied on country teams to make decisions informed by local conditions. However, given discrete resource envelopes and high unmet demand for many services, country teams have now requested guidance from PEPFAR leadership on expectations for how USG resources should be invested for greatest impact at the country level.

Between the rapid expansion of expenditure analyses, targeted costing studies, and other information, country teams should have an increasingly intimate understanding of their expenditures and the kinds of outputs being generated. Better information leads to better decision making, and this information in particular can improve resource allocation decisions, impact and efficiency if used well. It is imperative that PEPFAR teams have an accurate understanding of the unit costs of their programs. These data can be challenging to gather, but new tools generated through collaborations between headquarters and field teams are available to help. All teams should be planning an expenditure analysis with assistance from headquarters. While it may not be possible to

undertake this analysis before submitting an FY 2012 COP, it should be part of the planning process for the following year.

In order to achieve the greatest value for our investments, we must move more quickly to allocate our resources based on the impact of the interventions and on the complementarity of our programs with those funded by the national government and/or external funders such as the Global Fund. We should therefore be asking: 1) Have we made evidence-based decisions based on impact on human life and the epidemic, as well the outcome and impact goals articulated by the country? and 2) How is the epidemic changing and are we properly targeting areas along the continuum of services that people need? We need to be sure that inertia and perceived long-term funding commitments to agreements or contracts do not dissuade us from making more strategic allocation decisions. If they have, we need to take immediate steps to change that situation.

Through Partnership Frameworks and the work country teams do with governments every day, PEPFAR has made great gains in ensuring the complementarity of our investments with those of the national government, and the Global Fund. We must increasingly view our work through the lens of what the government sees as a priority for their people, and understand how what we do contributes to a program that can be absorbed and sustained with government and civil society leadership. However, we must maintain the high standards for which PEPFAR is known, and in the context of national priorities, our resources must be used wisely to have greatest impact.

Our greatest urgency is to reduce new infections with the best tools we have to do so. In most cases, this is a matter of spending more wisely on prevention, on evidence-based interventions (as specified in the Technical Considerations and forthcoming Prevention Guidance), that will have the greatest impact on new infections in the shortest timeframe. While we also need to invest in longer-term strategies to reduce HIV transmission, the bulk of prevention dollars should be invested with a goal of rapid impact. This should be done with the same commitment to efficiency that a dedicated provider demonstrates when asked to care for even more patients. This emphasis on short-term impact should save money and lives in both the near and longer term.

Our expenditures on care must be driven by the need to demonstrate impact- Supporting TB/HIV co-infection services and providing basic care packages including cotrimoxazole, clearly meet this criterion. Our work with OVC continues to have great impact on families and communities. Programs to enhance community support systems for adherence and retention should be implemented to ensure the impact of critical services such as PMTCT and pediatric care and treatment. These programs should be targeted, carefully monitored and evaluated.

Determining an approach to treatment scale-up: As a guideline, we need to spend every dollar mindful of the fact that it could have been used to directly save a life today with antiretroviral treatment. Treatment remains central to the much of our ongoing success in reducing morbidity and mortality. It is increasingly the intervention of choice for keeping mothers living with HIV healthy and preventing new infant infections. New studies continue to demonstrate that treatment also has tremendous impact on reducing sexual transmission of HIV. Therefore, every PEPFAR team, whether it *directly* supports treatment or not, should make the strong performance of country treatment programs a priority in its programs.

S/GAC expectations for treatment scale-up in generalized epidemics and our contributions to it vary. Factors include the types of internal and external resources available in a country, the burden of those living with HIV and coverage rates for treatment and other key interventions for people living with HIV/AIDS, as shown in the table below.

In this table, the countries in yellow are among those with the highest burdens of disease, lower levels of treatment coverage and the lowest internal and disbursed Global Fund resources. Using this framework, PEPFAR teams in these countries should consider raising their budgetary allocations to diagnosis and treatment over time, as needed, and in discussion with S/GAC. In yellow-highlighted countries that do not currently support direct treatment targets, these increases might represent increased technical support to treatment programs.

On the other hand, countries clearly at the other end of the spectrum in terms of available resources and disease burden would not be expected to raise their PEPFAR treatment budget allocation beyond current levels. It is in these countries in particular that we would expect substantial and increasing government commitments to funding, strong Global Fund applications and efforts to fully absorb these programs into the national systems. Only as a last resort should we be committing to greater proportions of our budgets to treatment in these countries.

This categorization provides only one important lens through which decisions could be considered. There may be other circumstances that require greater treatment funding, such as rapid acceleration of PMTCT or major increases in counseling and testing to facilitate male circumcision scale-up. These and other factors could contribute to decision-making for those countries in the middle swath of the table where there may be less clarity about whether to continue expansion of treatment investments. Funding allocations should also reflect deep engagement with government and agreements over projected needs and shared responsibilities. Teams should be in close touch with headquarters as well. The consensus treatment targeting process helped to align headquarters and country plans and expectations last year, and should help again in our 2012 planning.

PEPFAR Countries, by HIV Burden, Treatment Coverage (<350 cells/mm^3) and Resources

		Low Income Countries			Lower-Middle Income Countries			Upper-Middle Income Countries	
PLWHA Tertile	Treatment Coverage (<33, 33-66%, >66%)	Low GF$ per PLWHA	Med GF$ per PLWHA	High GF$ per PLWHA	Low GF$ per PLWHA	Med GF$ per PLWHA	High GF$ per PLWHA	Low GF$ per PLWHA	Med GF$ per PLWHA
High PLWHA	Low Treat. Cov.	Mozambique	Tanzania		Nigeria				
	Med. Treat. Cov.	Kenya Uganda	Zambia Zimbabwe					South Africa	
	High Treat. Cov.								
Med PLWHA	Low Treat. Cov.	Cote d' Ivoire	DRC Malawi		Cameroon Thailand	Lesotho			
	Med. Treat. Cov.			Ethiopia					
	High Treat. Cov.							Botswana	
Low PLWHA	Low Treat. Cov.		Burundi	Ghana		Angola			
	Med. Treat. Cov.			Haiti			Swaziland		
	High Treat. Cov.			Rwanda			Guyana		Namibia

* PEPFAR Countries with a generalized epidemic

Number of PLWHA (tertiles)- UNAIDS 2009
Low: 280,000 or less
Medium 280,001-940,000
High: 940,001-5,600,000

Treatment Coverage (<350)- WHO 2009
Low: <33%
Medium: 33-67%
High: >67%

GF Disbursement/PLWHA 2010
Low: <$50/PLWHA
Medium: $50-150/PLWHA
High: >$150/PLWHA

2. <u>Smart Investments to Increase Impact and Efficiency and Save More Lives</u>

The global economic crisis has forced all partners to do more to meet unmet needs with finite resources. PEPFAR is building upon ongoing work to make our programs more efficient and of greater impact. PEPFAR is working to accelerate these gains through policies and programs through these seven areas, and asks teams to consider the questions under each area:

1. Strengthen use of economic and financial data to ensure efficient use of resources.
   i. Have we targeted special costing studies to examine areas of our portfolio with the greatest investments and/or the least information?
   ii. Do we have annually updated information, by cost category on the USG costs of producing each of our program outputs and outcomes?
   iii. Have we prioritized PEPFAR expenditure analysis and support to government for understanding national funding streams?

2. Incorporate innovations that promote efficiency and allocate resources based on impact
    i. Have we made evidence-based decisions based on impact on human life and the epidemic, as well as the outcome and impact goals articulated by the country?
    ii. How is the epidemic changing and are we properly targeting areas along the continuum of services that people need?

3. Increase collaboration with governments, the Global Fund and other partners to align programs and target investments
    i. Are we engaging the appropriate local stakeholders, including the partner government and the CCM, in selecting the interventions on that continuum that we will cover?
    ii. Have we made appropriate adjustments to ensure complementarity of our investments with those of the national government and the Global Fund?
    iii. What additional resources, monetary and otherwise, are national governments contributing to their response to HIV through partnership frameworks and other avenues?
    iv. How are we supporting national governments in their efforts to design, implement, and evaluate programs? How are we supporting Global Fund Principal Recipients and Country Coordinating Mechanisms in planning and execution?
    v. Are we viewing our Global Fund investments as our USG multilateral contribution to the response and one that we have the opportunity to leverage and facilitate at the country level?

4. Reduce costs by streamlining USG operations and supporting increased country ownership
    i. Can we improve our whole of government response?
    ii. How well do our staffing patterns and other elements of the USG footprint match our program priorities and are they appropriately sized?

5. Achieve best all-inclusive commodity pricing
    i. How are we using information on drug and other commodity pricing to drive down annual costs?

6. Leverage creative mechanisms for healthcare finance to bring additional resources to bear

i. Are we exploring with government and other stakeholders, innovations such as health insurance and performance-based financing to improve sustainability and outcomes?

7. Develop an evaluation and research agenda that will show how to improve efficiency and impact
    i. Are we using the tools of program evaluation and research to address critical questions of efficiency and impact facing PEPFAR and the national program?

Please refer to http://www.pepfar.gov/smart/index.htm for further detail on these smart investment strategies.

5 Mandatory Earmarks; Budgetary and Reporting Requirements

Complying with legislative earmarks and responsiveness to Congressional reporting requirements are important elements of COP preparation. Both must be carefully considered by OU teams in a manner that takes into account the country/regional context and seizes every opportunity for integrated programming consistent with the Five-Year PEPFAR strategy and the imperatives of the Global Health Initiative.

5.1 Orphans and Vulnerable Children (OVC)

PEPFAR must devote at least 10% of program resources in Prevention, Care and Treatment funding globally to OVC programs.

Former focus countries (with the exception of Vietnam and Guyana) *must* spend at least 10% of their budget on OVC; justifications from these countries for amounts less than 10% will not be considered. OVC programming is essential for all countries/regions, but those with smaller OVC populations and concentrated epidemics may submit justifications for spending less than 10%.

Countries may wish to consider budgeting HIV prevention programs that have OVC as an explicit and exclusive target population in the HKID budget code. Pediatric treatment may **not** be counted towards the OVC earmark but remains a global priority and continues to have its own pediatric treatment program budget code.

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

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

5.2 Care and Treatment Budgetary Requirements and Considerations

Teams should be aware that under PEPFAR reauthorization, at least 50% of the total global prevention, care, and treatment resources must be dedicated to treatment and care for PLHIV, according to the following formula:

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

5.3 Other Budgetary Considerations

While they do not raise to the level of "hard" earmarks in authorizing legislation, our partners in Congress may use the annual appropriations process to emphasize priorities from their unique perspective and to indicate levels of funding for those priorities which they expect the program to achieve, sometimes referred to as "soft" earmarks. It is vitally important that teams are responsive to these concerns. As any such provisions are enacted for FY 2012, S/GAC and the implementing agencies will communicate any expectations for teams to incorporate such provisions in their planning processes.

5.3.1 Tuberculosis

Tuberculosis (TB) remains the most common cause of death among people living with HIV in sub-Saharan Africa. The PEPFAR Five Year Strategy identifies the urgent need to address the TB/HIV syndemic and commits to aggressively expand implementation of the Three Is and treatment of co-infected persons. Under President Obama's Global Health Initiative (GHI), integrated programming is to be enhanced. TB/HIV collaborative activities reflect the key concepts of coordination, collaboration, integration and systems strengthening that are central to GHI. In addition there is an increasing focus within PEPFAR on using an implementation science framework to improve program delivery and provide information on efficiency, effectiveness, and impact of PEPFAR activities. Thus an even greater emphasis is being placed on monitoring and evaluation of TB/HIV programs to ensure delivery of quality services, demonstrate impact, and suggest program adjustments to improve outcomes.

As the Global AIDS Coordinator Ambassador Goosby has articulated, there is increasing need to define priorities and make intentional resource allocation decisions to ensure

that PEPFAR more strategically, sustainably and efficiently meets its goals; allocation decisions must be driven by certain impact. Bringing TB/HIV activities to scale and providing basic care packages including cotrimoxazole and isoniazid preventive therapy, clearly meet this criterion. Investment in TB/HIV should therefore be maintained PEPFAR-wide.

HIV prevalence among patients diagnosed with active TB is much higher than the general prevalence in most sub-Saharan African countries, with rates as high as 80%. TB clinical settings provide an opportunity to identify large numbers of PLHIV who are in need of HIV care and treatment services, most of whom are eligible for ART based on low CD4 count and clinical stage; HIV care settings can greatly assist in identifying co-infected individuals.

PEPFAR has made important strides in expanding the number of countries and the number of TB patients tested for HIV, and in enrolling HIV-infected TB patients into HIV care and treatment. This is critically important, as a growing body of evidence suggests that initiating ART soon after starting TB treatment increases survival among those co-infected. On the other hand, expansion of TB screening of HIV-infected individuals has been unacceptably slow, especially when recent studies of patients on antiretroviral therapy (ART) have documented high rates of TB (7-20%) not only among individuals initiating ART, but also among patients on ART. Given the high morbidity and mortality associated with undiagnosed TB, it is clear that more must be done to rapidly screen, diagnose, and treat individuals with both infections.

The *WHO Interim Policy on Collaborative TB/HIV Activities* outlines the interventions critical to reducing the burden of HIV among TB patients and reducing the burden of TB among PLHIV. As stated in the State of the Program Area Report (SOPA) for TB/HIV, PEPFAR supports implementation of recommended interventions in countries through direct delivery of services and advocacy with ministries of health (MOHs) and partners, technical assistance to develop national guidelines/policies and operational tools, and program planning and evaluation based on the following priorities:

1) Provider-initiated HIV testing and counseling (PITC) and linkage to HIV care and treatment for people with TB
2) TB intensified case-finding (ICF) and TB treatment among PLHIV
3) Provision of cotrimoxazole prophylaxis (CPT) in TB clinics to PLHIV diagnosed with TB disease (with the ultimate goal of ART provision in TB clinics)
4) Isoniazid preventive therapy (IPT) for PLHIV who do not have active TB disease
5) TB infection control (IC) activities in both TB and HIV care and treatment settings
6) Laboratory services to support TB diagnosis and treatment
7) Strengthening program monitoring and evaluation (M&E)
8) Surveillance and management of multi-drug resistant TB (MDR TB)

9) Strengthening general TB control (DOTS)

PEPFAR appropriations in recent years have included an earmark for TB/HIV; the FY 2010 amount was $160 million, and we intend to maintain this level of investment in the 2012 cycle (no earmark was set forth under the FY 2011 Full-Year Continuing Appropriations Act). ***Submissions that do not reflect resource commitments commensurate to the TB burden should expect to receive additional scrutiny in the review process****.*

Countries are strongly encouraged to maximize TB/HIV programming and direct budget attribution (including placing TB/HIV associated laboratory costs in the HVTB budget code rather than under HLAB). Please consult with the TB/HIV technical working group for further guidance.

5.3.2 Food and Nutrition

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

Recent appropriations have included expanding earmarks for nutrition. For FY 2010, the food and nutrition earmark was $130 million, and we intend to maintain this level of investment in FY 2012.

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

Teams are encouraged to focus resources on this critical priority commensurate with the degree of HIV-related food insecurity and/or malnutrition among PLHIV and to fully consider opportunities for complementary programming with Feed the Future, World Food Program, etc. **While it does not have a separate program budget code, field teams should carefully and comprehensively quantify the level of financial commitment to food and nutrition represented in OVC, care and**

support, PMTCT, and treatment programs. The narrative below is intended to assist teams in ensuring they effectively program activities to both meet country needs and respond to Congressional expectations.

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

Nutrition Care

Nutrition assessment, counseling, and support (NACS) is an essential component of a comprehensive response to HIV care and treatment. Ensuring that basic nutrition assessments and effective nutrition counseling occur consistently and accurately creates a foundation on which all other nutrition activities are based. Therapeutic and supplementary feeding is a critical component of HIV care and support and is most effectively utilized when provision is based on anthropometric criteria. Provision of therapeutic and supplementary feeding support, particularly in resource-poor settings, should be prioritized to assist the most vulnerable individuals as follows:

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

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

PMTCT and HIV-Free Survival

HIV-free survival (infants who remain alive and HIV-free) is the ultimate goal of PMTCT and infant-feeding programs. Newly released WHO guidelines on PMTCT now include recommendations for ARV interventions that can drastically reduce the risk of MTCT during ante- and perinatal periods. The new infant feeding guidelines also recommend provision of ARVs to mothers not currently receiving ART or their infants through the duration of breastfeeding. In light of the effectiveness of the ARV treatment and prophylaxis interventions, HIV-infected mothers are encouraged to breastfeed for a minimum of 12 months and beyond until a safe and adequate replacement diet is available. Programmatic emphasis should be placed on pre- and postnatal counseling surrounding infant feeding, nutrition, and health. Special attention should be given to link counseling to early infant diagnosis to discourage premature weaning. Regular assessment, counseling, and support should be provided, particularly to encourage exclusive breastfeeding for the first six months of life and appropriate complementary feeding from six months of age and beyond and to provide post-weaning support. Establishing a continuum of care linking clinical and community services should allow

for tracking of mother-infant pairs, a focus on improving maternal nutrition status, and provision of basic child survival interventions until at least 24 months of age.

Economic Strengthening, Livelihoods and Food Security

Through provision of NACS and other services, care and treatment facilities assist in meeting the needs of PLHIV, their families and OVC. However, these services are not able to address underlying issues, such as generalized food and economic insecurity, that can compromise treatment success and long-term survival of PLHIV, nor are they able to address needs for OVC and their caregivers. Therefore, there is a need to link NACS clients with wrap-around services that address their current economic strengthening /livelihoods/food security (ES/L/FS) needs and the basic needs of children and families. Efforts are needed to identify promising ES/L/FS practices that can be effectively targeted, scaled-up and linked to clinical services to sustainably improve the economic and food security status of HIV/AIDS-affected households. Coordinating programming of PEPFAR nutrition activities and wraparound services with broader food security/nutrition programs, such as those implemented through Feed the Future, will assist in comprehensively addressing the nutrition needs of PLHIV and their families.

5.3.3 Abstinence and Be Faithful Reporting Requirement

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

If AB programmed activities do not reach a 50% threshold of all sexual prevention funding in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

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

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

5.3.4 Strategic Information

An important consideration when determining the overall COP planned budget is how much to allocate towards Strategic Information (SI). International standards suggest at least 5-10 percent of the budget should be dedicated to SI with a few exceptions for those countries with very large budgets. In PEPFAR, some countries with very large planned budgets may have a lower percentage in SI, while some technical assistance countries may have SI budgets that far exceed 5 -10 percent.

In addition to the overall support for SI activities in the country plan, further deliberations are necessary to determine what percentage of program-level funding should be set aside for basic program monitoring and evaluation. International standards suggest at least 5-10 percent of a program budget should be dedicated to monitoring and evaluation of the program. Regardless of the exact percentage, routine monitoring and evaluation should be integral to all PEPFAR programs.

5.4 Single-Partner Funding Limit

The single partner funding limit seeks to promote efficient use of funding, diversify organizations with which PEPFAR partners, and increase partnerships with local organizations, all with the goal of promoting long term sustainability of HIV/AIDS programs in partner countries. This long-standing administrative requirement is highly relevant in the context of the new PEPFAR strategy and its priority on country ownership and sustainability. Ongoing procurement reform at USAID is further expected to reinforce priority on the values associated with the funding limit.

For operating units receiving over $20 million in PEPFAR funds for FY 2012 (GHCS-State, GAP, and/or GHCS-USAID for HIV), the percentage limit on funding to a single partner remains 8%. For operating units receiving $20 million or less in FY 2012, the single partner limit is $2 million.

The single partner funding limit only applies to grants and cooperative agreements. The limit does NOT apply to:

- Competitively awarded contracts
- Allocations to USG agencies
- Umbrella awards
- Commodity/drug costs
- Allocations to government ministries and parastatals

The partner's percentage of total COP funding is calculated by dividing the partner's applicable funding (total partner funding [prime & sub] – exempted funding) by the

COP budget (central and field dollars), excluding U.S. Government team Management and Operations (M&O) costs:

$$\frac{\text{Partner Funding Applicable to the Single-Partner Funding Limit}\ (\text{Total Partner Funding (includes funding received as a prime or sub)} - \text{Exempted Funding from the Limit})}{\text{Country Budget Applicable to the Limit}\ \text{Country Budget (Central \& Field \$)} - \text{USG M\&O Costs}} = \%\ \text{Partner Funding}$$

Additional information about the limit and the exceptions is available in Appendix 4.

5.5 Justifications

Please submit a justification for any situation where the mandatory budgetary or reporting requirements cannot be met within the guidance above for OVC (in countries with concentrated epidemics or former non-focus countries, only; USG programs in former focus countries with generalized epidemics **must** meet the 10% OVC earmark), care and treatment, sexual prevention, and the single-partner funding limit. A sample is located on the PEPFAR Plan B SharePoint site for your convenience.

6 Other Guidance

6.1 Family Planning

There continues to be significant unmet need for family planning and reproductive health services worldwide in both HIV-positive and HIV-negative populations. For example, in Sub-Saharan Africa one in four women who wish to delay or prevent pregnancy do not use any family planning method (WHO, 2009). This same region has the highest rates of HIV, a disease which disproportionately affects women — nearly 60% of people living with HIV in Sub-Saharan Africa are women.

Among women infected by HIV, there is strong evidence to suggest that they have less access to family planning and reproductive health services, in the face of great need and often higher vulnerability to morbidity and mortality. Several studies have illuminated the unmet need for family planning for women living with HIV, and suggest that levels of unintended pregnancies among HIV positive women range from 51% to

91%.[4]

WHO guidance clearly recognizes the special needs of HIV-positive women and the important role of considering their fertility intentions. Voluntary family planning should be part of comprehensive quality care for persons living with HIV. HIV-positive women who desire to have children should have access to safe pregnancy counseling in order to protect their own health and reduce the risk of HIV transmission to their partners and children.

The GHI priorities placed on integrated health programming and implementation of a woman- and girl- and gender equality approach to health assistance reinforce the importance of voluntary family planning and other reproductive health services, including safe pregnancy care for women and families in U.S. Government foreign assistance programs. PEPFAR programs should be used as a platform on which to incorporate and integrate other health services.

USG-supported FP and HIV/AIDS programs must adhere to the following principles:

- HIV-positive individuals should be provided with information on, and be able to exercise voluntary choices about, their health, including their reproductive health.
- The U.S. Government supports a person's right to choose the number, timing, and spacing of their children, regardless of their HIV/AIDS status.
- Access to FP should be universally available and FP use should always be a choice, made freely and voluntarily, independent of the person's HIV status.
- The decision to use or not use FP should be free of any coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.
- ARVs for an HIV-positive person should never be conditioned on that person's choice to accept or reject any other service (other than what may be necessary to ensure the safe use of ART).
- Field teams are expected to prioritize opportunities to link PEPFAR-funded activities with those funded from separate USG accounts or other non-USG sources of funds supporting reproductive health and family planning. In wraparounds between HIV/AIDS and family planning activities, PEPFAR funds should be targeted to the HIV/AIDS portion of the wraparound.

Opportunities that should be actively pursued include:

- providing counseling and referrals (linkages) to family planning programs for women and men in HIV/AIDS prevention, treatment, and care programs – ideally at the same site;

[4] Heys et al. (2009).

- providing family planning clients with HIV prevention including HIV testing and counseling, particularly in areas with high HIV prevalence and strong voluntary family planning systems – again, ideally at the same site;
- integrating family planning services (funded from non-HIV accounts: both USG and non-USG) in PEPFAR-funded PMTCT and HIV care and treatment programs;
- provision of HIV prevention messaging and support, as well as HIV counseling and testing (funded by PEPFAR), within antenatal care, maternal and child health, and family planning programs (funded from other accounts) for both men and women;
- ensuring strong referrals for PMTCT and appropriate care and treatment for women who test HIV positive in any of these venues; and
- monitoring enrollment and receipt of services when referrals are made to capture linkages and ensure uptake of high quality services consistent with the principles for integrating family planning and HIV programs.

If you have any questions regarding the integration of services, please contact your S/GAC CSTL.

6.2 Most-at-risk Populations

Two additional guidance documents for prevention among most-at-risk populations are now available. Both documents describe the scope of USG HIV/AIDS prevention focused activities that PEPFAR will support for these prioritized populations. The guidance documents are a response to the urgent need to expand HIV prevention for most-at-risk-populations.

Guidance on Comprehensive HIV Prevention for People who Inject Drugs was released in July 2010 and is available on www.pepfar.gov/guidance/.

Technical Guidance on Combination HIV Prevention for Men Who Have Sex with Men has been recently released and is also now available on www.pepfar.gov/guidance/.

6.3 Implementation Science and Public Health Evaluation (PHE)

NEW APPROACH

Implementation Science

Based on extensive feedback, changes have been made to the public health evaluation (PHE) program. As PEPFAR implements scientific advances on a large scale through its

programs, the PHE program has shifted towards Implementation Science (IS), a scientific framework to guide program implementation and scale-up that focuses on effectiveness and efficiency in order to build the evidence base necessary to inform the best approaches to achieve sustainable prevention, care and treatment programs[5]. This transition is intended to broaden the scope of high-quality evaluations of PEPFAR-funded programs and ensure the dissemination and use of evidence in decision making and the adoption of best practices across PEPFAR programs. PEPFAR-funded research through IS should continue to guide policy and program development, inform the global community, identify areas where further evaluation and research may be needed, and assess the impact of PEPFAR programs on those at risk for and those infected or affected by HIV at community and national levels in order to determine the best methods for implementation at scale.

Requests for Implementation Science Applications

In FY 2011, the primary mechanism for submitting implementation science proposals is through the solicitation of PEPFAR Implementation Science proposals through CDC, NIH and USAID requests for applications (RFA), in collaboration with S/GAC. Proposals submitted in response to the FY 2011 IS RFAs should inform PEPFAR on effective and efficient approaches to HIV prevention, care and treatment, with a focus on bringing evidence into practice to improve PEPFAR service delivery and outcomes. Please see pepfar.net for further information regarding the PEPFAR Implementation Science RFAs. Please note that S/GAC is working with an interagency team to consider potential mechanisms for reinitiating a call for country-driven concepts. Further notification will be provided as this process develops.

Ongoing PHEs

For continuing PHEs which were concept approved in 2007 - 2010, please continue to follow the PHE protocol review and annual progress reporting process, which is separate from the COP. The following PHE Guidance documents and additional information can be found on pepfar.net.

- PHE Protocol Submission Guidance
- PHE Progress Report Guidance

[5] Padian NS, Holmes, CB, McCoy SI, Lyerla R, Bouey PD, Goosby EP. Implementation Science for the US President's Emergency Plan for AIDS Relief (PEPFAR). *Journal of Acquired Immune Deficiency Syndromes. 2011 Mar; 56 (3):199-203.*

Protocol Review Process
As a reminder, PHE concepts which were approved between FY07 – FY10 must continue to adhere to the protocol submission and review process, including technical review and approval of the protocol. Please see the PHE Protocol Submission Guidance on pepfar.net for additional information.

Progress Reports and Closeout Reports

As in prior years, all ongoing PHEs will be required to submit an annual progress report. Progress reports for previously approved PHE activities continuing into FY 2012 are due on **September 26, 2011.** For all PHE activities that were completed or ended in the previous year, closeout reports should be provided. Please see the PHE Progress Report Guidance on pepfar.net for additional information.

Contact

For questions related to PEPFAR Implementation Science research and ongoing PHE activities, please email PHEProtocols@state.gov**.**

Basic Program Evaluation

In general, evaluation should remain integral to all aspects of PEPFAR, including basic monitoring and evaluation of PEPFAR programs. Basic program evaluation (BPE) refers to studies that guide PEPFAR in program and policy development but are more locally focused on how a program is implemented and the direct effect of a program on the populations using or benefiting from the program resources. BPE studies tend to include needs assessments, formative and process evaluations, and some limited outcome evaluations. Basic program evaluations are strongly encouraged as they are critical to effective program implementation and **should continue to be funded through the COPs.**

7 COP Elements

7.1 Early Funding

OU teams wishing to request early funding for critical **continuing** activities will submit an early funding request in early September 2011. All Operating Units submitting a PEPFAR Operational Plan in FY 2012 are eligible to submit early funding requests, which are subject to HQ review and approval. Early funding requests will take place on

www.pepfarplanb.org. Guidance on how to submit early funding requests has been released in a separate document.

7.2 Operating Unit Overview

7.2.1 Executive Summary

The executive summary should give a high level overview of the OU's program and its priorities for FY 2012. The document should not exceed ten pages. Teams should provide narrative responses to the following topics; the approximate length of response per topic is noted.

Country context (1.5 pages)

Epidemiology of the HIV epidemic in the country
Status of the national response
How does USG fit into the national response?
What do other donors and the private sector contribute to the national response? How does PEPFAR coordinate with these other stakeholders?
Other contextual factors (i.e., status of women, conflict, economic/population growth etc)

PEPFAR focus in FY 2012 (1.5 pages)

What are the USG's key priorities this year? (bullets adequate, key areas of focus – for example 'scale up x activity, focus on x policy change, engage x person in government, increase collaboration with the Global Fund, CCMs and Principal Recipients (PRs), increase private sector engagement, plan on how to monitor PFIP', etc)

How does this COP fit into the broader GHI strategy (whether it is finalized or still in development)? How is PEPFAR contributing to the achievement of the 2-3 focus areas as outlined in the GHI strategy?

How is the PEPFAR program contributing to the GHI principles across the board through HIV programming?

PF/PFIP Monitoring (1 page)

Each OU's Partnership Framework and/or Partnership Framework Implementation Plan (PFIP) was to establish a plan for monitoring progress towards the Partnership's targets, meeting expected partner contributions, and measuring its impact. Please

provide an update describing either progress monitoring (for operating units with PFIPs that were finalized before March 2011) or *plans to monitor* progress of (for operating units with PFIPs that were finalized after April 1, 2011 or are nearing finalization/signature at the time of the COP submission) of the PFIP. Include in the description how this fiscal year's Country Operational Plan moves the Partnership closer to achieving results in prevention, care, and treatment of HIV/AIDS and the partner government's ability to assume greater responsibility for the national responses to HIV/AIDS in terms of management, strategic direction, performance monitoring, decision-making, coordination, and, where possible, financial support and service delivery. In addition, please see further guidance on page 48 about monitoring PFIP National Commitments as part of COP 2012 requirements.

Country Ownership Assessment (3 pages)

Headquarters has previously depended on the experience of the in-country leadership of PEPFAR OU teams to best determine the course of engagement with the host government, other development partners, local civil society etc in the development of Country Operational Plans, and the review of PEPFAR activities which contribute to the national HIV/AIDS response. Because sustainability is a core pillar for PEPFAR as we strive to achieve the goals of the second phase of PEPFAR and the Global Health Initiative, for the FY 2012 COP process a set of questions are provided below. These seek to ensure teams are using every opportunity to ensure greater transparency in USG planning processes, local players are given every opportunity to influence the decision making processes of the USG, local planning processes are being adequately leveraged to ensure USG resources are being efficiently and effectively utilized and USG staff are being provided with adequate planning and financial information from government partners in order to achieve an effective and meaningful shared partnership.

1. Please describe your PEPFAR team's engagement with its partner country at all levels (technical, political, civil society) and with all stakeholders during the COP development process to provide a context for how teams have changed the way USG is now engaging host governments and local partners. Discuss the impact of engagement and the level of officials consulted. Does your partner government come to the table with priorities at the beginning of the COP process or look to the PEPFAR team to take leadership in programming? If you have a PF, did you use the group designated to monitor the PF moving forward over the 5 year period to assess what this one year action plan should focus on? How does your team engage with other collaborating partners (DFID, the World Bank, the CCM and Principal Recipients for the Global Fund, HIV partnership forum etc) in the COP development process? How are national planning processes leveraged to ensure USG plans are embedded with national planning activities?

This is an attempt to establish a range for PEPFAR teams' engagements with partner countries. Each country will be in a different place on the continuum of engagement. During the COP review call, a possible topic could be ideas for the next year of engagement and how engagement could move on a continuum.

2. We strongly encourage teams to share the COP with their partner governments before submission to get endorsement. In this narrative, please discuss your success or challenges with this and if the partner country raised any concerns during this process. What is the capability of the partner country to give feedback on suggested programming by the PEPFAR team?

3. What are the challenges and opportunities in the newly defined country ownership dimensions: political ownership/stewardship, institutional and community ownership, capabilities and accountability? Please review the criteria of each dimension from the Country Ownership Programming Approaches section of this COP Guidance and assess your partner country across all four dimensions with these criteria in mind.

   For example, under political ownership/stewardship: Does the partner government, with support from civil society, the private sector and other funding partners, clearly articulate its priorities and plans for program development?

   Under capabilities: Does country leadership have the technical and management capabilities to oversee programs (and mention how this capability varies across programs)?

   How have you prioritized activities to assist the country in overcoming these challenges? Please identify a few key activities in the COP designed to improve the country's performance in any of these areas.

4. Please broadly assess how the USG in your country is supporting country ownership across the same four dimensions. Does your team have a shared vision of country ownership with your partner country? If there is disagreement with your partner country on policies and priorities, is there opportunity for open dialogue and successful resolution? Is PEPFAR in your country structured and staffed in a way that supports country ownership? Does PEPFAR model transfer and comprehensive information sharing with other stakeholders in the country? Please identify opportunities you see in the future to increase country ownership at the national and local levels. Since the ability to transition programs varies by program, and partner country interest to a great extent, teams should differentiate between program areas where possible when discussing transition plans (for example the timeline for transitioning blood safety programs might be much shorter than other program areas).

Central Initiatives (1 page)

If applicable, country teams should give brief status updates on any projects that are centrally funded. Please discuss funding that does not appear in the COP but has been planned for during the COP process, such as additional funds for the Local Capacity Initiative, Gender Challenge, GBV, Global Fund collaboration, centrally-funded Global Fund Liaisons, PPP incentive, TB/HIV, PMTCT, Food and Nutrition, MEPI/NEPI, PHEs etc.

As a central initiative, if your Mission received funds for a Global Fund Liaison position, please include an update on this position (e.g., How long have they been working in country? What are their main responsibilities? How has the position enhanced the Mission's working relationship with the Global Fund?).

7.2.2 Population and HIV Statistics

Statistics will be pre-populated by HQ. OUs can add their own data sources if desired.

7.2.3 Partnership Framework/Strategy Goals and Objectives

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

7.2.4 Global Fund/Multilateral Engagement

The USG is the largest contributor to the Global Fund and has a vested interest in ensuring that Global Fund grants succeed and that they complement our bilateral efforts. There is an increasing recognition that PEPFAR's success globally and at country-level is directly associated with the extent to which Global Fund-financed programs are – or are not – performing and whether they are delivering high quality, cost-effective services. The USG needs to work closely with Global Fund implementing partners, to evaluate how Global Fund resources and programs should shape and change PEPFAR investments and programs going forward. In the current and projected financial climate, reducing program duplication, creating efficiencies and synergies between Global Fund and PEPFAR investments will help to increase coverage and save more lives. Teams are expected to be: 1) communicating with Global Fund partners; 2) knowledgeable of Global Fund grants, programs, and investments; 3) contributing to improving Global Fund program performance; and 4) increasing coordination through joint planning and monitoring.

To this end, the USG has various options for both providing and facilitating technical assistance to CCMs and PRs, and for increasing the coordination and collaboration between PEPFAR and Global Fund-financed programs in country to reduce duplication and maximize program performance.

The recent, centrally-funded, Global Fund Country Collaboration initiative was one concrete way in which we supported field teams and partner governments to increase coordination and optimize Global Fund grant performance. We encourage country teams to consider which coordination and collaboration activities are appropriate for your specific country context.

In addition, USG projects can provide Technical Assistance (TA) through bilateral and centrally funded positions in order to build capacity of CCMs and PRs, and to resolve implementation bottlenecks. Some examples of areas in which this support can be provided include: CCM governance and oversight issues, PR programmatic and financial issues, PR M&E plans and PR procurement and supply-chain management (PSM) plans.

Some country teams have also added Global Fund Liaison positions to their staff in order to increase their capacity to coordinate and collaborate with the Global Fund. While every team does not need a dedicated Global Fund liaison, we would encourage you to designate one individual as a "Global Fund focal point" and ensure that some percentage of that person's level of effort (LOE) is specifically allocated for Global Fund work with associated performance objectives.

For this section of the FY 2012 COP overview, OUs will respond directly in FACTS Info to the questions below:

1. In what way does the USG participate in the CCM (voting member, observer or none)?
2. What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.
3. What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.
4. Has the USG or is the USG planning to provide support for Round 11 proposal development in any or all of the diseases? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.
5. Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months? If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any

actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.

6. In your country, what are the 2-3 primary challenges facing Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc.)? Are you planning to address these challenges through any activities listed in this COP and if yes, how?
7. Did you receive funds for Country Collaboration Initiative this year? If yes, supplemental materials will be submitted to support this effort.
8. Is there currently any joint planning with the Global Fund? If yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders. Please also describe if you think this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)
9. Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed HIV programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, or any other activity to prevent treatment or service disruption. There will be a table in FACTS Info to complete for this information.

7.2.5 Public-Private Partnerships

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

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

The key aspect of a public-private partnership is this: **a private sector partner must contribute resources.**

A contract with a private company is not a PPP, nor is an activity that will build off an existing investment with no new money or in-kind contributions from the private sector.

The following are critical core elements that reviewers of the FY 2012 COPs will expect to see represented in the public-private partnerships operating unit summary. Each field should be filled in to the extent possible. However, if a piece of data is not known (e.g. FY 2012 partner name) then the field should be listed as TBD. If the funding amount is not known (for either PEPFAR or the Private Sector), please leave the field blank and indicate in the description that the funding amount is TBD.

- **Operating Unit:** Should be pre-populated
- **COP Planning Cycle:** Should be pre-populated
- **Name of Partnership**
- **Name of Partner(s):** Private sector partners, not implementing partners
- **FY12 PEPFAR Planned Contribution:** Funding only
- **FY12 Private Planned Contribution:** Total of cash and in-kind
- **PPP Description:** Brief description describing activity, reason for partnering with private sector, year in partnership (e.g. Year 2 of 4), and main indicators to be tracked

7.2.6 Surveillance and Surveys

The surveillance and surveys table is used to collect a summary of PEPFAR-supported surveillance and survey activities in PEPFAR OUs. The FY 2012 COP table should reflect continuing and planned surveillance and surveys during FY 2012.

7.3 Indicators and Setting Targets for the COP

Quality data are needed to inform the design of COP activities, to monitor partner performance, and to set reasonable and achievable targets. Good target setting and results reporting are inextricably linked. In order for targets to be meaningful and realistic, the quality of the data on which they are based must meet minimum standards of acceptability.

PEPFAR looks at two levels of targets and results:

1. National – all operating units (countries and regions) will report national level data on a small core set of indicators, where applicable (see Next Generation Indicators Reference Guide for additional information). National data represent the collective achievements of all contributors to a program area (i.e., host country government, donors, or civil society organizations).

All operating units will report:

2. Direct – The contributions to HIV programs directly attributable to PEPFAR programs. These targets are expected achievements of the PEPFAR program through its funded efforts and activities. The Next Generation Indicator (NGI) guidance provides further detail.

Please refer to PEPFAR's *Next Generation Indicator Guidance* (located at: http://www.pepfar.gov/guidance/index.htm) for more guidance on indicator definitions.

National Level Indicators

National targets are the expected national achievements inclusive of all stakeholders in a country, and are based on a reporting timeframe defined by the partner national government. These are required for submission to headquarters for selected indicators. All Operating Unit teams must work with partner governments to set the annual targets for FY 2012 and 2013, at a minimum.

PEPFAR teams will be required to use the five "essential/reported" national output indicators that are "applicable" to the PEPFAR program.

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

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

PEPFAR Technical Area Summary Indicators and Targets

The PEPFAR Technical Area Summary Targets are based on the collective work of all PEPFAR partners, and should represent PEPFAR's direct contributions to the national program. Technical area summary targets will need to be adjusted for double counting prior to submitting the COP to headquarters.

PEPFAR teams will be required to provide two years of technical area summary targets for FY 2012 and FY 2013 time periods. Revision of out-year targets will be allowed during each year's COP cycle.

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

Similar to national indicators, additional non-NGI indicators associated with Framework and Strategy goals and objectives may be necessary at the technical area summary level, as defined in the Framework and Strategy monitoring and evaluation plans. These additional indicators may be submitted as custom indicators in the Technical Area Summary Indicators section of the COP together with corresponding targets (*please refer to FACTS Info training and data entry guidance for more information on custom indicators*).

The targets should reflect the expected direct program achievements in the fiscal-year time period October 1, 2011 to September 30, 2012 regardless of the fiscal year monies used to reach targets.

Implementing Mechanism-Level Indicators and Targets (Required for HHS Implementing Mechanisms Only)

Implementing Mechanisms (IM) target setting is important for management in country, but the targets are not required for submission to headquarters, with the exception of agency-specific requirements by Health and Human Services (HHS)/Centers for Disease Control and Prevention (CDC). In the case of HHS/CDC, country teams must provide a minimum of FY 2012 and FY 2013 targets, though you may provide later targets if available. The submission of Implementing Mechanism targets are optional for all other agency mechanisms, but at a minimum should be maintained in-country.

There are two ways to determine Implementing Mechanism-level targets:

- The first method involves setting targets for the expected program achievements for the defined reporting period based on anticipated fiscal year expenditures.

- The second method involves setting targets for the expected program achievements for the defined reporting period based on the planned fiscal year COP budget (i.e., with FY 2012 funds).

For more information on setting targets, see Appendix 5.

Monitoring of the National Commitments in the Partnership Framework Implementation Plan (PFIP)

To demonstrate accountability regarding National Government commitments stated in the PFIP, USG country teams will collaborate with partner governments to select appropriate metrics for annual monitoring of select PFIP national commitments. CSTLs and SI Advisors will be in contact with USG country teams to begin this process and propose a few key national commitments that might be feasible given country context and available data sources. This conversation can inform discussions with partner governments about how best to develop indicators based on the established national commitments.

7.4 Technical Area Narratives

In FY 2010, the last year that included technical area narratives (TANs), there were 14 narratives required. To align with streamlining efforts, reduce narrative burden on the field when possible, and have a more integrated description of PEPFAR country programs, there are four TANs required in the FY 2012 COP: Governance & Systems, Prevention, Care, and Treatment. For each technical area, the OU will describe the strategic overview in narrative form. The TAN should provide an overview of the country's strategy in the specific technical area, what role the USG will play, and how these activities fit into the Partnership Framework and the Global Health Initiative, where applicable. The TANs should not be more than ten pages. You are not required to use the entire space.

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

For each TAN there are suggested topics and questions from HQ Steering Committees and individual TWGs, highlighted for COP preparation this year. As it isn't possible to answer all the listed questions for each TAN, please use your discretion on which ones are most important for your country context. For the overall strategic direction of the technical area, please include reference to the strategy for the next two years.

Please see Appendix 6 for specific instructions for planning and writing each TAN, as the requirements differ by technical area.

7.5 Manage Partners and Implementing Mechanisms

7.5.1 Manage Partners

7.5.1.1 Prime Partners

Definition: A prime partner is an organization that receives funding directly from, and has a direct legal relationship (contract, cooperative agreement, grant, etc.) with, a USG agency.

There can be only one prime partner per implementing mechanism. When implementing mechanisms are awarded to a joint venture/consortium, the lead partner is the prime, and any other partners in the consortium should be identified as sub-partners. With the exception of the prime partner, you will only need to enter those members of the joint venture/consortium that are active in your country. See additional guidance on local joint ventures in Appendix 4.

Do not name a partner as a prime or sub under an implementing mechanism until it has been formally selected through normal Acquisition & Assistance processes, such as Annual Program Statements, Requests for Application, Funding Opportunity Announcement, or Requests for Proposals. If a partner has not been formally selected, list the prime partner for the implementing mechanism as "To Be Determined" (TBD). See Appendix 4 for guidance on notifying S/GAC once you have identified a prime partner.

For all direct programming to be implemented by a USG Agency, the agency should have an implementing mechanism with itself named as the prime partner. Note that all of the costs associated with a USG agency's footprint in country, i.e., costs of doing PEPFAR business or "Management and Operations" costs (including staffing to support technical assistance), will be entered in the M&O section. Technical staff salaries will be

attributed to the applicable budget code through the M&O section, **not** through implementing mechanisms.

For more information on partner definitions, please see appendix 4.

7.5.1.2 SUB-PARTNERS

For FY 2012, sub-partner names need to be provided for each implementing mechanism proposed in the COP. If sub-partners are unknown for an implementing mechanism, nothing need be entered in the mechanism at this time; however, sub-partner lists must be updated throughout the year during the COP/ROP update process.

Definitions

Sub-Partner: An entity that receives a sub-award from a prime partner or another sub-partner under an award of financial assistance or contract and is accountable to the prime partner or other sub-partner for the use of the Federal funds provided by the sub-award or sub-contract.

Sub-Award: Financial assistance in the form of money, or property in lieu of money, provided under an award by a recipient to an eligible sub-partner (or by an eligible sub-partner to a lower-tier sub-partner). The term includes financial assistance when provided by any legal agreement, even if the agreement is called a contract but does not include either procurement of goods or services or, for purposes of this policy statement, any form of assistance other than grants and cooperative agreements. The term includes consortium agreements.

Note: Information is only to be submitted on Prime Partners and Sub-Partners, not on "Subs of Subs."

No Sub-Partners When a USG Agency is the Prime Partner

For those occasions where a USG Agency is the prime partner, you may NOT have sub-partners under that funding mechanism. A sub-partner under a USG Agency is the same as a prime partner, and the entity should be entered as a separate funding mechanism. For instance, CDC should only be listed as a prime partner for technical programming that CDC provides directly in-country. (Costs of staff time, including the provision of technical assistance, should be entered as costs of doing PEPFAR business in the M&O section, not as a funding mechanism.) If funding will eventually be obligated to another organization, then CDC should NOT be the prime partner. For more assistance with this issue, please contact Heather Pumphrey (hbp7@cdc.gov).

Subdivisions of an Organization

If an organization has one or more subdivisions or sub-offices that are receiving funding, you should not enter each subdivision or sub-office as a sub-partner of the parent organization. You would only enter the subdivision or sub-office if it is receiving the funding directly from a USG agency prime partner, independently of the parent organization.

Examples
1. If you are funding the national Red Cross in your country, you would not list each subdivision of the Red Cross as a sub-partner if it is receiving its funding from the national headquarters office. You should only list local chapters of the Red Cross as sub-partners if they are receiving funds directly without it first going through the national headquarters office. 2. If you are funding the national Ministry of Health (MOH) in your country, you would not list any district level health ministry as a sub-partner if the funding flows through the national MOH. You should only list the district level health ministries as sub-partners if they are receiving funds directly from a prime partner without going first through a national level headquarters.

7.5.1.3 Track 1.0 Partners and Central GHCS-State Funds

Central funding for ART (formerly Track 1.0) agreements has been continued at historic levels regardless of whether the OU has completed the transition from Track 1.0 partners. The central funding (Central GHCS-State funding account) is to be used only for those activities that have replaced the Track 1.0 agreements in the same historic budget codes.

Any Track 1.0 ART grants that have been extended should work with their Track 1.0 managers to ensure the correct amount of funds are allocated to those continuing grants in order to finish those agreements. If these agreements will not be extended through the end of the COP, Central funds should be programmed to the new local partners selected for the transition.

7.5.1.4 UNALLOCATED FUNDING

As in FY 2011, FY 2012 COPs/ROPs may not include **any** unallocated funding. Countries may still utilize TBD mechanisms where necessary, being careful to ensure that the implementing mechanism template identifies the relevant program budget category/ies, cross-cutting issues, and the USG agency expected to manage the TBD. However, OU teams should take into consideration the increasingly rigorous scrutiny of our performance reporting and TBD balances. TBD submissions that are delayed in the procurement process limit ability to sustain or scale-up vital services, and contribute to the scope of unobligated balances. Teams should be able to concretely discuss planned TBD procurements in the COP/ROP review process. TBD submissions that include a full year of funding for a TBD that will not be identified and awarded for several months will not be approved.

7.5.2 Manage Implementing Mechanisms

An implementing mechanism (IM) is a grant, cooperative agreement, or contract in which a discrete dollar amount is passed through a prime partner entity and for which the prime partner is held fiscally accountable. Examples of implementing mechanisms are bilateral contracts, bilateral grants, field support (USAID) to a HQ-managed project/entity, cooperative agreements, etc.

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

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

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

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

7.5.2.1 IMPLEMENTING MECHANISM DETAILS

In general, these implementing mechanism details should remain static over time:

- Prime Partner Name
- Funding Agency
- Procurement Type

- Implementing Mechanism Name
- HQ Mechanism ID (system assigned)
- Legacy Mechanism ID
- Field Tracking Number (optional)
- Agreement Timeframe (may change if there are no-cost extensions)
- TBD mechanism?
- Global Fund/Multilateral Engagement?
- Benefitting Country(ies) (only required for Regional OU programs)

Prime Partner Name

The prime partner name will be selected from a list of pre-existing partner names. If the partner is new, you will select "New Partner" as the partner name and Operating Unit teams will need to request the addition of the partner by submitting a New Partner form to your CSTL. Once the partner form is received and the new partner name validated, you will be notified that "New Partner" can be changed in the FACTS Info – PEPFAR Module system to the actual partner name (note, this update will not be possible via templates).

Funding Agency

It is critical that you identify the correct agency because the USG Agency / Operating Division selected will be the one that receives funding from S/GAC (see table on next page).

Agencies	

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

- NIH – Field teams should ensure that they are familiar with the scope of HIV-related clinical or other research that NIH (and potentially other USG agencies) currently fund in country to determine whether or not there are non-research activities appropriate for inclusion in the COP that may be logically "appended" to these research efforts. If there are opportunities to provide country/regional PEPFAR funding to add a service component to an NIH study, country funding for the additional service component *only* would be put into the COP. The NIH study would NOT be included. You can also include support for training through NIH via Fogarty International Center (FIC) research training grants that support the strengthening of human capacity in strategic information: surveillance, HIS, targeted and public health evaluations, program monitoring and evaluation, modeling, and bioethics. Operating Unit teams should be in contact with the FIC research training program officer or directly with grantee and their in-country collaborators to discuss capacity building needs (see research training websites at www.fic.nih.gov for contact info for AIDS International Training and Research Program, International Clinical, Operations and Health Services Research Training Award for AIDS and TB, and International Research Ethics Education And Curriculum Development Award). To expedite the distribution of funds, please identify the grant name (e.g. Vanderbilt AITRP) or number (D43TW001035) in the narrative. As with all agencies, NIH should be listed as the associated agency, and the Prime Partner who will eventually receive the

funding should be listed as the Prime Partner.

- HRSA - Please note that although CDC locally manages HRSA partners such as ITECH (the University of Washington), the Twinning Center (American International Health Alliance (AIHA)), New York AIDS Institute (HIVQUAL), Harvard University, Catholic Relief Services, and Columbia University (Nursing Capacity Building), HRSA should be listed as the associated agency.

- Peace Corps – Funding going to the Peace Corps should be identified with Peace Corps as the USG Agency receiving the funding. Peace Corps should never appear as another USG Agency's prime partner. For more information on how to capture Peace Corps costs, please see Appendix 9.

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

- State **–** Please identify the State Department Bureau for all mechanisms where the Department of State is the USG Agency. For any project using State's Regional Procurement Support Offices (RPSO) for construction or renovation, list the relevant State regional bureau as the USG Agency (guidance on using RPSO as an option will be forthcoming).

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

Procurement Type

The types of procurement types are:

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

contract, the partner government agency that is a principal signatory party to the instrument. Note: IQCs should be listed as contracts.

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

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

- Umbrella Award – An umbrella award is a grant or cooperative agreement in which the prime partner does not focus on direct implementation of program activities, but rather acts as a grants-management partner to identify and mentor sub-recipients, which in turn carry out the assistance programs. See Appendix 5 for additional criteria.

- Inter-agency Agreement (IAA) **-** An Inter-Agency Agreement is a mechanism to transfer funding between agencies. This mechanism should only be used in **very rare** occasions and is not permitted for use with GHCS-State funding. If the USG team decides that one agency has a comparative advantage and is better placed to implement an activity with either GHCS-USAID or CDC GAP funding, the USG team has the option of requesting to transfer money from one agency to another through an IAA. This is not the most efficient way of providing funds from one agency to another. However, one example of an appropriate use of an IAA is agency buy-in for census bureau (BUCEN) services.

Implementing Mechanism Name

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

- Partner Acronym: AIHA; CHAZ
- Project Name: Support to RDF; Sun Hotel PPP; GHAIN; Track 1.0 buy-in; Track 1.0 OVC

If this is a HQ buy-in implementing mechanism, you must put the name of the HQ project in the implementing mechanism name field. For example, if you are using the

CTRU Project or UTAP, you should use these names in the implementing mechanism name field. Otherwise, there are no limitations on mechanism name; we recommend that Operating Unit teams choose unique values for the mechanism name.

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

Examples of Prime Partners and Implementing Mechanism Names:

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

HQ Mechanism ID, Legacy Mechanism ID, and Field Tracking Number

The HQ Mechanism ID will be assigned by the new FACTS Info – PEPFAR Module system when the mechanism is saved in the system (either through a template upload or on-screen).

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

- For mechanisms that existed in the FY 2009 COP in the COPRS I system, Operating Unit teams should use the COPRS I "mechanism system ID."
- For mechanisms that were created in the FY 2010 or 2011 COP or using the "Plan B" system, OU teams should use the mechanism ID from that system. For example, if the file name included "new017" in the name, the mechanism ID would be "17."
- For new mechanisms in FY 2012, the FACTS Info – PEPFAR Module system will assign a new HQ Mechanism ID when it is saved to the system, so OU teams using templates should name their template files starting with where they left off last year as a means to tracking the files offline; however once saved in FACTS Info, this number should no longer be referenced.

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

systems." Examples of possible field tracking numbers include:

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

Agreement Timeframe

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

7.5.1.3 FUNDING SOURCES / ACCOUNTS

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

USG Agency	FY 2011-12 COP Funding Source Categories
USAID	GHCS (State) Central GHCS (State) GHCS (USAID)*
HHS/CDC	GAP** GHCS (State) Central GHCS (State)
HHS/HRSA	GHCS (State) Central GHCS (State)
HHS/OGA	GHCS (State) Central GHCS (State)
DoD	GHCS (State)
DoL	GHCS (State)
State	GHCS (State) Central GHCS (State)
Peace Corps	GHCS (State)
ALL OTHERS	GHCS (State)

* The GHCS-USAID account is the account appropriated directly to USAID, formerly the Child Survival and Health (CSH) Account (FYs 2008 and prior).
** The GAP account was formerly called "Base (GAP Account)," and is still applicable for HHS/CDC activities.

As noted elsewhere, please ensure that you are coordinating as a USG Team in determining funding decisions and that *all* USG HIV/AIDS funding is being programmed as an interagency USG Team. Please also ensure that your programming is consistent

with your budget controls (e.g., if your OU team is not receiving GHCS (USAID) funding, you should not program GHCS (USAID) funds).

7.5.1.3 IMPLEMENTING MECHANISM NARRATIVES

Narratives for both the overall Implementing Mechanism (IM) and the budget codes that Implementing Mechanism works in are required for the FY 2012 COP.

Each IM should have an overall narrative and at least one budget code narrative completed. Please be concise. Each overall IM narrative is limited to ½ page, while each budget code narrative is limited to 1 page. The table below summarizes the information to be included in the implementing mechanism summary narrative, along with an illustrative example of information that may be required for the budget code narratives. Do not repeat information in both sections.

Implementing Mechanism Narrative Please address the following:	**Budget Code Narrative** Please address the following:
1. The implementing mechanism's goals and objectives and if applicable, how it links to the country's PF/strategy and/or the country's approved GHI strategy. 2. The implementing mechanism's geographic coverage and target population(s). 3. The implementing mechanism's strategy to become more cost efficient over time. 4. The implementing mechanism's strategy to transition over time to the partner government, local organization or other donor. 5. Monitoring and evaluation plans for included activities. 6. If a vehicle is necessary to the support of the implementing mechanism, purchase or lease information needs to be justified.	Details on what should be included **for each budget code narrative** are provided in Appendix 6.
Page Limit: ½ page per IM	Page limit: 1 page per BC

7.5.1.4 GLOBAL FUND/MULTILATERAL ENGAGEMENT QUESTIONS

This section is used to identify activities supported by PEPFAR Prime Partners that also support Global Fund grant implementation. Only complete this section of the Implementing Mechanism if:

1. The Prime Partner of this mechanism is also a Global Fund Principal Recipient or Sub-Recipient (PR or SR), and/or
2. The mechanism supports Global Fund grant implementation or provides technical assistance to Global Fund recipients.

7.5.1.3 CROSS-CUTTING PROGRAMS AND KEY ISSUES

The importance of cross-cutting budget attributions cannot be over-emphasized. They represent areas of PEPFAR programming with great potential to contribute to PEPFAR II and GHI by more consciously seeking opportunities for integration and synergy across program areas. They also reflect areas in which there is continuing stakeholder interest, including recommended ("soft") Congressional earmarks for food and nutrition activities.

In the absence of implementing mechanism narratives, correct identification of cross-cutting attributions and key issues will be **critical** to minimize data calls in the future.

All mechanisms that are working in any of the eight cross-cutting attributions (Human Resources for Health (HRH), Construction/Renovation, Food and Nutrition, Economic Strengthening, Education, Water, or Gender-based Violence) **must** have the cross-cutting budget attributions identified and accurately quantified; if you need assistance in developing standard approaches to quantifying cross-cutting attributions, please contact your CSTL. For definitions of cross-cutting attributions, please see Appendix 6.

In FY 2012, we will be capturing funding information for eight cross-cutting areas, which are listed below and defined in Appendix 6. Individual attributions should not total more than the mechanism planned funding, but the sum of all cross-cutting attributions may exceed the mechanism total planned funding. For example, if a partner is being funded at $1,000,000 for Pediatric Treatment, the planned funding for each cross-cutting attribution cannot be more than $1,000,000. A single activity can often have more than one cross-cutting attribution (e.g., service training on safe water would be split between both HRH and Water), and together these attributions could exceed $1,000,000 in funding. Cross-cutting attributions should be identified for all relevant mechanisms, even in the case of "To Be Determined" (TBD) mechanisms. In these cases, OU teams should estimate the amount of funding for each of the cross-

cutting budget categories. The cross-cutting budget information can be updated during subsequent update cycles if necessary.

Cross-Cutting Budget Attributions
1. Human Resources for Health
2. Construction/Renovation
3.A Food and Nutrition: Policy, Tools, and Service Delivery
3.B. Food and Nutrition: Commodities
4. Economic Strengthening
5. Education
6. Water
7. Gender: Reducing Violence and Coercion

While they do not require budget attributions, accurately identifying the key area/s in which a given activity contributes to priorities associated with integrated health programming or other priorities associated with PEPFAR II or GHI is also important.

Activity managers and technical working groups are asked to give thoughtful consideration to identifying the extent to which planned activities contribute to progress in these areas.

Key Issues
Health-Related Wraparounds • Child Survival Activities • Family Planning • Malaria (PMI) • Safe Motherhood • TB
Gender • Increasing women's legal rights and protection • Increasing gender equity in HIV/AIDS activities and services • Addressing male norms and behaviors • Increasing women's access to income and productive resources
End-of-Program Evaluation
Mobile Population
Military Population
Workplace Programs

7.5.1.4 CONSTRUCTION/ RENOVATION FOR HIV/AIDS ASSISTANCE PROJECTS ONLY (NOT FOR USG- OCCUPIED PROJECTS 6)

The Construction/Renovation cross-cutting attribution should be identified for all relevant mechanisms that support the purposes outlined below. Please refer to the following considerations in programming funds to support these aims.

PEPFAR Funding for HIV/AIDS Clinics, Laboratories and Similar Public Health Facilities
The primary purpose of PEPFAR funds is to provide vital services to those infected and affected by HIV/AIDS and to prevent new HIV infections. In general, Operating Unit (OU) teams should only use PEPFAR funds for construction or renovation of facilities where the intent is to provide the completed facility as a form of foreign assistance (e.g., to the Ministry of Health), and when the construction activities are considered a "necessary expense" that is essential to the ability to provide HIV/AIDS services. Separate guidance on use of PEPFAR funds to renovate USG-occupied facilities is provided in the USG Office Space and Housing Renovation guidance (see footnote 6). Thus, PEPFAR funds may be used to construct or renovate medical and public health facilities, such as inpatient and outpatient hospitals or clinics, laboratories, and counseling and testing centers that reach critical populations and/or provide sustainable community-based services. In particular, PEPFAR funds may be used to construct or renovate host government medical or public health facilities, including Ministry of Health infrastructure, provided these facilities will be used to support HIV/AIDS services.

PEPFAR Funding for USG-Direct Contracting/In-Kind Transfer for Construction/Renovation
OU teams have several USG options for undertaking construction and renovation projects in support of PEPFAR programs in foreign countries. These include providing assistance through grants and cooperative agreements to partners who have the capacity to manage construction contracts, as well as direct USG contracting, where the USG implementing agency will transfer the facility in-kind to the HIV/AIDS partner (usually the Ministry of Health or other host government agency) upon completion.

The appropriateness of using USG direct/in-kind mechanisms (e.g., RPSO) should be carefully evaluated against other available options before proceeding. Given the bureaucratic procedures inherent in government procurement, constructing or renovating through the USG can take upwards of two years from start to finish. Teams should first consider whether such projects could be funded and managed by the host government, an international organization, or another implementing partner, or whether such entities could manage construction efficiently with grant funding from the USG. Country teams should also carefully consider individual agency policies on

[6] See **USG Office Space and Housing Renovation** guidance in the *FY 2012 Country Operational Plan (COP) Guidance, USG Management and Operations (M&O)* section (2011).

construction when identifying the USG implementing agency before requesting COP funding for construction to be managed by a USG agency.

If the team would like to construct or renovate using USG direct/in-kind mechanisms, teams have the option of using the U.S. Agency for International Development (USAID), the Department of Defense (DOD), or the Department of State (DOS). HHS/CDC has under consideration a program that would provide construction funding through grants or cooperative agreements, but at this time HHS/CDC does not engage in direct contracting for construction services abroad, and thus should not be identified as the USG implementing agency for construction. The Department of State should generally be the implementing agency for PEPFAR construction, unless USAID or DOD indicate a wish to manage construction on a particular project.

Host Country MOU on Construction and Facility Handover

Beginning with the FY 2012 COP, S/GAC is implementing a new requirement that all OU's with construction/renovation funding in their COP that uses direct contracting/in-kind mechanisms conclude with the host government a Memorandum of Understanding (MOU) on PEPFAR construction and renovation. The goal of the MOU is to improve coordination with host government officials on construction needs in-country, to facilitate the planning and tracking of projects, and to establish appropriate host country responsibilities for facilities following transfer. In response to questions that have arisen in the field, the MOU also provides a simplified form for transfer of completed projects (*Project Handover Acceptance Form*). A model MOU and related template forms are located under Construction/Renovation on the PEPFAR Plan B website. It is a requirement that all PEPFAR countries use the above mentioned documents for direct contracting/in-kind transfers. Substantive departure from the templates should be cleared by S/GAC and the Office of the Legal Adviser.

Any OU that requests funding for direct contracting/in-kind construction/renovation in its FY 2012 COP must conclude a host country MOU on construction substantially in the provided template. Because the MOU establishes essential host country responsibilities for facilities, a signed MOU is required before beginning project activities (i.e., before requisitioning construction services). Construction projects may be proposed in the COP in anticipation of an MOU, and may be conditionally approved by S/GAC subject to conclusion of the MOU.

Once completed projects have been transferred to the host government, post keeps legal documentation (MOU and Transfer documents) on file and sends signed copies to the S/GAC Management Officer, Siri Dell (dellsl@state.gov).

In cases where OU teams are entering into contracts, grants or cooperative agreements with partners who will undertake construction activities under the terms of the award, but the intent is not to provide the completed facility to the host country government as

a form of in-kind assistance, a host country MOU is not required. In such cases, the assistance instrument governs the terms of the project.

Construction/Renovation Project Plan

As noted above, OU teams may request the use of PEPFAR funds for construction or renovation of facilities where the intent is to provide the completed facility as a form of foreign assistance. The new *Construction/Renovation Project Plan* form must be completed for each such project request regardless of implementing type. The form will be uploaded into the FACTS Info – PEPFAR Module Document Library as part of the FY 2012 COP Submissions. In submitting proposed construction projects, country teams should consider the most appropriate implementing agency option as noted above (see section 9.2 for details).

Procedural Steps When DOS is the USG Implementing Agency

DOS has the authority to undertake overseas construction in support of PEPFAR programs. When State acts as the implementing agency, PEPFAR funding for projects remains within State (i.e., funds are allocated to relevant regional bureau for allotment to posts), and the country team must have adequate State Department capacity to implement construction and manage projects. Thus, the OU must have identified State Department personnel at Post who can act to requisition the project (i.e., through RPSO, which is the contracting mechanism for all State-implemented PEPFAR construction), certify to RPSO that funds are available, oversee and manage the project as necessary, and ensure all steps needed for orderly handover of the completed facility. Post also must have an individual available to serve on location as the COR for the project, though an appropriate non-State Department employee may be designated to serve as the COR (e.g., a CDC technical expert may be appropriate for medical facilities). Detailed procedural steps[7] for implementation are located under Construction/Renovation on the PEPFAR Plan B website.

End Use Monitoring (EUM)

Starting with the FY 2012 APR, an End Use Monitoring (EUM) report on completed facilities is due to S/GAC as part of the APR Submissions.

Effective with this guidance, the requirements provide more uniform and comprehensive monitoring and reporting procedures. The purpose of the annual review is to ensure that all facilities provided through PEPFAR funding through construction/in-kind grants continue to be used in ways consistent with the purposes for which the property was made available. The EUM guidance includes reporting on facilities provided through other mechanisms, such as construction grants or cooperative agreements. This will ensure oversight of these facilities, and provide a full picture of

[7] See *Procedural Steps When DOS is the USG Implementing Agency for Construction (2011*) located on the PEPFAR Plan B website under the PEPFAR Construction/Renovation folder

PEPFAR support for the host country's health systems infrastructure. The *PEPFAR Construction/Renovation End Use Monitoring Report (EUM) Guidance* is located under Construction/Renovation on the PEPFAR Plan B website.

The EUM report form will be uploaded into the FACTS Info – PEPFAR Module Document Library as part of the **APR** Submissions.

Semi-Annual Activity Reports
OU's with construction/renovation projects will be required to provide semi-annual project status reports to S/GAC as part of the SAPR and APR submissions, beginning with the **FY 2012** SAPR. Detailed guidance will be available under Construction/Renovation on the PEPFAR Plan B website.

8 USG Management and Operations (M&O)

This section captures information about the USG PEPFAR footprint in country – how the team is organized; each agency's roles and responsibilities on the interagency team; staffing requests and vacancies; and the costs of doing business (CODB) in country, by agency, for PEPFAR. This reflects an effort to centrally organize these costs in one location and allow easier itemization of individual costs; reduce the burden for country teams by centralizing data entry; and provide more transparency to Congress, OMB, in-country and other stakeholders on the costs for each USG agency of managing and implementing the PEPFAR program. The methodology captures funding for continuing costs that had been captured in prevention, care and treatment budget codes prior to FY 2010. These funds support the costs of key personnel (including Host County National (HCN) staff) to provide oversight, technical assistance, management, and leadership of the PEPFAR programs in country.

Activities in which the PEPFAR OU team purchases services from an USG agency acting in the capacity of an implementing partner should be captured in the "Managing Implementing Mechanism" section. For example, costs associated with Peace Corps volunteers should be reflected in M&O, but a Peace Corps grants program should be included as an implementing mechanism in the Managing Partners section; similarly, State Department personnel and CODB are reflected in M&O, but support for an Ambassadors' small grants, Public Affairs/Public Diplomacy (PA/PD) outreach, and self-help activities should be entered as implementing mechanisms. State RPSO construction should be entered as an implementing mechanism to capture the construction contracting services provided on behalf of the OU team.

Only USG agencies that have staff in-country and receive funding for in-country staff should be reflected in this section. USG agencies that do not have a presence in

country should be captured as implementing mechanisms (e.g. Department of Labor or Department of Treasury).

Budgetary Requirements
The headquarters M&O COP review team will consider a series of metrics and the OU team's responses to the guiding questions included in the COP. Operating Unit teams should evaluate the appropriate alignment of M&O costs, interagency organization and structure, and staffing data to the program in evaluating M&O investments.

8.1 Background

USG interagency coordination continues to be an important priority for PEPFAR. Each OU team is expected to manage strategic and interagency deliberations around changes to the PEPFAR-funded USG staffing footprint. Deliberations should include review of the staffing and organizational structure of the in-country USG team regularly throughout the year and especially during the COP planning process. While planning for the FY 2012 COP, OU teams should reevaluate their USG staffing footprint and organizational structure to ensure that it continues to maximize interagency planning, implementation, and evaluation. As part of their staffing analysis, OU teams should consider staffing needs for program technical and management demands for the next two years.

PEPFAR continues to be committed to addressing issues hindering our ability to sufficiently recruit and retain HCNs, formerly referred to as Locally Employed staff (LE Staff), working for PEPFAR around the world; they are critical members of our PEPFAR team and are essential to long-term sustainability of programs addressing HIV/AIDS. The PEPFAR Interagency Working Group on Issues Affecting HCN is available to assist teams in improving recruitment, retention, and empowerment of HCN and has created numerous resources that are available on the Extranet Human Resources page at: https://www.pepfar.net/C15/C9/Human%20Resources%20Issues/default.aspx.

Additional guidance on engaging HCNs, work with agency management offices, CODB funding information and definitions, staffing data, and PEPFAR Coordinator hiring are included in Appendix 8.

M&O Review / Metrics

As an ongoing process and especially during COP planning, OU teams should evaluate the appropriate alignment of M&O costs across technical areas, interagency organization and structure, and staffing footprint to their program in evaluating M&O investments over the next two years.

The headquarters M&O review team will consider the allocation of funding and staffing data submitted in the COP, historical data and vacancies, prioritization of proposed new positions (as appropriate), and the OU team's responses to the guiding questions included in the COP. Review metrics reflect PEPFAR rightsizing principles, unique country/regional contexts, and field planning processes. They emphasize OU teams' careful consideration of the appropriate mix of technical, professional and administrative staff; ratio of HCNs to USG direct hires (USDH); growth in CODB annually and over time; and increases in staff in relation to financial growth of the overall program portfolio.

Field teams should consider only those metrics that make sense within their own country/regional contexts, and may also wish to consider other types of metrics not listed here. Headquarters will also consider the metrics as part of the overall review of M&O investments across all PEPFAR operating units.

8.2 Interagency M&O Narratives

For COP 2012, OU teams are asked to respond to three narratives that concretely address issues related to team structure, management, interagency planning processes, staffing skill sets, and construction/renovation. The narratives should respond to the guiding questions with a view toward strategic staffing and planning over the next two years.

Each narrative should be no more than 2250 characters (less than one page); teams should use as much or as little of the available space as needed to convey their answers.

Narrative 1: Agency M&O Narratives

For all USG agencies present in country, a single supporting narrative is required to describe the PEPFAR program's management strategy in country. The narrative should highlight agencies' staffing, unique roles and core strengths and should address the strategic direction of the interagency team for the next two years.

The narrative should also address issues affecting recruitment or retention across your team. What is the team's approach to addressing these issues? Can headquarters provide any assistance with recruitment and retention issues?

Narrative 2: Current and Future Staffing

This narrative should assess whether the OU team's staff footprint is appropriate to manage the program based on the trajectory outlined in the COP. The narrative should also describe how the staff footprint might change as PEPFAR programs transition.

Guiding Questions: In conjunction with the second five-year strategy, PEPFAR's role in the Global Health Initiative, and your Partnership Framework as appropriate, describe the OU team's staffing strategy for the next two years.

- What staff needs or changes does your team anticipate as programs transition?
- Does the OU team have the appropriate mix of technical staff required to implement the program, during and beyond Partnership Framework or Strategy implementation (where relevant)?
- Under a scenario of much reduced annual increases or level resources available for FY 2012 and outyears, are current management resources (staff, space, etc.) sufficient to manage the program?
- Have any adjustments been made to adapt to the current budget climate (e.g. repurposing existing long-term vacancies)?
- Have any adjustments been made to current staffing to minimize duplication?
- How have you considered increasing the number of or empowerment of HCN Staff in the context of your overall staffing strategy, namely increasing the number of leadership positions and responsibilities across the interagency team?

Narrative 3: USG Office Space and Housing Renovation

As noted in Section 8.4, OU teams may request, in exceptional circumstances, the use of PEPFAR funds to renovate USG-occupied facilities, which provide office space or housing for USG PEPFAR personnel. Please provide a narrative for each proposed renovation project.

The narrative should provide the dollar amount, describe the project in detail, and provide a breakout of costs associated with the renovation of buildings occupied by USG PEPFAR personnel. Please list the owner of the property in the narrative. Significant renovation of properties **not** owned by the USG may be an ineffective use of PEPFAR resources, and costs for such projects will be closely scrutinized. Additional information required in this section includes:

- The number of USG PEPFAR personnel that will occupy the facility, the purpose for which the personnel will use the facility, and the duration of time the personnel are expected to occupy the facility.
- The expected timeline for the USG renovation activities (start/end date)

- A detailed description of the renovation project and the associated cost.
- The mechanism for carrying out the renovation project, e.g. Regional Procurement Support Office (RPSO).
- Name of the city/town where the building is located.
- The USG Agency which will implement the project, and to which the funds should be programmed upon approval. If the project will be implemented by DOS through RPSO, the funding agency should be the State Bureau (e.g., State/AF).
- The appropriate funding source (e.g., GHCS (State)).
- Brief description why alternatives – facilities that could be leased and occupied without renovation – are unavailable or inadequate to personnel needs.

Staffing Narratives: Justify Vacant and Proposed New Positions

For all vacant (as of September 30, 2011) and/or planned (newly requested) positions, OU teams are asked to provide additional details within the Staffing section of the PEPFAR module. Position narratives should be no more than 500 characters and should be entered directly into the Staffing section of the PEPFAR module. There should be one justification per each staffing record marked as vacant or planned.

Updating staffing data prior to or simultaneous to responding is advised.

JUSTIFY VACANT POSITIONS

For all approved but vacant positions, the OU team must submit a brief narrative describing the plan and timeline for filling the vacant position. If possible, please provide the date the position became vacant and the position title, to enable enhanced tracking in the field and at headquarters.

PROPOSED NEW POSITIONS

For each proposed new position, please provide a description of the requested personnel. There should be one explanation for each staffing record marked as planned in the staffing data.

A brief narrative is required describing: (1) the interagency process by which additions to the overall US staffing footprint were prioritized and approved; (2) technical assistance (e.g., Framework Job Descriptions) or other support that may be needed from headquarters to fill proposed new positions; and (3) how the new positions are explicitly linked to one or more of the following overarching priorities in the second five-year strategy and/or PEPFAR's role in the Global Health Initiative.

Please note that country/regional programs with significant vacancies among previously approved positions and/or proposing new positions not aligned to the priorities above may anticipate that any proposed new positions will be rigorously evaluated for relevance. Teams should be prepared to discuss why they are proposing new positions given their vacancies, and are encouraged to address this directly in the above narratives. Wherever possible, OU teams are advised to repurpose existing vacancies to fill new staffing priorities (particularly long-standing vacancies, i.e. having been vacant greater than 1-2 years). In the COP 2012 review process, all proposed new positions will be heavily scrutinized and may not be approved.

8.3 Planned Funding of USG Costs of Doing PEPFAR Business

USG CODB includes all costs inherent in having the USG footprint in country, i.e. the cost to have personnel in-country providing the technical assistance and collaboration, management oversight, administrative support, and other program support to implement PEPFAR and to meet PEPFAR goals.

By capturing all CODB funding information in the M&O section, data are organized in one location, allowing for clear itemization and analysis of individual costs. In addition to providing greater detail to headquarters review teams and parity in the data requirements for field and headquarters management costs, the data provides greater transparency to Congress, OMB, in-country and other stakeholders on each USG agency's costs for managing and implementing the PEPFAR program.

OU teams will enter the CODB information annually to reflect the USG agency's planned CODB budget for the fiscal year. Appendix 9 provides CODB category definitions and supporting guidance for the ten categories:

1. USG Staff Salaries and Benefits
2. Staff Program Support Travel
3. ICASS (International Cooperative Administrative Support Services)
4. Non-ICASS administrative costs
5. CSCS (Capital Security Cost Sharing)
6. Computers/IT Services
7. Management Meetings/Professional Development
8. USG Renovation – see section 8.4 below for further guidance
9. Institutional Contractors (non-PSC/non-PSA)
10. Peace Corps Volunteer Costs (including training and support)

Indirect Costs

As of July 2011, all of the agency indirect cost models have been finalized. All indirect costs will be funded through the Headquarters Operational Plan (HOP).

8.4 USG Office Space and Housing Renovation

OU teams may include support for USG Renovation in their CODB submission. All other construction and/or renovation should be included in the Implementing Mechanism section of the COP. The notes below outline how USG renovation funds may be used.

PEPFAR Funding May Not Be Used for New Construction of USG Office Space or Living Quarters

Consistent with the foreign assistance purposes of PEPFAR appropriations, PEPFAR GHAI and GHCS-State funding should not be used for the construction of office space or living quarters to be occupied by USG staff. The Embassy Security, Construction and Maintenance (ESCM) account in the State Operations budget provides funding for construction of buildings to be owned by the Department of State, and the Capital Investment Fund (CIF) is a similar account appropriating funds for USAID construction. Other agencies such as HHS/CDC and DOD have accounts that provide funding to construct USG buildings, and implementing mechanisms may contribute to the ESCM account through the Capital Security Cost Sharing program. ESCM, CIF and similar accounts are the primary funding source for construction of facilities occupied by USG staff, and PEPFAR funds should not be used for this purpose.

PEPFAR Funding May be Used to Lease USG-Use Facilities

Where essential office space or living quarters cannot be obtained through the Embassy or USAID Mission, a request to use PEPFAR funds may be made in the context of a Country or Regional Operational Plan (COP/ROP) to rent or lease such space for a term not to exceed 10 years, if necessary to implement PEPFAR programs.

PEPFAR Funding for Renovation of USG-Owned and Occupied Properties

OU teams may request the use of PEPFAR funds to renovate USG-occupied facilities in exceptional circumstances. The justification for using PEPFAR funds to renovate USG-occupied facilities must demonstrate that the renovation is a "necessary expense" that is essential to carrying out the foreign assistance purposes of the PEPFAR appropriation, and should show that the cost of renovation represents the best use of program funds. The justification should also explain why appropriate alternative sources of funding for

renovation are not available. The OU team must submit a comprehensive plan that includes an explanation of the unique circumstances around the request to renovate USG-occupied facilities. The plan must have support from the Ambassador that justifies the renovation project. In addition, renovation of facilities owned by the USG may require coordination with the State Department's Office of Overseas Buildings Operations (OBO) and other State Department bureaus, and will require the clearance of the State/Office of the Legal Adviser.

8.5 Staffing Data

As a part of COP 2012, OU teams are asked to update staffing data in the FACTS Info PEPFAR Module. Staffing data submitted in COPs 2010 and 2011 will be available in the database; required data fields are subject to change from year to year. Appendix 8 provides additional information on strategic staffing, engagement of HCN, hiring PEPFAR Coordinators, and additional resources on the staffing tools available within the FACTS Info PEPFAR Module.

Staff Information is inclusive of HCNs, Third Country Nationals (TCN), US Direct Hire (USDH), USDH-equivalents (e.g., Personal Services Contractors, PSC), Institutional Contractors/Fellows, and Other (for which there should be very few entries) employment mechanisms. As in past years, Global Fund Liaison positions (whether centrally-funded or cost-share) should be included in Staff Information. Data should be entered for all current, vacant (as of September 30, 2011), or proposed positions that will spend at least 10% of their time working on PEPFAR planning, management, procurement, administrative support, technical and/or programmatic oversight activities. Note that any proposed new positions should spend at least 50% of their time on PEPFAR activities.

FY 2010	FY 2011 and FY 2012
Technical Leadership/Management	Technical Leadership/Management
Technical Advisor/Non-Management	Technical and Programmatic Oversight and Support
Technical Advisor/Program Manager/Public health Advisor	
Wraparound and other Programmatic Support	
Contracting Officer	Contracting/Financial/Legal
Financial Budget	
Legal	
Administrative Support	Administrative and Logistics Support
Drivers	
Other Management/Leadership	US Mission Leadership and Public Diplomacy
Public Affairs/Public Diplomacy	

8.6 Country Team Functional and Agency Management Charts

As in COP 2010, OU teams are asked to submit charts reflecting the functional and management structures of the country team. The functional chart is not required of smaller country teams that do not have TWGs. The functional staff chart and agency management charts should be uploaded as required supporting documents to the FY 2012 COP, and are outlined in detail in Appendix 9.

8.7 Peace Corps Volunteers

For each OU and in aggregate, Peace Corps Washington will submit to S/GAC the number of PEPFAR-funded:

- Volunteers on board as of September 30, 2011;
- Peace Corps Response Volunteers on board as of September 30, 2011;
- New Volunteers proposed in the FY 2012 COP; and
- New Peace Corps Response Volunteers proposed in the FY 2012 COP.

Peace Corps Washington will obtain this information from Peace Corps country programs.

9 Supplemental Documents

9.1 Health Care Worker Salary Report

Background:

Country estimates of the number of health worker salaries that PEPFAR supports have become increasingly important. This information is critical to our ability to advance, with host country and international partners, strategies and approaches to address what may be the single largest barrier to improving HIV/AIDS care and health care in general in the countries in which we work: an adequate workforce.

This request for estimates of the number of health care workers whose salaries are supported either in full or part by PEPFAR includes all individuals that PEPFAR is supporting to implement and manage programs and deliver services through the private, non-government and government sectors. Please note that the request excludes USG staff including direct hires, host country nationals, and contract staff working at US agency country offices or headquarters. The request includes, however, all USG agency or contractor staff who may be sitting in government facilities and

whose primary role is the provision of technical assistance and support for implementation. Examples are provided in the section on Definitions.

We request that you estimate the number of health care workers receiving full or partial USG support in three categories and upload this information as a supporting document. Partial support is defined as anything from 1-99% and full support is defined as 100%. These estimates should be unduplicated numbers of workers to be supported through all COP activities. Please include only support from field resources. Information for Track One grantees and grantees with central funding will be provided through a separate data call at headquarters. **Please enter these estimates (according to the following definitions) into the table available on PEPFAR Plan B's COP planning site and upload it as a required supporting document into FACTS Info.**

Definitions:

Individuals may receive support ranging from partial support (anything less than 100%) to full support (100%). A health worker should only be counted once in any of the three categories. The three categories are as follows:

Clinical care service providers (clinical) - in facility-based clinical service delivery settings such as MTCT clinics; counseling and testing sites; treatment and care sites; and OVC family support units such as physician, clinical officer, nurse, midwife, nursing assistant, pharmacist, psychologist/social worker and other professionally trained providers that deliver direct patient care services.

Clinical service staff (non-clinical, non-managerial) - laboratory technicians, epidemiologist, M&E and data clerks, counselors and other professionally trained staff that provide non-clinical, non-managerial services within clinical settings.

Managerial and Support Staff (clinical service sites, public and private) at facility and community level. Managerial and administrative staff include senior management, technical advisors, budget analysts, clerks, monitoring and evaluation staff, information technology, transportation, security, clerical and reception staff, etc.

Managerial and Support Staff (non-clinical, government office sites) at all levels of government. Included in this category are government workers who are receiving additional support in keeping with PEPFAR guidance, Peace Corps volunteers posted at district HIV/AIDS management offices, CDC employees or contractors placed in government facilities but whose primary task is technical assistance, and USAID institutional contractor technical advisor staff who are placed in governmental or non-governmental organizations.

Community services staff - community health care workers, outreach workers, adherence counselors, peer educator and counselors, DOTS workers, prevention counselors and staff for whom support will be provided to work in community-based service delivery settings such as home-based community care, prevention outreach, and community-based OVC programs. *Managers and administrative staff are excluded from this count.*

If healthcare workers provide services in more than one category, for example nurses who provides both clinical services and community outreach, place their counts in the category where they spend the majority of their time.

Where it is not clear in which category to report a particular type of health worker, please use your best professional judgment as to which is the most appropriate category.

9.2 Construction/Renovation Project Plan

CONSTRUCTION/RENOVATION OF HIV/AIDS ASSISTANCE PROJECTS ONLY (NOT FOR USG- OCCUPIED PROJECTS[8])

As noted above, OU teams may request the use of PEPFAR funds for construction or renovation of facilities where the intent is to provide the completed facility as a form of foreign assistance (see section 7.5.1.4). The new *Construction/Renovation Project Plan* form must be completed for each such project request, regardless of the type of implementing document. The form should be uploaded into the FACTS Info – PEPFAR Module Document Library as part of the FY 2012 COP Submissions. In submitting proposed construction projects, country teams should consider the most appropriate implementing agency option as noted above.

The purpose of the *Construction/Renovation Project Plan* form is to identify the scope and purpose of each PEPFAR construction/renovation project, where the intent is to provide the completed facility as a form of foreign assistance, estimate the cost and work involved, and create a project schedule and timeline. The form is located under Construction/Renovation on the PEPFAR Plan B website. USG-Direct Contracting/In-Kind Transfer projects approved under the COP should be included in the PEPFAR-Host Country MOU on Construction.

[8] See **USG Office Space and Housing Renovation** guidance in the *FY 2012 Country Operational Plan (COP) Guidance, USG Management and Operations (M&O)* section (2011).

The *Construction/Renovation Project Plan* form will collect the following information (data field definitions are included below):

1. **Project Type:** Select the appropriate type from the list: **New Construction, Renovation, or Update**. A project **Update**=adding/amending PEPFAR funds for a PEPFAR construction/renovation project approved in a prior year COP.

2. **Implementing Document Type:** Select the appropriate type from the list: Construction MOU, Cooperative Agreement, Grant.

3. **Mechanism ID Number:** Provide the Mechanism ID Number.

4. **Legacy Mechanism ID:** Provide the Legacy Mechanism ID.

5. **Mechanism Name:** Provide the name of the mechanism.

6. **Fiscal Year:** Select the appropriate fiscal year from the drop-down list. This is the current COP approval year (e.g., 2012).

7. **Date Project Plan Created:** Provide the date that the *Construction/Renovation Project Plan* was created.

8. **Project Name:** Enter the name of the construction/renovation project.

9. **Project Number/Control Number:** The project number/control number will be used to track the life cycle of the project from the COP to the contract obligation in the US Department of State (DoS) Regional Financial Management System (RFMS). Headquarters will assign a unique number to each project. The same project number and title will be used to identify projects that continue from one year to the next.

10. **Prime Partner:** Select the appropriate mechanism type from the drop-down list.

11. **Landowner:** Provide the name of the landowner (usually the host government).

12. **Type of Funding:** Select the appropriate funding source from the drop-down list.

13. **Construction MOU Date Signed (if applicable):** Provide the date that the Host Country Construction MOU was signed. If not yet signed, please describe status and expected date for signature.

14. **Benefitting Country:** Select the appropriate country or region from the drop-down list.

15. **Recipient Organization:** Provide the name of the recipient organization (e.g., Ministry of Health).

16. **USG Implementing Agency:** Select the appropriate implementing USG Agency in country or region from the drop-down list. If the project will be implemented by DOS through RPSO, the funding agency would be State Bureaus.

17. **Funding:** Enter the **Total Original Funding** amount for the project. The amount should include all anticipated or actual costs, including cost for A&E, actual construction costs and any equipment necessary to make the building operational and ready for use. For **Updates**, it is required to provide the **Total Original Funding** amount in addition to the **Total Amended Funding** request.

18. **In-Country Management Plan:** Provide the contact information for the following: person who will serve as the post Contracting Officer's Representative (COR) , individual who will sign the requisition and transfer documents, person who will provide technical assistance and oversight, PEPFAR Coordinator, post Financial Management Officer (FMO), point of contact on the country team responsible for overseeing the construction project, and post Management Officer.

19. **Narrative (~ 1 page):** Provide a **detailed** description of the scope and purpose of the project, work involved, size and type of facility, and location of the project. Indicate if any USG PEPFAR personnel will work in the facility. If so, indicate the purpose for which such personnel will use the facility, and the duration of time the personnel are expected to occupy the facility. For project **Updates**, provide a justification under the **Project Update Justification** section and a brief summary of the originally approved project description in this narrative section.

20. **Timeline**: Select the appropriate date from the drop-down calendar for the Estimated Start Date, Estimated Completion Date, and Estimated Transfer to Partner Government (if applicable). For project **Updates**, please provide the original and amended timelines.

21. **Project Goals (max 1 page):** Please provide the goals and longer term objectives for this project.

22. **Project Update Justification (max 1 page):** Provide an explanation of the progress to date, the name of the Architecture & Engineering provider if known, and a justification for the funding request.

9.3 Obligation and Outlay Plan

A thorough pipeline analysis consists not only of analyzing past performance, but of being able to project financial indicators into the future.

We request that you estimate monthly obligations and outlays and upload this information in a supporting document. These estimates should be program-wide and include total outlays (or expenditures) from all agencies with COP allocations. Calculations should be based upon projected partner expenditures per month, and projected procurement and granting actions.

It is required that TBD and new granting actions be broken out of the above totals in a separate section provided in the supporting document. This projection will help both the country teams and headquarters in the analysis of all TBD funding levels.

Please enter these estimates into the table available on PEPFAR Plan B's COP planning site and upload it as a required supporting document into FACTS Info. Further definitions of terms used in the table and instructions will be included in the table.