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

FY 2013

Country Operational Plan (COP) Guidance

October 12, 2012

Version 2

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1 Introduction – PEPFAR and the Beginning of the End of AIDS

On November 8, 2011, Secretary of State Hillary Clinton set a powerful new goal for PEPFAR and its global partners: creating an AIDS-free generation. While we may be many years from eliminating all HIV infections, the Secretary marked a path to the point where no one infected with HIV ever develops AIDS.

On December 1, 2011, President Barack Obama set bold targets for PEPFAR to be achieved by the end of FY 2013. Calling this moment "the beginning of the end of AIDS," he committed the USG to:

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

In FY 2013, PEPFAR is also renewing and strengthening its focus on key populations both most at risk of contracting HIV and most stigmatized for their risk behaviors, including men who have sex with men, people who inject drugs, and sex workers.

This document translates those goals into concrete guidance for PEPFAR country teams[1] on how to prioritize and budget for these activities.

2 What is a Country Operational Plan?

The Country Operational Plan (COP)[2] 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

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

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-level deliberation 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 in country, this team develops one annual work plan in the form of the COP, which is reviewed by an interagency headquarters teams and then approved by the U.S. Global AIDS Coordinator.

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

FY 2013 is the second year in a two-year cycle, and thus is a 'low narrative year.' The FY 2012 COPs allowed the Office of the Global AIDS Coordinator (S/GAC) and agency headquarters to review and evaluate the strategic direction and program planning for a given country or region for both FY 2012 and FY 2013.

3. COP Preparation

3.1 Which Programs Prepare a FY 2013 COP?

The following programs are required to complete a FY 2013 COP: Angola, Botswana, Burma, Burundi, Cambodia, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Ghana, Guyana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zambia and Zimbabwe. Regional Operational Plans are required from the Caribbean, Central Asia, Asia Regional, 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 U.S. Foreign Assistance Resources (F) at the Department of State coordinates the development the Foreign Assistance Operational Plans. HHS/CDC programs in countries/regions that do not prepare COPs will account for their resources through CDC Country or Regional Assistance Plans.

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[3] plan, implement, and monitor a unified country program as one USG team, in most cases with the coordination, active facilitation, and support 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.** For agencies that have in-country programs but no direct in-country presence, this includes email and/or telephone correspondence. 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 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. It is best practice for scopes of work for any new/renewed procurements to be carefully reviewed in an interagency manner at the country level before being included in the COP. 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 or country strategy. Sharing of information with government authorities, e.g., Ministry of Health,

[3] 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.

National AIDS Council, local multi-sectoral coordinating body, multilateral partners (e.g., Global Fund, UN agencies), and/or civil society is an essential aspect of effective planning, leveraging resources, and fostering sustainability of programs. Consultation and collaborative planning 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.

PEPFAR programs must transition from USG-owned to country-owned. As teams approach planning for the FY 2013 COP, it is essential that there be transparency in the budgeting process for successful "transition of ownership" of PEPFAR-supported programs to occur. To ensure sustainable service delivery for the continuum of care for those infected and affected by HIV/AIDS, the management, technical oversight and financing of these services must be led by the host government in partnership with civil society and the private sector. Country teams and government must know the available financing from PEPFAR, the Global Fund and the government (inclusive of other bilateral and multilateral aid), and the implementing partners contracted to provide services, including the geographic location of these partners. This provides the foundation from which a transition strategy, orchestrated by the partner government and committed to by all stakeholders, can be pursued. Having an effective dialogue with the highest authorities is only possible when there is transparency in budgeting. The ultimate goal is a successful transition to a role for the USG that provides technical support to programs led, and managed, including the allocation of resources, by the host country.

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 2013 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/country strategies and furthering country ownership, the USG team may share the entire FY 2013 COP with partner government officials that have responsibility for COP approval and Global Fund officials coordinating programs, 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. 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

The Country Support Team Lead (CSTL) and Country Support Team members, including the Strategic Information (SI) Advisor, Agency-specific country support staff, and Technical Working Groups (TWGs) are important participants and can help support the COP process. The CSTL is your main point of contact at 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 2013 Technical Considerations*, drafted by the TWGs, is a companion document to be used in conjunction with this *FY 2013 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 2013 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. "COP Clarifications" will be disseminated through News to the Field and by posting them on the PEPFAR Plan B SharePoint site on the FY 2013 COP Planning page.

Please refer to Section 4.3 (Tools for Decision making – The Efficiencies Project) for more guidance on COP planning tools.

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 (country teams' program planning, management, and oversight (please refer to the Efficiencies Project section of the guidance which provides optional tools for teams to use in holding interagency portfolio reviews). The collection of performance data helps ensure consistency and allows teams to evaluate trends over time. 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 (Annual Program Results), and SAPR (Semi-Annual Program Results) 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 format to capture the outcomes of the review that can be shared across 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 with all agencies on the team. Although expenditure rates may not be captured in the pipeline report, program

managers are expected to also monitor and evaluate partner expenditure rates ("burn rates").

In support of COP 2013 OU teams will develop an outlay estimate (Outlay Plan), by Agency, 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. These forms will be critical in the budget review of COP 2013, and in being able to determine the impact COP 2013 funds will have on each agency's pipeline.

See Appendix 2 for additional information.

3.5 COP Timeline

All COPs/ROPs must be submitted by March 1, 2013.

COP Guidance released	October 1, 2012
Country-specific target templates available to Operating Units	October 2012
Early Funding Requests Due	Late October 2012
COP/ROP Due	March 1, 2013
COP Cleaning	(approx) March 2 – March 22
COP Reviews	(approx) April 2013

3.6 COP/ROP Submission Via FACTS Info – PEPFAR Module

All OUs will submit their COP/ROP for 2013 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 U.S. Foreign Assistance Resources at the Department of State (State/F) to ensure that PEPFAR-specific planning and reporting requirements are represented in the PEPFAR Module and that all PEPFAR implementing agencies have appropriate access to the system.

Training

This Guidance is intended to describe "what" should be contained in your COP and will not describe "how" to use the FACTS Info – PEPFAR Module. Details on how to access and use FACTS Info are described in the PEPFAR Module training and user support materials that are available in the News and Tutorials section of FACTS Info and on the PEPFAR Plan B SharePoint site. Also, please consult with your local OU Administrator, Coordinator or Point of Contact to identify those individuals who attended an in-person

training in the fall of 2011. These staff members should serve as your local training and help resources for PEPFAR-Module questions.

Templates and Data Entry

COP/ROP submission may be done using PEPFAR Module templates that teams can upload directly into FACTS Info, or via direct data entry using the screens in the PEPFAR Module. **S/GAC intends to open the PEPFAR Module COP section in October for the purpose of downloading prepopulated mechanism templates**. The intent is to allow teams to gain access to the prepopulated templates and share these templates with their partners in advance of opening the system in January for data entry/upload. Blank templates will also be made available in October, however, please note that **blank templates <u>CAN NOT</u> be used for existing mechanisms**. Please only utilize prepopulated templates for existing mechanisms in order to maintain the mechanism ID number and history.

The table below gives a brief outline of which elements are required for the FY 2013 COP/ROP.

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 will complete a PF or Strategy by March 1st, 2013
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 or Strategy
Implementing Mechanisms	
Implementing Mechanism (IM) Overview Narratives	Required only for new mechanisms
Budget Code Narratives by IM	Required only for new mechanisms
Management and Operations	
Narratives	Required
Agency Costs of Doing Business	Required
Staffing	Required
Supplemental Documents	
Ambassador's Letter	Required
Budgetary Requirements Justification	As Needed

Health Care Worker Salary Table	As Needed
Outlay Plans	Required
Central Initiative documents e.g. Updated GF collaboration work plan, PMTCT acceleration plan, LCI template	As Needed

3. 7 Programmatic Reviews

Upon submission of a country's COP/ROP, programmatic reviews are scheduled to review the soundness of the operational plans and alignment/compliance with guidance and global directives. To ensure that review members appropriately highlight key issues that may require clarifications, revisions or technical assistance prior to approval, a coding system has been developed to elevate post-COP actions that may require further review.

An activity or mechanism that has a conditionality may be documented as either a yellow light or red light. During Programmatic Reviews, a reviewer may propose a yellow light on one or more proposed activities or mechanisms. A "Yellow Light" means that additional information is needed before an activity can be approved. In some cases, Yellow Light indicates that the activity may be contrary to policy. A "Red Light" means that the activity does **not** meet policy guidelines and is not eligible for approval.

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

4. FY 2013 Priorities and Approaches

In order to achieve both PEPFAR's ambitious targets and the vision of an AIDS-free generation, PEPFAR programs need to prioritize among competing activities and issues. This section of the COP guidance presents a set of overarching PEPFAR technical and programmatic priorities, as well as a set of tools that all country teams are asked to use to apply those priorities in local context. Each priority may not be appropriate for each country or regional program; teams are asked to carefully consider the local epidemiology, donor landscape and national government plans in their countries as they apply these priorities in FY 2013.

All the priorities, approaches and tools below will contribute to an AIDS-free generation. An AIDS-free generation entails that first, no one will be born with the virus; second, that as people mature, they will be at a far lower risk of becoming infected than they are today; and third, that if they do acquire HIV, they will get the treatment and

support that keeps them healthy and minimizes the likelihood of their transmitting the virus to others.

4.1 Technical Priorities

As it works to promote sustainable country programs and achieve program goals and targets, PEPFAR is focusing in FY 2013 on the following strategic areas, presented in non-hierarchical order. Although these priorities are highlighted for FY 2013, teams should also continue to pursue country-specific and context-specific priorities that fall outside of the areas noted below. Letters to U.S. Ambassadors in our PEPFAR countries that go out with FY 2013 planning levels should be referred to for country/regional-specific priorities.

1. Increase PMTCT Coverage, Effectiveness and Retention:

President Obama and Secretary Clinton have cited PMTCT as a core intervention in achieving an AIDS-free generation and have set a target of 1.5 million additional HIV+ pregnant women to receive PMTCT interventions by December 1, 2013.

Antenatal clinics are a frequent point of entry for women to healthcare systems, and the scaling up of PMTCT programs offers important opportunities to extend HIV prevention services to women testing negative for HIV, as well as to link mothers and infants to MCH and family planning programs. These platforms can also extend HIV testing, prevention, and treatment services to male partners and families. PMTCT programs should consider the new WHO statements in scaling up programs to meet the President's goals and should include methods to ensure initiation, retention, and medication adherence of HIV+ pregnant women, mothers, and infants on ART; monitoring of PMTCT sites to ensure quality service delivery; and integration of PMTCT with ART and HIV prevention services for women and their partners and children.

While all WHO-approved PMTCT Options (A, B, B+) include ART for women considered eligible according to national guidelines, few countries have managed to achieve the expected 40-50% of women in PMTCT who would qualify using a CD4 threshold of 350. PEPFAR programs are expected to ensure that ART-eligible women receive ART and to document this as they report disaggregated ARV regimens delivered.

In FY 2013, PMTCT Acceleration Funds will be rolled into PEPFAR base budgets, rather than given as one-time funds, but USG investments in PMTCT should not be reduced. **All PEPFAR teams that received PMTCT Acceleration or Plus-up Funds in prior years should maintain their PMTCT budget allocation at FY 2011 or increased levels in FY 2013.**

Consider Option B or B+ where appropriate: The WHO recommends that HIV-positive pregnant women in low and middle-income countries receive one of two prophylaxis options (Options A and B) for the prevention of mother-to-child transmission (PMTCT). Both WHO Options A and B provide eligible pregnant women with life saving triple ARVs as soon as diagnosed and continues for life for those with CD4 <350 . For women with CD4+ >350, Option A provides intermittent ARV regimens at key points during the pregnancy intrapartum and postpartum/breast feeding period, while Option B recommends starting triple ARVs as early as 14 weeks gestation and continued through the intrapartum and childbirth (if not breast feeding) or after cessation of breast feeding. All Options provide daily nevirapine (NVP) for infants from birth but with Option A the meds are given daily through completion of breastfeeding (or up to 4-6 weeks if not breast fed); with Option B, daily NVP or AZT is given through 4-6 weeks regardless of feeding method.

While Option A and Option B are considered equally effective at preventing MTCT when implemented properly, many PEPFAR-supported countries initially began to implement Option A due to cost considerations. However, recent data indicate that an Option B approach, which involves the provision of a full antiretroviral regimen throughout pregnancy and breastfeeding, will reduce horizontal transmission while also potentially benefiting the health of the mother. As CD4 testing is not required before starting antiretrovirals under this approach, Option B also avoids delays in the initiation of antiretrovirals for PMTCT prophylaxis. In addition, over the past year newly released WHO Guidelines offer the Option B+ approach, which involves starting pregnant, HIV+ women on antiretroviral therapy (ART) for life regardless of CD4 count. Given the potential benefits of Option B and B+ in reducing HIV-transmission to serodiscordant partners and in decreasing barriers to PMTCT and HIV treatment, all PEPFAR programs providing PMTCT should conduct an analysis to determine the incremental cost of transitioning to Option B in countries currently implementing Option A, and to estimate incremental cost of B vs. B+. Countries must assume that 40 percent of HIV-infected pregnant women are eligible for ART prior to the post-partum period, and therefore provision of ART for life to these patients should be considered in the costing analysis regardless of which Option is used.

2. Treatment: for Health and Prevention

In 2011, a HIV Prevention Trials Network study (HPTN 052), demonstrated that provision of antiretroviral therapy reduced HIV transmission to HIV uninfected partners in sero-discordant heterosexual couples by 96%. **ART is now viewed by the scientific community and PEPFAR both as a central tool for decreasing morbidity and mortality, and an essential tool for the prevention of HIV transmission, and achievement of an AIDS-free generation.** In recognition of these benefits, as well as PEPFAR's successful track record of decreasing morbidity and mortality in its treatment programs, on World AIDS Day 2011, President Obama

announced PEPFAR's new ambitious treatment target of 6 million persons directly supported on treatment by 2013. This goal will increase the size of the PEPFAR treatment program by 50% and will require substantial reallocations of PEPFAR country budgets to support elements of national treatment programs.

PEPFAR's policy for supporting national treatment programs to increase access to those in need of treatment for their own health as a first priority remains a central tenet of the PEPFAR program. PEPFAR also endorses and will assist national programs in the implementation of recent WHO Guidelines on treatment for serodiscordant couples regardless of immune status. In addition, PEPFAR will support interested national programs in adoption of the new PMTCT Option B+ "test and treat" approach for pregnant women described in the recent WHO Programmatic Update. Treatment for prevention services should be driven by local priorities and context, and strategically adopted with prioritization of coverage of those most in need.

In 2011, field teams with treatment portfolios participated in treatment consensus targeting for 2012 and 2013. The aggregate of these data informed the President's decision to set the USG target of 6 million on ART by the end of 2013. Country teams are expected to achieve or exceed these targets. Regular SAPR and APR calls will provide opportunities for country teams to report progress, identify challenges and engage headquarters support for course corrections, as necessary.

Country teams are also expected to budget appropriately to meet treatment targets. S/GAC expectations for support 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 lower internal and disbursed Global Fund resources. **Using this framework, PEPFAR teams in these countries highlighted in yellow must raise their year-over-year proportional and absolute budgetary allocations to treatment (HTXS, HTXD, PDTX, and related budget codes such as HTC). Deviations from this approach will require approval from the GAC.**

On the other hand, countries clearly at the other end of the spectrum in terms of available resources and/or disease burden would not necessarily 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.

All teams that report direct treatment targets are expected to complete the Treatment Calculator, found in the FY 2013 Country Operational Plan Guidance Appendices and also on the COP13 planning site on Plan B. This form will ensure that both country teams and headquarters staff understand the planned year-over-year treatment targets and the relationship to budget allocations.

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 Treatment Coverage	Mozambique Uganda	Tanzania		Nigeria				
	Medium Treatment Coverage	Kenya	Zimbabwe			Zambia		South Africa	
	High Treatment Coverage								
Med PLWHA	Low Treatment Coverage	Cote d'Ivoire	DRC Malawi		Cameroon	Lesotho			
	Medium Treatment Coverage			Ethiopia	Thailand				
	High Treatment Coverage							Botswana	
Low PLWHA	Low Treatment Coverage		Burundi	Ghana		Angola			
	Medium Treatment Coverage			Haiti			Swaziland		
	High Treatment Coverage			Rwanda			Guyana		Namibia

** PEPFAR Partner Countries with Generalized Epidemic*

Number of PLWHA (Tertiles) - UNAIDS 2009		Treatment Coverage (<350) - WHO 2010		GF Disbursements/PLWHA 2010	
Low:	280,000 or Less	Low:	<50%	Low:	<$50/PLWHA
Medium:	280,001-940,000	Medium:	50-79%	Medium:	$50-150/PLWHA
High:	940,001-5,6000,000	High:	>80	High:	>$150/PLWHA

**The above table depicts factors S/GAC considers in setting expectations for treatment scale-up in generalized epidemics. These 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. 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.*

Special consideration should be given to costing and budgeting of pregnant women in need of treatment for their own health and PMTCT. Regardless of their entry point (PMTCT or Treatment program), treatment for eligible pregnant women should be forecasted, costed and fully and adequately budgeted for in PEPFAR-supported programs. In addition, key populations (men who have sex with men, sex workers, and people who inject drugs) typically have higher HIV prevalence than the general population. However, stigma, discrimination, and fear of legal sanctions often significantly reduce their access to services. Treatment services for these populations

should be prioritized and ART programs should support a non-stigmatizing clinical environment that enables key populations to have consistent and safe access to treatment services, including both facility and community-based care and support.

As programs mature and healthier populations begin to access treatment, PEPFAR teams and implementing partners must increase their attention to systematically ensuring adherence and retention on ART (including setting partner and program-level targets for the PEPFAR ART retention indicator: T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy). This will maximize the beneficial effects for individuals receiving treatment, and ensure the broad and important contributions of ART to the prevention of vertical and sexual transmission of HIV infections are optimized. Teams must also create strengthened facility-based continuums of care. These should be appropriately linked to community-based care and support activities that foster conducive environments for service uptake, adherence and retention. PEPFAR teams must work with national and other donor partners to ensure that PEPFAR or other resources are allocated in support of HIVDR surveillance and pharmacovigilance activities.

Please refer to Section 5.2 for further programming guidance.

3. Voluntary Medical Male Circumcision

Voluntary medical male circumcision (VMMC) is a one-time, rapid procedure that reduces men's risk of acquiring HIV through vaginal intercourse for a lifetime. In 14 priority countries with generalized HIV epidemics where male circumcision is uncommon (either nationally or regionally) VMMC has the potential to dramatically reduce the rate of new HIV infections at a significant, long-term cost savings. Mathematical modeling suggests that if 8 out of 10 adult men will choose to become circumcised within 5 years, approximately 3.5 million new HIV infections may be prevented in 15 years, saving as much as $16.5 billion in HIV care and treatment costs. In 10 of the 14 priority countries, 1 case of HIV may be prevented for every 10 or fewer men who become circumcised in this scenario. VMMC programs also offer unprecedented opportunities to engage men in health education and counseling, notably HIV testing and counseling services. Furthermore, men who are identified as HIV-positive by VMMC programs are referred for HIV care and treatment, benefitting their health, and broadening the potential community-level HIV prevention benefits of the program. As HIV prevalence decreases in men as a result of becoming circumcised, women's probabilities of encountering HIV-infected partners are also reduced. Almost half of the new HIV infections that may be prevented in the above modeling scenario if scale-up is rapid, are among women. Women with circumcised male sex partners also have reduced risk of sexually transmitted infections, including carcinogenic strains of HPV, and cervical cancer. Secretary Clinton confirmed VMMC as an HIV prevention priority for

PEPFAR in late 2011, and President Obama committed PEPFAR to support 4.7 million VMMCs by the end of 2013.
Reaching the President's target presents an enormous but critical challenge for PEPFAR. In FY 2013, teams are expected to fully fund and actively support the most ambitious VMMC program they can responsibly manage. Budgets should reflect unit costing agreed upon with the HQ Male Circumcision Task Force Teams, and targets for FY 2013 should be discussed and agreed upon with the Task Force prior to COP submission. Additionally, country teams should anticipate WHO pre-qualification (approval/recommendation) of one or more adult male circumcision devices in mid-2013 (calendar year), at which time PEPFAR funds could be used to support VMMC with the pre-qualified device(s). Introduction and incorporation of device-based services may result in additional training and supply chain costs initially. Teams should be in frequent contact with both their CSTL and the Task Force as they encounter successes and difficulties.

4. TB/HIV integration

Tuberculosis (TB) remains the most common cause of death among people living with HIV in sub-Saharan Africa.

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

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.

Investment in TB/HIV should therefore be maintained PEPFAR-wide and every effort should be made to have PEPFAR investments leverage and complement those of the Global Fund and other donors.

Please refer to Section 5.3.1 for further programming guidance.

5. New OVC Programming Guidance- Key Themes:

"I know that creating an AIDS-free generation takes more than the right tools, as important as they are. Ultimately, it's about people …We need to make sure we're looking out for orphans and vulnerable children who are too often still overlooked in this epidemic."

- Secretary of State, Hillary Clinton, AIDS 2012 Address

A central part of achieving an AIDS-free generation is ensuring children grow up HIV-free, and that they are strategically linked to other services across the continuum of response, so they have the knowledge and access to services that help them transition into adulthood knowing their status and how to keep themselves and their families safe from infection. Programs for orphans and vulnerable children (OVC) form a key piece of this continuum of response and should continue to be prioritized.

To ensure cutting-edge, evidence-based practice, the OVC TWG released new Guidance for OVC programming in July 2012. Important themes from the guidance relevant to COP planning include:

- There is no "minimum package of services." Program planners and implementers should ensure prioritized and focused interventions that address children's most critical care needs through family strengthening.
- While programs must continue to improve child outcomes, the primary strategy for achieving this is strengthening parents and caregivers so they can provide for their children's basic needs. The seven core areas have been reinterpreted to better reflect this shift.
- A young person who turns 18 while receiving OVC services should not automatically be terminated from receiving assistance. Programs should plan for appropriate transition strategies and be prepared to cover a buffer period for a seamless transition to adulthood.
- At least 10 percent of OVC project funding should be allocated to monitoring and evaluation (M&E) to ensure that the evidence base continues to grow and to inform better practice.

Detailed descriptions of the evidence-base of each of the sectors below as well as outlined priority interventions are included in the Guidance for OVC Programming:

- Child protection
- Health and nutrition
- Capacity building
- Education
- Household economic strengthening
- Legal protection
- Psychosocial care and support
- Social protection

There is also a section with detailed guidance for strategic planning for portfolio development that is intended to guide country teams in COP planning and overall portfolio development. The new Guidance can be found at www.pepfar.gov/guidance.

Please refer to Section 5.1 for further programming guidance.

6. Testing and Counseling

Knowledge of HIV serostatus is fundamental to the prevention, care, and treatment of HIV. It is the gateway to a range of core interventions including voluntary medical male circumcision (VMMC); prevention of mother-to-child transmission (PMTCT); HIV care and treatment; and TB screening and services. Despite the central importance of HIV testing and counseling (HTC), globally fewer than 40% of people living with HIV know they are positive. Increasing knowledge of serostatus, especially among PLHIV, should be a critical focus of PEPFAR-funded HTC programs.

Scale-up of HTC programs should be strategic, with an emphasis on testing those populations with highest prevalence and attention to yield of PLHIV per program. All programs should strive for early enrollment in care and treatment for PLHIV, both for the benefit of the individual, and to achieve maximum prevention benefits; special attention should be paid to identifying PLHIV in discordant couples (see section above on Treatment for Health and Prevention).

FY 2013 COP-supported HTC programs should focus on:

- Establishing HTC targets that meet VMMC and PMTCT targets;
- Using a range of cost-effective and innovative approaches to make HTC accessible and acceptable to a wide range of populations, including key populations (PWID, SW, MSM and TG) who may not be served by traditional HTC programs; and
- Implementing explicit strategies to ensure that individuals, couples, and families are linked with appropriate follow up HIV treatment, care and support, and prevention services based on their sero-status. All PEPFAR programs should be working to link 100% of HIV positive people to care and treatment, and building strong linkages between testing and treatment programs.

7. Increase Coverage and Effectiveness of Programs for Key Populations

Key Populations are persons who are affected by punitive laws, regulations and policies; stigmatized and marginalized in access to and utilization of services; and disproportionately affected by HIV disease. This includes men who have sex with men (MSM) including male sex workers; transgender persons (TG); people who inject drugs (PWID); and female sex workers (FSW). Recent studies show that HIV disproportionately impacts key populations in low and middle income countries in all regions of the world, including PEPFAR countries. Data from country-specific surveillance surveys have demonstrated the existence of concentrated epidemics among key populations even within larger generalized epidemics.

In a review of low and middle-income countries, MSM were found to be 19 times more likely to be living with HIV than people in the general population. In a similar global review, FSW were 13.5 times more likely to be living with HIV when compared to other females of reproductive age in the general population. Globally, 16 million individuals report injection drug use, and an estimated three million injectors/PWIDs are living with HIV. Despite the disproportionate HIV disease burden, only 9% of MSM and 22% of FSW in sub-Saharan Africa have access to HIV prevention services. Of the 3.2 million opioid injectors living in 13 PEPFAR supported countries, only 3.4% are receiving methadone treatment from government clinics (a core component of comprehensive HIV prevention programs).

Reaching key populations with effective HIV prevention and treatment services is critical to achieving PEPFAR goals. The 2012 PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections lists comprehensive programs for key populations as a core prevention intervention and directs every PEPFAR program to collect data on these populations, and provide HIV/AIDS prevention, care, and treatment designed to meet their needs.

Key Populations are often highly stigmatized and partner countries may be reluctant to invest in programming for them. PEPFAR teams should make breaking down these barriers a priority for both policy and programs in order to most effectively address the epidemic. PEPFAR's expectations for the type of investment in key populations vary based on local epidemiology, presence and activities of other donors, as well as political commitment and financial ability of the host government.

Additional guidance documents for prevention among key populations are available. These 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 the continuum of HIV prevention, care, and treatment for key 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 was released in May 2011 and is also available on www.pepfar.gov/guidance.

8. Addressing the needs of Girls and Young Women across the Continuum of Response

In Southern Africa, prevalence among young women aged 15–24 years is on average three times higher than among men of the same age (UNAIDS 2010). This disparity

arises from systematic disadvantages faced by adolescent girls and young women. Many girls are forced into sexual activity and marriage at very young ages and are extraordinarily vulnerable to unintended pregnancy, HIV, sexual violence, and exploitation. Because of existing gender biases, many girls are seen as unworthy of investment or protection by their families, communities and governments.

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

In these countries, PEPFAR programs should fund evidence-based activities that empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities, and economic assets. PEPFAR programs should also target the men with whom girls and young women engage in sexual activity – whether voluntarily or not – with programs that address harmful gender norms, provide HIV prevention, and link male PLHIV with services. Clinical partners must develop and strengthen innovative platforms that make HIV care and treatment services accessible and acceptable to girls and young women living with HIV. At a policy level, PEPFAR leadership in country should reach out to other stakeholders to develop longer-term plans for addressing the needs of adolescent girls and young women, mindful that population trends across this region suggest continued growth of this cohort over the next 30 years.

What PEPFAR programs should do now:

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

through clinical and community platforms should be actively working to meet the needs of adolescent girls. This work should also be reflected in the OVC and Prevention portfolios, with PEPFAR staff working closely together to ensure that GBV prevention and care programs are well-aligned, funded, and consistently attributed across multiple budget codes.

9. Increasing Demand for HIV Prevention, care, and treatment Services Among Men

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

Treatment programs also reach disproportionally fewer adult men. In sub-Saharan Africa, only 32% of those PEPFAR supports on ART are men. Again, data on PEPFAR programs in concentrated epidemics is less clear, but we know challenges exist.

These issues also arise in VMMC programs, where implementing partners are often finding great demand from adolescent boys, but weak demand from the adult men who must be reached first in order to have the greatest impact on incidence.

These gaps are damaging – for those men who are not getting the services they need, for their sexual partners who are at greater risk for HIV, and for their families and communities.

Men fail to get prevention, care, and treatment services for a number of reasons. Gender norms across the world discourage men from seeking healthcare or disclosing an HIV positive status. Economic hardship often leads men to migrate for work, making adherence to daily drug regimens very difficult. Stigma associated with an HIV positive status, alongside the stigma associated with other identities and behaviors (having sex with other men, using injecting drugs, selling or paying for sex) adds to men's difficulty in accessing services. Health policies and systems also fall short in effectively reaching men by overlooking their unique needs in planning and implementation of services, and through providers and facilities that can be stigmatizing towards men who do access services.

In order to increase demand for and uptake of services among adult men, PEPFAR programs and their implementing partners will need to be innovative and flexible,

thinking beyond traditional public health approaches. We need to see mothers, wives, girlfriends and sisters – as well as men, themselves – as partners in our efforts to bring men into services, and continually identify and test new ways to make these services attractive and accessible.

In FY 2013 and onward, all PEPFAR teams should be carefully analyzing the data on service uptake and adherence among adult men in their localities to better understand the gap between needs as indicated through DHS and modeling data, and services currently provided. All areas of the response from HTC through treatment should be considered. Teams should then work with implementing partners and other stakeholders to:

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

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

4.2 Programming Approaches

The nine technical priorities highlighted above are ones for which there is a change in guidance or that should receive a renewed focus by PEPFAR country teams this year. The priorities should all be considered in the context of the following approaches: integration under GHI, the continuum of the HIV response, country ownership, and collaboration with the Global Fund/UN.

PEPFAR and the Global Health Initiative Principles and Targets

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

Since the launch of GHI, measurable strides have been made towards achieving bold goals. To date, USG global health teams in the field and at headquarters are implementing more than 40 GHI strategies, applying the GHI principles and pursuing the GHI targets. As the USG moves from individual program activities to coordinated

actions that can save more lives, three key areas of focus have been identified under the GHI:

- Creating an AIDS-free generation,
- Investing in women and saving mothers, and
- Ending preventable child death.

While PEPFAR's work primarily focuses on creating an AIDS-free generation, S/GAC recommends that country teams explore opportunities to integrate and leverage the PEPFAR platform in order to advance progress toward all the GHI targets. In addition, PEPFAR teams should focus on the ways in which PEPFAR programs can reflect and incorporate the GHI principles, listed below, into their programming:

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

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

Because of PEPFAR's HIV/AIDS mandate, it is important to note that PEPFAR resources can be integrated with other programs only when PEPFAR resources are linked to HIV/AIDS outcomes. Country teams who have proposals or questions about potential uses of PEPFAR funding should call their CSTL. These proposals will be evaluated on a case-by-case basis to ensure that the proposed use of funds is in accordance with PEPFAR's authorizing legislation and appropriations account language before submission of the COP.

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

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 to the larger GHI interagency team.

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

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

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

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

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

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

- Link to and between HIV prevention, care, and treatment opportunities within and between facilities and communities;
- Link to and between HIV services to other health sector services;

- Link to and between HIV services to broader development opportunities; and
- Ensure that holistic needs of beneficiaries, including social and emotional needs created by the epidemic, are integrated into the response.

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

3. Country ownership

In order to realize the vision and end goal of an AIDS-Free generation, PEPFAR country teams, host governments, civil society including faith-based organizations, and the private sector, must collectively continue to make advancements on country ownership. To guide country teams, the U.S. Government (USG) published a supporting document on country ownership which can be found by following the link: http://www.ghi.gov/documents/organization/195554.pdf

The document outlines how country teams can pursue a dialogue on country ownership of PEPFAR-supported programs and provides specific actions that can be taken to advance local ownership, and to monitor progress. This dialogue is supportive of, and is an evolution of the partnership framework processes and documents. In the FY 2012 COP guidance, all country teams were requested to describe the results of an assessment of the four dimensions of country ownership: Political Ownership and Stewardship; Institutional and Community Ownership; Capabilities; and Mutual Accountability including finance. To provide continued support for implementation of roadmaps, a working group of field and headquarter staff is working on a set of tools to be made available throughout FY 2013 to help teams continue to make progress in transitioning ownership of the management, technical oversight, and eventually financing of PEPFAR-supported programs.

Through the country ownership process, PEPFAR is working to articulate how transition of ownership for each country receiving PEPFAR funds is being pursued and the expected timelines for such transition. To facilitate this process, S/GAC has utilized a broad "country categorization" process to discuss PEPFAR countries around country ownership. Some common concepts are described below for each category. For the FY 2013 COP, country teams are requested to provide an update on progress made on the dialogue and actions around financial accountability as outlined in Section 3.2.2. Examples of the type of information requested could include details on progress made in sharing or co-financing of programs or activities previously wholly supported by PEPFAR, activities previously not on budget that are now on budget, or processes being pursued to create the environment for transparency in the budget/resource allocation process, as country contexts dictate.

Descriptions of Country Categories:

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

For the FY 2013 COP, country teams are requested to provide an update on progress made on the dialogue and actions around financial accountability (as outlined in Section 3.2.2). Examples of the type of information requested could include details on progress made in sharing or co-financing of programs or activities previously wholly supported by PEPFAR, activities previously not on budget that are now on budget, or processes being pursued to create the environment for transparency in the budget/resource allocation process, as country contexts dictate.

4. Multilateral Engagement: UNAIDS and the Global Fund

Working with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and UN Family Organizations

The Joint United Nations Program on HIV/AIDS (UNAIDS) is a partnership of 11 UN Cosponsors.[4] The Cosponsors have diverse experience and mandate, not unlike PEPFAR's USG implementing agencies. The UNAIDS Secretariat provides leadership, advocacy, coordination, and accountability for the joint program. The "Division of Labour"[5] defines the responsibilities of each of the cosponsors, which have staff in most PEPFAR countries.

Working together, PEPFAR and UNAIDS have each made significant contributions to the global AIDS response. At the headquarters level there has been productive collaboration between S/GAC, USG implementing agencies, and the UNAIDS Secretariat and Cosponsors. This partnership has delivered concrete results including: joint planning for the 2011 High Level Meeting, joint development of technical guidance documents for HIV prevention, treatment and care, development and promotion of the Shared Responsibility agenda, development and implementation of the Global Plan for the Elimination of Mother to Child Transmission by 2015 and Keeping their Mothers Alive, and most recently a successful AIDS 2012 Conference.

In many cases, collaboration at the country level has also been strong and productive. UNAIDS has a critical role to play in talking to the *right people* with the *right message* and can be a powerful advocate. PEPFAR country teams should consider their relationship with UNAIDS as a joint program and how the role of the UN as an "honest broker" can be used to advance USG interests, particularly when it involves moving government towards accountability and action. UNAIDS can also serve as an important link to civil society, which can help move governments to act and be more accountable. It is important to work closely together to ensure that misunderstanding and other issues not get in the way of true teamwork and cause missed opportunities. In partnership both partners can have a tremendous impact if they (and their sub-units) come together in a spirit of unity.

UNAIDS has Country Coordinators (UCCs) posted in over 80 countries. PEPFAR Coordinators are recommended to be in frequent contact with their country UCCs. The UCC is the entrance into the UN family in the same way that the PEPFAR Coordinator can be the entrance to the USG family. Teams are encouraged to identify one or two common program issues that require a diplomatic solution and work together with UCC

[4] UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, World Bank, and UN Women.
[5] Division of Labor outlines collective implementation of the UNAIDS Strategy for 2011–2015: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2063_DivisionOfLabour_en.pdf.

to solve these issues. Be strategic and allow UNAIDS to convene or lead when it makes sense. The UN family is also actively engaged with the Global Fund at all levels, on the Board, on Country Coordinating Mechanisms (CCMs), and in direct work with Principal Recipients (PRs). Their relationships with government and role as the "honest broker," and their mandate to help government convene partners, including civil society, and focus Global Fund specific work as one part of the national strategy, can be important tools as PEPFAR engages more strongly with the Global Fund. In a few PEPFAR countries, UNDP serves as the acting Global Fund PR. In these countries there are additional opportunities to engage with UNDP, for example around their capacity development plans. UNDP recently released a Capacity Development Toolkit for Global Fund programs to support national partners and UNDP Country Offices in developing national capacity to successfully implement Global Fund grants.[6]

Note: if PEPFAR Coordinators or other USG staff have a conflict with UCCs or other UN family staff members, then Coordinators can communicate this information to the S/GAC Multilateral Diplomacy team, who can work with CSTLs and UNAIDS headquarters or regional offices to remedy the situation.

Working with the Global Fund

The Global Fund represents a critical multilateral vehicle for donors to contribute to the shared global responsibility and support country leadership for the three diseases. The USG's contribution to and engagement with the Global Fund continues to help us achieve our bilateral program results, reach more people with quality services, leverage contributions from other donors, expand the geographic reach of our investment, and promote a shared responsibility among donors, host countries and implementers for financing countries' responses to the three diseases.

Support for AIDS programs in many countries is increasingly a mix of domestic, Global Fund, and U.S. and other donor resources, with the government playing the orchestrating role. This mix of resources is often present at the site level – a degree of interdependence and co-financing of health systems and services that represents progress toward shared responsibility. As we move aggressively to a sustainable response to HIV/AIDS, PEPFAR, the Global Fund, and partner countries are working more closely together – ultimately producing an overall decrease in costs while saving more lives. Together Global Fund and PEPFAR account for over 90% of donor funding for HIV control in the world's highest-burden and lowest-resourced countries, and through further strategic cooperation we can achieve more. Reaching our global goals is clearly beyond the capacity of any single country, donor or partner. Because of this, we want to increase our focus and support for the Fund within the context of one

[6] Capacity Development Toolkit: http://www.undp-globalfund-capacitydevelopment.org/home/cd-toolkit-for-hivaids,-tb-malaria-responses.aspx.

national strategy, and with clear transparency and communication with government and other partners in country.

A critical tenet of shared responsibility is to ensure that all resources are used as efficiently and effectively as possible. With strong U.S. encouragement, the Global Fund has taken a number of actions over the last year to internally transform the Fund and reorient the organization as an active investor. Resulting increases in efficiency, effectiveness, and accountability will increase the impact of Fund resources on the ground and improve more lives. Given the new Global Fund Strategy for 2012-2016,[7] the organizational overhaul and reforms at the Secretariat, and the renewed openness of Secretariat staff to fully engage with the USG, PEPFAR teams should seize this opportunity to change the way we do business with the Global Fund.

All USG staff should see the success of Global Fund programs and partners as a core measure of their own success and central element of their work in country. USG bilateral programs are and should be deeply interconnected with Global Fund-financed programs. USG staff engagement in these activities is highly valuable to ensure that PEPFAR, the President's Malaria Initiative (PMI), other USG health resources, and Global Fund investments are utilized to the maximum gain of all stakeholders by ensuring increased efficiencies and greater health outcomes. PEPFAR's success in the field is directly associated with the extent to which Global Fund-financed programs deliver high quality, cost-effective services. **As such, PEPFAR teams are expected to demonstrate increased coordination between PEPFAR and Global Fund-financed HIV programs through COP activities and technical assistance (TA).**

The USG can and should play a critical role in supporting the mission of the Global Fund to make strategic investments and ensure effective grant implementation. All PEPFAR countries are expected to place a renewed emphasis on coordination with the Global Fund to inform their COP 2013. Ultimately, this collaboration should serve to:

- Improve investment, through more strategic investment of PEPFAR and Global Fund resources;
- Improve management, through joint work towards better, more efficient and evidence-based use of funds at country-level; and
- Improve technical and programmatic quality, through technical support and quality assurance to ensure high-quality service delivery, and to maximize outcomes.

Reducing program duplication, decreasing costs, and creating efficiencies and synergies between Global Fund and PEPFAR investments will help to increase coverage and save more lives.

[7] Global Fund Strategy 2012-2016: **http://www.theglobalfund.org/en/about/strategy/**.

4.3 Tools for Portfolio Decision Making

1. Making Smart Investments

Now more than ever, PEPFAR needs to ensure smart investments of every dollar. This requires both technical efficiency in program implementation and allocative efficiency, i.e. investing in what works. Evidence-based investments must be 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. S/GAC has traditionally provided little formal direction on allocation decisions across program areas and has 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.

In order to achieve the greatest value for our investments, PEPFAR must move more quickly to allocate our resources based on the impact of the interventions and on the complementarity of our programs with those funded by the national government and/or external funders such as the Global Fund. PEPFAR should therefore be asking: 1) 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?; 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 it has, 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. PEPFAR 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, prioritizing country ownership does not mean using PEPFAR funds to support activities

that lack an evidence base even if the country supports them, and country teams must ensure PEPFAR's programmatic integrity is maintained.

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

Determining an approach to treatment scale-up: As a guideline, PEPFAR needs 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 and new evidence has shown that treatment is also a valuable tool in preventing sexual transmission in serodiscordant couples. It is also increasingly the intervention of choice for keeping mothers living with HIV healthy and preventing new infant infections. Therefore, every PEPFAR team, whether it *directly* supports treatment or not, should make the strong performance of country treatment programs a priority in its portfolio.

2. Applying the Impact and Efficiency Acceleration Plan

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 in areas detailed in the acceleration plan referenced above, 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. Where expenditure analysis (EA) is being implemented, is there a plan for using data and sharing it with stakeholders?
    ii. IF EA is not available, has the country team identified any priority areas for costing studies?
    iii. Has the country team engaged the Finance and Economics Working Group on obtaining and applying economic data for planning purposes in the country context?

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 PRs and CCMs 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 and the article in Health Affairs (PEPFAR'S Past And Future Efforts To Cut Costs, Improve Efficiency, And Increase The Impact Of Global HIV Programs. Health Aff July 2012 31:71553-1560) for further detail on these smart investment strategies.

Investment Framework

The UNAIDS Investment Framework was developed by an international group of experts, including UNAIDS, PEPFAR, the Global Fund, Gates Foundation, World Bank, WHO, and academic and policy institutions. The Framework is an important tool that puts informed country ownership and decision making at the forefront of the HIV response.

The primary goals of the Framework are to:

- Maximize the impact of national HIV responses
- Support national strategic planning and more rational resource allocation based on country epidemiology and context
- Encourage countries to prioritize and implement the most effective programmatic activities
- Increase efficiency in HIV prevention, treatment, care and support programming

PEPFAR teams should be aware that there is a lot of interest in the Investment Framework and they may see it being used in different ways to help guide more strategic investment of HIV resources. Currently it is being used as both an advocacy (communication) tool and as a more technical tool at country level to guide discussions or decision making around resource allocation.

UNAIDS has successfully used the Framework as an advocacy tool to ensure that "strategic investment" stays on the global HIV agenda. At country level UNAIDS is using the tool to advocate with Ministries of Health and Finance to reallocate funding towards "high impact" interventions. During national strategic planning processes, the tool is being used to guide discussions towards a rational allocation of HIV resources.

This investment approach is largely a branding and packaging of decision making principles PEPFAR is already using, and which are still very much in line with PEPFAR guidance. UNAIDS will be working with countries to systematically and deliberately apply these principles to optimize and rationalize the resource allocations of national programs through the development of "investment cases."

PEPFAR teams should actively participate in UNAIDS convened or government-led discussions in countries, together with GF, civil society, and other partners, about strategic investment. Teams are encouraged to explore how a national investment case may be helpful in their own planning processes, recognizing that PEPFAR is only one of several funding sources. As always, the COP will provide the guidance on which pieces of a national investment case can be funded with PEPFAR dollars.

PEPFAR teams already engaged in similar exercises intended to rationalize the allocation of resources can contribute their experience to these national discussions. PEPFAR Coordinators should consider contacting the local UNAIDS Country Coordinator (UCC) for a briefing on the UNAIDS country office plans to implement the Framework.

Supporting documents can be found here:
A New Investment Framework for the Global HIV Response (principles of Framework)
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2244_InvestmentFramework_en.pdf

Investing for results, Results for people - A people-centered investment tool towards ending AIDS (a tool for implementing the Investment Framework)
http://www.unaids.org/en/resources/publications/2012/name,72628,en.asp

3. The Efficiencies Project

The Efficiencies Project – an HQ initiative with participation from all PEPFAR implementing agencies – was established to find ways to help field teams reduce the amount of time spent on COP budgeting. The premise was that field teams were spending too much time in unproductive budgeting discussions, and with better tools, processes and support, they could reduce the amount of time it takes to develop a COP budget, and in addition, have a better outcome.

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

A team of HQ and field representatives from all agencies reviewed best practices, and then developed tools and processes to help teams to "optimize" the interagency process, which both reduces time spent on budgeting, while also making interagency efforts more strategic and meaningful, including:

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

Before COP Planning Starts

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

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

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

Portfolio Reviews

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

The Efficiencies Project team has reviewed several different portfolio review processes and tools, and has compiled a Portfolio Review package that is now formally recommended for teams to use and adapt. This document can download at http://www.effproj.com/docs/.

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

- Achievements (Performance) – What has a partner or activity achieved in the past year? This explores how our partner is performing against what we have asked them to do in their agreement.
- Alignment (Strategy) – How well is the partner or activity aligned to PEPFAR's current strategy and goals? While a partner may be performing well at what we asked them to do, perhaps new evidence has shifted our strategy, and we need to make sure our partners are shifting as well.
- Financial Performance – Does the partner have a pipeline? What are their costs, and how do they compare with other partners/activities?
- Sustainability/Country Ownership – If this is an international partner, are they building local capacity to take over the project at some point? If this is a local partner, are they fully capable of managing and sustaining their programs?

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

The Efficiencies Project also encourages teams to conduct their portfolio reviews outside of the COP planning cycle if possible. This helps separate the review from budgets, and gives partners an opportunity to respond and make adjustments based on the feedback outside of the process in which their budget levels are being considered. However, as there may be several months between the portfolio review and the COP planning begins, teams should develop a Portfolio Review report which captures some of the major themes, issues and discussions that emerged from the portfolio review.

Strategic Country Support Team Engagement

HIV/AIDS science and policy are constantly evolving. New guidance, new initiatives and new approaches are discussed throughout the year. However, the primary time that headquarters gives clear feedback to teams on how to adapt these policies and approaches to their context is during the COP review – *after* teams have spent months on planning.

Stronger headquarter country support team collaboration can help bring new guidance, information on new initiatives and expectations for adoption of new approaches to the country team well in advance of the formal COP review. By engaging field teams during key points in the year, for example, around APR/SAPR and portfolio reviews, country support teams (which usually consist of headquarters points of contact across

implementing agencies, deputy principals, SI advisors, and relevant TWG representatives)can help field teams as they discuss and debate how best to apply new strategies to their programs, and what appropriate program adjustments need to be made. When country support teams help field teams throughout the year, surprises during COP reviews can be eliminated.

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

While there will not be a one-size-fits-all approach, the Efficiencies Project has set an expectation for a minimum level of engagement and standardization to the Country Support Team process. Existing, highly functioning Country Support Teams will not be expected to change, but in programs where there is no existing, limited, or inconsistent Country Support Team activities, the Efficiencies Project will:

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

Efficiencies Project Considerations in COP Planning and Development

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

Conducting a Top-Down Strategic Budgeting Process

Bottom-Up budgeting process well utilized in PEPFAR. Bottom-up budgeting requests budgetary 'asks' from specific technical areas, incentivizing activity managers to submit highly optimistic budgets and avoid self-imposed budget reductions. The iterative budget-reducing process that ensues as a result, is time-consuming, emotionally draining, and may result in unstrategic results.

A Top-Down strategic budgeting process, on the other hand, has the potential to reduce time spent in budget negotiations, with an improved outcome. The central

ingredient for this approach to succeed is a strong, small leadership team with a shared vision for the PEPFAR program; a small team that can set priorities for the coming year, and strategically align the budget to fund priorities.

The Efficiencies Project has developed an outline of a top-down budgeting process, as well as tools that can be adapted for teams to use. The make-up of leadership teams will vary, as will the priorities in each country; however, the basic framework of the process can be adapted to each country's context:

- Step 1: The budgeting process is linked to the Portfolio Review through an executive summary presentation of the Portfolio Review and discussion. The minimum expectation is the portfolio review executive summary provides summarized data for the leadership team on:
    - Strategy: Overarching progress on major strategic themes/initiatives
    - Performance: Specific Program Performance and Achievements
    - Issues: Issues/Challenges/Areas of concern, and the USG team's plan for addressing
    - Financial: Pipeline/Financial Performance
    - Sustainability: Summary of progress on country ownership, sustainability, and/or local capacity
    - Depending on the timing of the portfolio review vis-a-vie the budget discussions, the PEPFAR Team may want to provide the leadership with a brief update on any progress made since the portfolio review.
- Step 2: Priority Setting Exercise
    - The leadership team then should discuss rank priorities for the upcoming year. **The expectation is that country teams are consulting with partner governments during this priority setting process**.
        - Priorities may be defined as budget codes, or themes that cut across budget codes, or in some cases, an individual project that is a high priority. Teams may choose to have a mixture of approaches in their priorities, or agree to use a specific system of budget categories.
        - Ideally, the outcome of this exercise provides a prioritization framework that covers every program area and activity. For large programs, leadership teams may want focus primarily on the highest priorities, and leave a few catch-all categories for the remaining, lower-priority activities.
    - The leadership team should provide high-level bullets on expectations for each priority to guide the team. Bullets may set goals for targets, or transition, or other programmatic or financial guidelines.
- Step 3: Data Gathering
    - The next step is for a team to put together background data on the priorities. This would include:
        - SI data on historical targets and achievements

        - Financial data on pipelines
        - Historical budget data
    - This data would be put together by the PEPFAR Coordination Office, with support from SI Advisor and agency financial people
- Step 4: Priority Budgeting Exercise
    - A budgeting team designated by the leadership (or the leadership themselves) should conduct a process of setting budget levels by priority, starting with the first priority, and moving through the priorities until they reach the end of the list. It may be prudent for the budgeting team to reserve a small amount of funding to support opportunities later identified by the TWGs as potential add-backs.
    - This budgeting exercise should designate for each priority the level of funding (both new funding and pipeline) and, where relevant, further expectations for targets or costs.
    - The budgeting team may also want to include a summary of any challenges they foresee with the budget (i.e. lower priorities having to take significant reduced budget levels, etc.)
- Step 5: Leadership Approval of High-Level Budget
    - It should be emphasized that at this level no individual partners, activities or agency-level budgets should be discussed (unless there is a one-off activity that for a clear reason is singled out as a priority for that year.)
    - The technical team should present their budget breakdown to the leadership for final approval. The teams may also want to present this budget to the Host Government as well. In some cases, the team may also want to present this budget for feedback from the Country Support Team DP/ADPs.
    - At this stage, it will be easier to make budget adjustments before activity and partner levels are set.
- Step 6: Activity Level Budgeting
    - TWGs are then provided with a budget level and the bullets from the leadership team for each priority. They are expected to budget activities within this budget level that meet the expectations set out by the leadership and, if they choose, recommend potential additions to their guidance level. The budgeting team might limit such additions to a set number of items (1 or 2 per TWG) or a set percent of the guidance level (up to 10% above guidance, for example), and TWGs should include estimates of outcomes, impact, and key assumptions in these proposals.
    - If there are problems at the TWG level, the budgeting team should try to resolve the issues first, and then push it up to the leadership team if there is no resolution.
    - While it may be necessary to consult with partners at this stage, there should be no guarantees of budget levels to partners.
- Step 7: Activity Level Budget Approval

- The budgeting team should then review the results of the activity-level budgeting exercise by each of the TWGs. Based on the priorities identified in step 2, the data gathered in step 3, and the quality of proposals received from the TWGs, the budgeting team should allocate any previously unallocated funds to selected proposals. They should be ensuring that the activity level budget meets the guidelines set by the leadership team.
- Engagement of Government and leadership will depend on the expectations/traditions within each country.

- Step 8: Detailed partner-level Narrative Development/targeting
  - Once the activity-level budget is approved, Activity Managers can then go to partners with activity level budgets.
  - Disputes between partners should be resolved at the budgeting committee.

Additional Efficiencies Project Resources

The Efficiencies Project team is pilot testing these tools and approaches during the development of the FY 2013 COP. Teams are strongly encouraged to use these tools and processes, and adapt them as they see fit. Please provide the Efficiencies Project Team with feedback on your experience so we can make the tools better for FY 2014. Please contact Chris O'Connell at o'connellc@state.gov for questions, or to provide feedback. Please visit the unofficial Efficiencies Project website, where all tools are posted, as are easy-to-use forms to provide your feedback. No login is required.
http://www.effproj.com

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%. If your program submits a justification, it should be uploaded to the document library as a 'Budgetary Requirement Justification.'

OVC programming centers on reducing the socio-economic impacts HIV has on children and adolescents affected and infected by HIV and AIDS. OVC funding should *complement* rather than *supplant* other funding sources aimed at meeting the needs of children and adolescents. Pediatric treatment may **not** be counted towards the OVC earmark but remains a global priority and continues to have its own pediatric treatment program code.

While OVC funds cannot be used for treatment related expenses such as drugs and diagnostics, programs should pro-actively include HIV positive children and adolescents in psycho-social and economic support activities funded through the HKID budget code. Additionally, OVC funds may, within the context of a comprehensive OVC program, fund HIV prevention activities that are explicitly integrated into other OVC activities in order to respond to the needs of children and youth targeted by the OVC platform.

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 perspectives and to indicate levels of funding for those priorities which they expect the program to achieve, sometimes referred to as "soft" earmarks.

It is vitally important that teams are responsive to these concerns. As any such provisions are enacted for FY 2013, 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. TB/HIV collaborative activities reflect the key concepts of coordination, collaboration, integration and systems strengthening

Ending HIV-associated TB among PLHIV is possible through a combination of widespread ART coverage, early identification and treatment of TB, isoniazid preventive therapy (IPT) and infection control activities. These high-impact interventions are critical to reducing HIV-associated morbidity and mortality and therefore are essential components of COP planning and program implementation.

As the Global AIDS Coordinator 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 including early access to ART and providing basic care packages including cotrimoxazole and IPT, clearly meet this criterion. **Investment in TB/HIV should therefore be maintained PEPFAR-wide.**

PEPFAR has made important strides in expanding the number of TB patients tested for HIV; yet there is more work to be done. In many PEPFAR-supported countries, especially in Sub-Saharan Africa, HIV prevalence among TB patients ranges from 40-80%. According to the 2009 revised WHO ART guidelines, all HIV-infected TB patients irrespective of their CD4 count should be initiated on ART. This is critically important, as a growing body of evidence suggests that initiating ART soon after starting TB treatment significantly increases survival among HIV-infected TB patients. TB clinics are therefore high yield sites for identifying persons living with HIV eligible for ART. Yet, despite WHO recommendations, in 2010, only 42% of HIV-infected TB patients (154,000 of 366,000 identified) in sub-Saharan Africa were initiated on ART. As a result, 212,000 HIV-infected TB patients eligible for ART were not initiated on ART, a huge missed opportunity to avert preventable deaths.

Improving uptake of ART among HIV-infected TB patients will reduce mortality and substantially contribute to the AIDS-free generation target set by President Obama to initiate 6 million PLHIV on ART by the end of 2013. Country programs should identify and address the challenges to initiating ART for HIV-infected patients and develop

models or scale-up existing models of service delivery to increase uptake and achieve the treatment target. Interventions could include provision of ART in TB clinics, strengthening of referral systems between TB and HIV programs and improved M&E systems to ensure program optimization and documentation.

Expansion of TB screening of HIV-infected individuals has been unacceptably slow, especially in light of recent studies of patients on antiretroviral therapy (ART) that have documented high rates of TB (7-20%) not only among individuals initiating ART, but also among those already on ART. If not adequately addressed, TB has the potential to undermine the great strides that PEFPAR has made in rapidly expanding HIV care and treatment. Given the high morbidity and mortality associated with undiagnosed TB, PEPFAR must play a critical role in catalyzing screening, diagnosis, and treatment of individuals with both infections. This advances the AIDS-Free Generation goal of improving survival of PLHIV in care and treatment by reducing HIV-associated morbidity and mortality. Country programs should continue to scale up intensified TB case finding, isoniazid preventive therapy and TB infection control (collectively known as the "Three I's of TB/HIV") as well as measure the impact of these interventions on reducing the morbidity and mortality among PLHIV.

The *WHO 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. 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 enrollment into HIV care and early initiation of ART for HIV-infected TB patients
2) Provision of cotrimoxazole prophylaxis (CPT) and ART in TB clinics
3) HIV testing for partners and family members of TB patients and linkage to care and treatment of HIV-infected partners/family members.
4) Intensified TB case-finding (ICF) efforts among PLHIV including appropriate diagnosis and TB treatment.
5) TB infection control (IC) activities in both TB and HIV care and treatment settings
6) Isoniazid preventive therapy (IPT) for PLHIV who do not have active TB disease
7) Laboratory services to support TB diagnosis and treatment, including the roll-out of Xpert MTB/RIF assay:
    a. With an emphasize on implementation as a (near)POC rapid diagnostic in settings serving high volumes of PLWHA in care and treatment
    b. Accompanied by appropriate technical assistance and evaluation components

8) Strengthening program monitoring and evaluation (M&E)
9) Surveillance and management of multidrug-resistant TB (MDR-TB)
10) Strengthening general TB control (DOTS)

Efforts should be made to maximize opportunities for integrated programming in order to expand access and reach. For example, TB/HIV activities have not been integrated into most PMTCT settings. Implementation of TB intensified case finding (ICF) and appropriate TB treatment, coupled with early initiation of antiretroviral therapy (ART), appropriate use of IPT, and TB infection control in PMTCT and MNCH settings, has been shown to be the most effective strategy for reducing TB/HIV-related morbidity and mortality among HIV-infected pregnant women and their infants.

For FY 2013, S/GAC intends to maintain the level of TB/HIV investment at $160 million.

Submissions that do not reflect resource commitments commensurate with the national burden of TB and HIV 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.

For FY 2013, S/GAC intends to maintain food and nutrition funding at approximately $130 million.

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. WHO recommends ARVs for PMTCT during ante- and perinatal periods and through the duration of breastfeeding. HIV-infected mothers are encouraged to breastfeed exclusively for 6 months and to continue breastfeeding for a minimum of 12 months and beyond until a safe and adequate replacement diet is available. Programmatic emphasis should be placed on pre- and postnatal counseling

surrounding infant feeding, nutrition and testing; and maternal nutrition and health. Special attention should be given to link counseling to early infant diagnosis to discourage premature weaning. Regular assessment, counseling, and support should be provided, particularly to encourage EID and exclusive breastfeeding for the first six months of life and appropriate complementary feeding from six months of age and beyond and to provide post-weaning support at 12 months and beyond. Establishing a continuum of care linking clinical and community services should allow for tracking of mother-infant pairs, a focus on improving maternal nutrition status, and provision of basic child survival interventions until at least 24 months of age.

Economic Strengthening, Livelihoods and Food Security

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

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

Central Support for SI – HVSI Budget Code:

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

Program Budget Allocated for M&E:

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

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 expected to reinforce priority on the values associated with the funding limit.

For operating units receiving over $20 million in PEPFAR funds for FY 2013 (GHP-State, GAP, and/or GHP-USAID for HIV), the percentage limit on funding to a single partner remains 8%. For operating units receiving $20 million or less in FY 2013, 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:

- 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:

$$\frac{\text{Partner Funding Applicable to the Single-Partner Funding Limit}}{\text{Country Budget Applicable to the Limit}} = \%\ \text{Partner Funding}$$

Partner Funding Applicable to the Single-Partner Funding Limit: (Total Partner Funding (includes funding received as a prime or sub) – Exempted Funding from the Limit)

Country Budget Applicable to the Limit: Country Budget (Central & Field $) – USG M&O Costs

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 for:

1.) Care and treatment
2.) OVC
3.) AB
4.) 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 voluntary family planning and reproductive health services worldwide. For example, in Sub-Saharan Africa one in four women who wish to delay or prevent pregnancy do not have access to and are not using 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% (Heys et al. 2009).

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. PEPFAR teams must seek to ensure that those in need of referrals and care receive those referrals and care.

The GHI priorities placed on integrated health programming and implementation of a woman, 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 optimized as a platform on which to incorporate and integrate other health services.

USG-supported family planning 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 USG, including PEPFAR, supports a person's right to choose, as a matter of principle, the number, timing, and spacing of their children, as well as use of family planning methods, regardless of HIV/AIDS status.
- Family planning use should always be a choice, made freely and voluntarily, independent of the person's HIV status.

- The decision to use or not to use family planning should be free of any discrimination, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.
- Access to and provision of health services, including antiretroviral treatment, for an HIV-positive person should never be conditioned on that person's choice to accept or reject any other service, such as family planning (other than what may be necessary to ensure the safe use of antiretroviral treatment).
- HIV-positive women who wish to have children should have access to safe and non-judgmental pregnancy counseling services.
- 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 to ensure access to voluntary family planning as part of comprehensive care for HIV/AIDS.

PEPFAR funds may not be used to purchase family planning commodities. Opportunities that should be actively pursued, and health workers provided training as appropriate, include:

- providing counseling and referrals (linkages) to voluntary family planning programs for women and men in HIV/AIDS prevention, treatment, and care programs – ideally at the same site;
- providing family planning clients with HIV prevention including HIV testing and counseling, particularly in areas with high HIV prevalence and strong voluntary family planning systems – again, ideally at the same site;
- integrating family planning services (using commodities funded by sources other than PEPFAR) in PEPFAR-funded PMTCT and HIV care and treatment programs;
- provision of HIV prevention messaging and support, as well as HIV counseling and testing (funded by PEPFAR), within antenatal care, maternal and child health, and family planning programs (funded from other accounts) for both men and women;
- ensuring 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.

All USG personnel should be aware of legal restrictions and program requirements relating to family planning, and should consult with relevant Agency legal counsel with any questions in this area. Implementing Agencies must ensure that staff are trained as needed on compliance with relevant provisions, and that implementing partners are made aware of the provisions.

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

6.2 Implementation Science and Impact Evaluations (IS)

Implementation Science

As PEPFAR implements scientific advances on a large scale through its programs, it has shifted towards an Implementation Science (IS) model, 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[8]. This framework is intended to broaden the scope of high-quality evaluations of PEPFAR-funded programs from basic program evaluations to impact evaluations in order to 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.

Impact Evaluations (to be submitted with COP)

For country-driven rigorous study evaluations, we have implemented the **Impact Evaluation** (IE) mechanism. As PEPFAR programs move to strengthen the evidence base for interventions funded within their operating plans, we recognize the unmet demand for more rigorous impact evaluations (IE) than those allowed under current guidance on operations research or monitoring and evaluation (M&E). Whereas outcomes monitored through M&E examine whether targets have been achieved and whether trends in outcomes are promising, IEs examine impact compared to the counterfactual or what would have happened in the absence of the program.

To address the need for this type of field-driven evaluation under PEPFAR, the IE process was created in 2011 to allow for IE concept submissions from PEPFAR programs. This revised process allows funding of IEs of increased rigor for existing or new PEPFAR programs through the COP process. A key goal of the process is to ensure the quality and rigor of the evaluations while creating efficiencies in the application and review process, and to streamline funding mechanism issues so these evaluations can move forward rapidly in line with implementation of the program being evaluated.

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[8] 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.*

For guidance on how to submit country-driven IE concept proposals in the FY 2013 COP, please see Supplemental **FY 2013 Impact Evaluation Guidance**.

Implementation Science Awards

In 2011/2012, OGAC, in collaboration with CDC, NIH, and USAID issued a series of PEPFAR Implementation Science requests for applications (RFA). Managed through each of the respective agencies, solicitations were open to a broad range of investigators in order to create more direct linkages to researchers and institutions in countries receiving PEPFAR support.

Proposals awarded in response to these IS RFAs will 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. These studies will yield crucial knowledge on optimizing the delivery of HIV/AIDS services and identifying high-efficiency service delivery models, and are a critical component of PEPFAR's focus on using scientific evidence for decision-making across programs.

For a list of PEPFAR funded IS evaluations or to find out current funding opportunities, please see PEPFAR Plan B or contact PEPFAR_ORS@state.gov**.**

Ongoing/Closed Public Health Evaluations (PHE)

As noted in last year's COP guidance, the PHE mechanism has ended. For prior year PHEs with concepts approved between 2007–2010 and that are ongoing, please continue to follow the existing process for PHE protocol review and annual progress reporting, which is separate from the COP and detailed below.

As in prior years, all ongoing PHEs are required to submit an annual progress report. Progress reports for previously approved PHE activities continuing into FY 2013 will be due on **August 23, 2013.** For all PHE activities that were completed or that ended in the previous year, closeout reports should be provided. Please see the *PHE Progress Report Guidance* for additional information.

As a reminder, PHE studies which were in protocol development or revision in the previous progress reporting round will be expected to have made substantial progress (e.g. protocol submission, PHE protocol approval, or study initiation) in this year's progress reporting round. Studies failing to demonstrate such progress will be considered for termination. Studies with delayed or halted implementation will also be considered for termination unless a clear plan for resolution is provided.

The following PHE Guidance documents and additional information can be found at: https://www.pepfarplanb.org/2013phesub

- PHE Protocol Submission Guidance
- PHE Progress Report Guidance
- FY 2013 Budget Template for PHE Progress Reports

Contact
For PHE-related questions, 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. As they are critical to effective program implementation, basic program evaluations are strongly encouraged and should continue to be implemented through the COPs.

7 COP Elements

7.1 Pre-COP Funding

OU teams wishing to request Pre-COP funding for critical **continuing** activities will submit a pre-COP request in early October 2012. All Operating Units submitting a PEPFAR Operational Plan in FY 2013 are eligible to submit Pre-COP funding requests, which are subject to HQ review and approval. Pre-COP requests will take place in FACTS Info. Guidance on how to submit Pre-COP funding requests will be released in a separate document.

7.2 Operating Unit Overview

7.2.1 Executive Summary

During the "light" COP year, the Executive Summary is the only narrative that the field team submits that describes the program on the ground. As such, it is perhaps the single most important element of the light year COP submission.
The Executive Summary gives a high level overview of the OU's program and its priorities for the coming year. As this is the 2nd year of the 2-year COP cycle, the Executive Summary should also explain any changes from the previous year.

Executive Summary Purpose:

- High Level OU Overview
- Priorities for Coming Year
- Changes from Previous Year
- Plans for Future Years
- Address Funding Level Letter Priorities

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

Second, in the FY 2013 funding level letters, a one-page summary of country-specific priorities and guidance is included. Teams should address how they are responding to these priorities in their COP.

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

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

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

Outline

I. Country Context (~½ -1 ½ pages)

a. Epidemiology of the HIV epidemic in the country
b. Status of the national response
c. How does USG fit into the national response?
d. As appropriate:

i. What do other donors and the private sector contribute to the national response? How does PEPFAR coordinate with these other stakeholders?
ii. Other contextual factors (i.e., status of women, conflict, economic/population growth etc)

II. PEPFAR focus in FY 2013 (~1-1 ½ pages)

a. The USG's 3-5 top priorities this year
b. What, if anything, is PEPFAR changing from the 2012 full-COP?
c. Respond as needed to the priorities outlined in the FY 2013 funding level letter, and explain how the team has responded in the COP.

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

a. PF/PFIP/Country Strategy Monitoring – Update on the progress of your partnership framework PFIP, or country strategy, as appropriate. Explain how this year's COP furthers the objectives of the PF/PFIP or country strategy.
b. Please provide an update on Country Ownership, where the program has progressed since your assessment in the 2012 COP, and where you intend to focus in 2013, either through COP activities, or through USG staff work. *[For more, please see the Country Ownership guidance under the Program Priorities section.]*
c. Trajectory in FY 2014 and beyond – Provide any major changes, challenges or programmatic needs you foresee in FY 2014. This is not an opportunity to pitch a "wish list," but rather a place for the team to describe its plans within its understood funding trajectory. Consider reviewing the Country Ownership categories described in the Country Ownership section of this guidance section 2.1.3.4, and reflect on how your programming advances the country ownership policy for PEPFAR.

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

Example Program Areas for a PEPFAR TA Country in a Concentrated Epidemic:
- Prevention
- SI
- Lab
- Governance and Systems/Policy

IV. Program Overview (~5-7 pages)

- Provide additional details on each of the major program areas of your COP. Choose major areas (4-5) relevant to your country's context.

- For each program area, discuss the following:
    i. Major PEPFAR activities/targets or initiatives as appropriate.
    ii. Any significant changes since last year in this area, including plans for scale-up, new activities, transition, or significant changes in strategy.
    iii. Any new procurements planned for this area.

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

a. If your country has completed a GHI strategy, please provide an update on how this COP will advance progress towards achieving the cross-cutting areas and targets defined in the GHI strategy. If your country has not done a GHI strategy, please describe how your PEPFAR program is implementing one or more of the GHI principles in this COP. *[For more information, please see the GHI guidance under Program Approaches.]*
b. As applicable, please describe how PEPFAR programs are integrated with other USG, private sector, Global Fund or other donor funded programs.
c. As applicable, describe additional PEPFAR funds not reflected in the COP that the country is programming through Central Initiatives.
d. As applicable, please describe any other key program considerations relevant to your program's context that is not discussed elsewhere in the executive summary.

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 Engagement

To build upon the programmatic gains of the last decade, harmonization of PEPFAR- and Global Fund-supported programs must be strengthened. Already, close collaboration between the U.S. and the Global Fund is happening on many levels in country and at headquarters. Over the next year, PEPFAR headquarters and field teams will systematize our work with the Global Fund Secretariat through increased communication and information-sharing. USG teams should work closely with the Global Fund Secretariat and implementing partners to evaluate how Global Fund

programs should shape PEPFAR programs going forward (and vice versa). PEPFAR teams are expected to: 1) communicate with Global Fund stakeholders about key program activities and planning calendars; 2) contribute to improving Global Fund program performance; 3) increase coordination with Global Fund stakeholders through joint planning and monitoring; and 4) be knowledgeable about Global Fund grants, programs, and investments, particularly where interventions or partners overlap and efficiencies may be achieved.

PEPFAR country teams can engage with the Global Fund stakeholders in a myriad of ways – whether by jointly tackling a technical challenge shared by both funders, or by providing intensive engagement during Global Fund grant renewals or reprogramming. The goal of this targeted collaboration should be meaningful to the national health response in country, and may include aligning investments in a particular program area, holding a joint program review, or mapping jointly-financed sub-recipients and sites for possible duplication of efforts. Grant renewals and Phase 2 reviews provide a particularly critical opportunity: USG field staff engagement in this process serves to better align Global Fund and PEPFAR programming, enrich the decision-making process, and better inform the USG vote as a member of the Global Fund Board. The Global Fund's new funding model, currently under development and to be implemented over the course of 2013-2014, will provide further entry points for PEPFAR and Global Fund collaboration. Support for proposal development may include USG staff time, a financial contribution, TA through a USG-funded project, sharing of cost data, joint procurement forecasting, etc. Country teams who have questions about opportunities to engage in the Global Fund grant lifecycle, best practices or tools for coordination, or about central and field mechanisms to support Global Fund grant performance, should contact your CSTL and the Multilateral Diplomacy team at S/GAC.

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

- *Bilateral TA:* USG projects can provide TA through bilateral and centrally-funded staff positions and mechanisms in order to build the capacity of CCMs and PRs, to resolve implementation bottlenecks, or to improve program quality. Possible areas of support include: CCM governance and oversight issues, PR programmatic and financial management issues, M&E, HMIS systems, procurement and supply chain management (PSM) planning, provision of epidemiologic or costing data to inform proposal development, etc.
- *Global Fund Liaisons:* An increasing number of country teams have added Global Fund Liaison positions to their staff in order to increase their capacity to coordinate and collaborate with the Global Fund. While every team may not need a dedicated FTE, all teams are strongly encouraged to designate one individual as a "Global Fund focal point" and ensure that some percentage of that person's level of effort (LOE) is specifically allocated for Global Fund work with

associated performance objectives. Headquarters can provide support in developing position descriptions and options for hiring mechanisms.

- *Country Collaboration Initiative:* Under the centrally-funded Global Fund Country Collaboration Initiative, several PEPFAR field teams and partner governments received additional support to increase coordination and optimize Global Fund grant performance. We encourage all country teams to consider which collaboration activities are appropriate for your specific country context through both central- and COP-funded programming. For a comprehensive list of ongoing activities under this initiative, please contact the S/GAC Multilateral Diplomacy team.

Teams should describe their planning and engagement with the Global Fund by responding directly in FACTS Info to the questions below:

1. How is the USG providing support for Global Fund grant proposal development?
2. Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months? If yes, please indicate which round and how this may impact USG programming. Please also describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).
3. In your country, what are the 2-3 primary challenges facing Global Fund grant implementation and performance (e.g. poor grant performance, PSM issues, CCM governance/oversight issues, M&E systems, etc.)? Are you planning to address these challenges through your COP or any other activities; if yes, how? How are you harnessing the strengths of the UN family towards this effort?
4. Please describe your engagement strategy with the Global Fund stakeholders (e.g. Geneva Secretariat, CCMs, PRs, SRs) to increase coordination, facilitate better joint planning, and achieve harmonized programs. What are the intended outcomes of this enhanced collaboration (e.g. adjustments to PEPFAR programming to increase coverage, increase impact of Global Fund Phase 2 proposals, better anticipate service interruptions and/or TA needs, better communicate with PRs, identification of duplication, etc.)?
5. To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders? If yes, how have these areas been addressed? If not, what are the barriers that you face?

7.2.5 Public-Private Partnerships

PEPFAR defines Public-Private Partnerships (PPPs) as collaborative endeavors that combine resources from the public sector with resources from the private sector to accomplish HIV/AIDS prevention, care, and treatment goals. Private sector stakeholders include health (insurance, device, equipment, pharmaceuticals, etc.) and non-health companies (banks, consulting companies, manufacturing, etc.), private health sector service delivery providers or associations, foundations, and NGOs.

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 or private health provider to deliver services is <u>not</u> a PPP unless the partners are directly contributing matching resources to the collaboration, nor is an activity that will build off an existing investment with no new money or in-kind contributions from the private sector collaborator designated specifically for the newly proposed partnership.

The following are critical core elements that reviewers of the FY 2013 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 2013 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, <u>not</u> implementing partners
- **FY 2013 PEPFAR Planned Contribution:** Funding only
- **FY 2013 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 and related to core COP PEPFAR goals and objectives. Also a brief narrative on how the partnership activity is considered to be innovative and may lead to sustainable and scalable solution in country or regionally.

As needed country teams should refer to the technical considerations as a basic resource and guidance as they consider the development, implementation, and scale-up of PPPs as appropriate to their country context and COP FY 2013 strategies. Country teams are encouraged to contact the OGAC's Private Sector Engagement (PSE) Office and PEPFAR's PPP TWG to assist during the COP FY 2013 process as needed. Inquires can be sent to OGAC's PSE Office**:** *Ms. Whitney Ewing, Program Support Officer (EwingWF@state.gov) and Dr. Jeff Blander, Acting Deputy Director and Senior Advisor (BlanderJM@state.gov).*

7.2.6 Surveillance and Surveys

The surveillance and surveys table is used to collect a summary of PEPFAR-supported surveillance and survey activities in PEPFAR OUs. The FY 2013 COP table should reflect continuing and planned surveillance and surveys during FY 2013.

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 2013 and FY 2014, 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 2013 and FY 2014 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 FY 2013 targets should reflect the expected direct program achievements in the fiscal-year time period October 1, 2012 to September 30, 2013 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 2013 and FY 2014 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 2013 funds).

For more information on setting targets, see Appendix 5.

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

Building on efforts from FY 2012 COP, countries with signed PFIPs and completed Strategies will continue to set annual targets to demonstrate accountability on National Government commitments stated in the PFIP. These results will continue to be reported through the APR process.

For those countries who are working on their PFIPs and Strategies, USG country teams will follow the same process completed by the countries with established PFIPs and 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 these 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.

7.5 Manage Partners and Implementing Mechanisms

7.5.1 Manage Partners

.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.

Maximizing Efficiencies:

1) In order to maximize efficiencies in administrative costs, countries should have no shared prime implementing partners with multiple agency agreements, including with partner governments (see cable entitled: MESSAGE FROM SECRETARY CLINTON ON GOVERNMENT-TO-GOVERNMENT MECHANISMS FOR PEPFAR). If you feel that this is necessary in your country's context, you will be expected to submit a request for a waiver of this requirement.

2) In order to avoid duplication in program implementation by partner, agency, program area and geography, country teams are not allowed to fund different partners that are working in the same program area in the same facilities or geographic locale – independent of whether or not they are currently funded by one agency or different agencies. The following is allowed however:

- Different partners; same program; same agency; distinct geographic locales
- Different partners; same program; different agency; different locale
- Different partners; different program; different agency
- Partners working in multiple geographic areas on technical assistance only

As above, if you feel that funding multiple partners is necessary in your country's context, you will be expected to submit a request for a waiver of this requirement.

Do not name a partner as a prime or sub under an implementing mechanism until it has been formally selected through normal Acquisition & Assistance processes, such as Annual Program Statements, Requests for Application, Funding Opportunity Announcement, or Requests for Proposals. If a partner has not been formally selected, list the prime partner for the implementing mechanism as "To Be Determined" (TBD). See Appendix 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 2013, 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 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.

7.5.1.2 UNALLOCATED FUNDING

As in FY 2012, FY 2013 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 partner will have a separate mechanism. One prime partner will need to have multiple mechanisms only if:

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

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

Note: Pipeline information submitted as a part of each mechanism will be reviewed in conjunction with past performance as provided by Agency HQ to determine how COP 2013 funds will impact partner pipelines.

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
- G2G
- 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
- New Mechanism
- Global Fund/Multilateral Engagement?
- Benefitting Country(ies) (only required for Regional OU programs)

Prime Partner Name

The prime partner name for a mechanism, regardless of prime partner type, will be selected from a list of pre-existing partner names that currently exist within the FACTS Info – PEPFAR Module system. If the partner is new, 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).

Partnership for Supply Chain Management

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

It is critically important that teams carefully plan the amount budgeted in the COP for SCMS. Unlike other mechanisms, SCMS is not able to receive additional funding through future reprogramming of obligated funds, except in emergency circumstances. Information on the process for shifting additional funding to SCMS in emergency situations is provided in the COP Update Guidance.

Government to Government Partnerships

A tickbox designating the mechanism as "government to government" (G2G) should be checked if the mechanism represents GHP-State direct government-to-government assistance. G2G funding is defined as "Funding which is transferred to a Host Government or ministry (including parastatal organizations) for the obligation and disbursement of those funds by that government."

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 – GHI and the second phase of PEPFAR place an increased focus on country ownership and increased multilateral engagement. In this context, it will be important to develop public financial management capacity within partner governments. Treasury's Office of Technical Assistance (OTA), which provides advisors with expertise in public financial management to government ministries, was included in PEPFAR's most recent authorization for this purpose. Depending on country context, Operating Unit teams may wish to incorporate this element into their broader health systems strengthening portfolio. For these mechanisms, please identify Treasury as the 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 GHP-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 2013, 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.

TBD Mechanism

If the mechanism is TBD, the tickbox "TBD Mechanism" should be checked. A new tab will appear requesting the user to enter projected outlays.

New Mechanism

If the mechanism is new, a tickbox "New Mechanism" should be checked.

Global Fund/Programmatic Engagement

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

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

Construction/Renovation

This tickbox is used to identify mechanisms that contain funding for construction and/or renovation projects. Checking this box will then result in separate tabs in the IM to complete required information on the projects.
A Construction/Renovation tab will appear requesting the user to enter each proposed project. All fields on the Construction/Renovation Project Plan form must be completed. There is no cap on the amount of funds to be included in the COP submission i.e., all

projects, regardless of amount, need to be submitted for approval. The construction and renovation cross-cutting attributions for each IM should match the total of all IM project plans. Please see Appendix 10 for more information on how to complete the project plan screens directly in FACTS Info.

Motor Vehicles

This tickbox is used to identify mechanisms that contain funding for the purchase or lease of motor vehicles.

A Motor Vehicle tab will appear requesting the user to enter the proposed motor vehicle information. Please include the total number of motor vehicles purchased and/or leased for a continuing mechanism as well as for any new implementing mechanism. For new requests in COP FY 2013, please provide a brief (in a few words) narrative explaining the purpose of the vehicle (s) and associated cost(s). Please also include the type of vehicles requested (boat, truck, car, ambulance). The motor vehicle cross-cutting attribution should also match the total dollar amount for all vehicles in the IM tab.

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 2013 COP Funding Source Categories
USAID	GHP (State) GHP (USAID)*
HHS/CDC	GAP** GHP(State)
HHS/HRSA	GHP (State)
HHS/OGA	GHP (State)
DoD	GHP (State)
DoL	GHP(State)
State	GHP (State)
Peace Corps	GHP(State)
ALL OTHERS	GHP (State)

** The GHP-USAID account is the account appropriated directly to USAID, formerly the Child Survival and Health (CSH) Account (FYs 2008 and prior), FY 2009-2012 Global Health and Child Survival Account (GHCS).*
*** 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 GHP (USAID) funding, you should not program GHP (USAID) funds).

Pipeline

For each implementing mechanism, there will be a 'Pipeline' field in FACTS Info on the funding source tab. The pipeline information that should go in this field is: additional prior year funding, from all accounts, that will be applied to this mechanism's activities during the year of COP 2013 implementation. Therefore, if a mechanism is receiving 100,000 in total new COP 2013 funds, but will also expend 50,000 in total prior year funding in the same year of implementation, 100,000 will go into the funding source field, and 50,000 will go into the pipeline field.

7.5.1.4 IMPLEMENTING MECHANISM NARRATIVES

Narratives for both the overall Implementing Mechanism (IM) and the budget codes that Implementing Mechanism works in are only required for **new mechanisms** in the FY 2013 COP.

Each new 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 new implementing mechanism summary narrative, along with an illustrative example of information that may be required for the budget code narratives. Do not repeat information in both sections.

Implementing Mechanism Narrative 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.	Details on what should be included **for each budget code narrative** are provided in Appendix 7.
Page Limit: ½ page per IM	Page limit: 1 page per BC

7.5.1.5 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 the second phase of PEPFAR 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 cross-cutting attributions (Human Resources for Health (HRH), Construction/Renovation, Motor Vehicles, Food and Nutrition, Economic Strengthening, Education, Water, Gender-based Violence, or Gender Equality) **must** have the cross-cutting budget attributions identified and accurately quantified; if you need assistance in developing standard approaches to quantifying cross-cutting attributions, please contact your CSTL. For definitions of cross-cutting attributions, please see Appendix 7.

In FY 2013, we will be capturing funding information for nine cross-cutting areas, which are listed below and defined in Appendix 7. 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
3. Renovation
4. Motor Vehicles: Purchased
5. Motor Vehicles: Leased
6. Key Populations: MSM and TG
7. Key Populations: FSW
8. Food and Nutrition: Policy, Tools, and Service Delivery
9. Food and Nutrition: Commodities
10. Economic Strengthening
11. Education
12. Water
13. Gender: GBV
14. Gender: Gender Equality

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

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

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

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. Collecting this information under the M&O heading centrally organizes data in one location and allows for easier itemization of individual costs; reduces the burden for country teams by centralizing data entry; and provides more transparency to Congress, OMB, as well as in-country and other stakeholders, on the costs for each USG agency of managing and implementing the PEPFAR program. The funds captured in M&O reflect the costs of the field-based personnel who provide oversight, technical assistance, management, and leadership of the PEPFAR programs in country.

Activities in which the PEPFAR OU team purchases services from a 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 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

Each OU team is expected to manage the in-country program and deliberate strategic changes to the PEPFAR-funded USG staffing footprint as a cohesive interagency unit. Teams should review 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 2013 COP, OU teams should reevaluate their USG staffing footprint and organizational structure to ensure that it continues to maximize interagency planning, implementation, and evaluation – especially in consideration of any programmatic and/or budgetary changes. As part of their staffing analysis, 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 recruit and retain locally employed (LE) staff working for PEPFAR around the world. LE Staff may be host country nationals, locally resident Americans, or locally recruited Third Country Nationals (TCNs). Providing a work environment that fosters collaboration, respect, and professional development is an essential element in supporting the long-term retention of these staff who maintain critical relationships with the host government and partners and are essentially the institutional knowledge for our programs. These staff members, especially the host country nationals, build capacity within the country, ideally leading to greater sustainability of the program and improving the likelihood of achieving both national and PEPFAR goals. The PEPFAR Interagency Working Group on Issues Affecting LE Staff is available to assist teams in improving recruitment, retention, and empowerment of LE Staff 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 locally employed staff, working with agency management offices, CODB funding information and definitions, staffing data, and PEPFAR Coordinator hiring are included in Appendix 8.

M&O Review

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. The reviewers will bear in mind 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 LE Staff to U.S. citizen direct hires/appointees and Personal Services Contractors (PSCs); growth in CODB annually and over time; and changes in staff in relation to programmatic and funding level shifts.

8.2 Interagency M&O Narratives

For COP 2013, OU teams are asked to respond to three narratives that concretely address team structure, management, interagency planning processes, staffing skill sets, and construction/renovation. The narratives should *directly* respond to the questions with a view toward strategic staffing and planning over the next two years.

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

Narrative 1: Interagency M&O Strategy Narrative

A single supporting narrative is required to describe the PEPFAR program's management strategy in country. The narrative should be inclusive of all USG agencies present in country and how the team manages the program collaboratively. Highlight each agency's staffing, unique roles and core strengths; address the strategic direction of the interagency team for the next two years. In conjunction with the second five-year strategy, PEPFAR's role in GHI, and your Partnership Framework as appropriate, describe the OU team's staffing and management strategy for the next two years.

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

Narrative 2: Assessment of 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 specifically describe any adjustments to the staff footprint to adapt to changes in the program and/or budget (please indicate specific changes to overall staffing numbers, including vacancies).

OU Teams Should Address the Following Questions:

- Does the OU team have the appropriate mix of technical, management, and administrative staff required to implement the program, during and beyond Partnership Framework or Strategy implementation (where relevant)?
- Did the OU team conduct a staffing review during the year to determine any changes in size or mix or staff in the program and/or budget? If yes, please describe what changes have been implemented or are planned.
- Are current management resources (staff, space, etc.) sufficient to manage the program?
- What specific adjustments been made to adapt to the current budget climate (e.g. repurposing existing long-term vacancies)?
- What changes were made in the previous year or will be made in the upcoming year to increase the number of host country national and other LE Staff in the context of your overall staffing strategy, namely increasing the number of leadership positions and responsibilities across the interagency team?

For any proposed new positions, describe: (1) the interagency process by which additions to the overall US staffing footprint were prioritized and approved; (2) technical assistance (e.g., Framework Job Descriptions) or other support that may be needed from headquarters to fill proposed new positions; 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. Specific comments should be included in the staffing data (see below).

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.

In addition to the narrative, OU teams must provide the total costs associated with renovation of buildings owned/occupied by USG PEPFAR personnel under the **Agency Cost of Doing Business (CODB)** section (COP Guidance Appendices Appendix 9). Costs for projects built on behalf of or by the partner government or other partners should be budgeted for and described as Implementing Mechanisms (see Section 7.5.1.4 of the COP Guidance).

The narrative should provide the dollar amount, describe the project in detail, and provide a breakout of costs associated with the renovation of buildings occupied by 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 March 1, 2013) and/or planned (newly requested) positions, OU teams are asked to provide additional details in the Comments field within the Staffing section of the PEPFAR module. Position narratives should be no more than 500 characters and should be entered directly into the Staffing section of the PEPFAR module. There should be one justification per each staffing record marked as vacant or planned.

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

EXPLAIN VACANT POSITIONS

For each approved but vacant position, the OU team must explain the reasons it is vacant and describe the plan and timeline for filling the vacant position within the Comments section of the staffing data. If the position has been previously encumbered, please provide the date the position became vacant and whether the position has been recruited yet. If recruitment has occurred but the team has been unable to fill it, please indicate why (e.g. lack of candidates, salary too low, etc.). Submitting this information will inform understanding of program wide recruitment and retention issues and assist in identifying specific remedies where possible.

JUSTIFY PROPOSED NEW POSITIONS

For each proposed new position, describe how it fits into the overall and individual agency staffing footprint (e.g. meets changes in the program, addresses gaps, compliments the existing staff composition) within the Comments section of the staffing data. Indicate why a new position is necessary instead of repurposing an existing filled or vacant position. For positions that the team plans to fill with a U.S. citizen direct hire, appointee, or PSC, indicate why this position cannot be hired locally. There should be one explanation for each staffing record marked as planned in the staffing data.
Please note that country/regional programs with significant vacancies among previously approved positions and/or proposing new positions not aligned to programmatic priorities, should anticipate that any proposed new positions will be rigorously evaluated for relevance. Teams should be strongly justify why they are proposing new positions given their vacancies and are encouraged to address this directly in the narratives and staffing data fields. Wherever possible, 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 2013 review process, all proposed new positions will be heavily scrutinized and may not be approved.

Note that any proposed new positions should spend at least 50% of their time on PEPFAR activities.

8.3 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. Non-ICASS Motor Vehicles
6. CSCS (Capital Security Cost Sharing)
7. Computers/IT Services
8. Management Meetings/Professional Development
9. USG Renovation – see section 8.4 below for further guidance
10. Institutional Contractors (non-PSC/non-PSA)
11. 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 GHP-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 to the narrative, OU teams must provide the total costs associated with renovation of buildings owned/occupied by USG PEPFAR personnel under the **CODB** section. Note, 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 2013, OU teams are asked to update staffing data in the FACTS Info PEPFAR Module. Staffing data submitted in COPs 2010-2 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 LE Staff, hiring PEPFAR Coordinators, and additional resources on the staffing tools available within the FACTS Info PEPFAR Module.

Data should be entered for all current, vacant (as of March 1, 2013), and proposed positions that will spend at least 10% of their time working on PEPFAR planning, management, procurement, administrative support, technical and/or programmatic oversight activities. Positions may be filled by:

- LE Staff (locally hired host country nationals, Americans, and TCNs),
- internationally recruited TCNs,
- US Direct Hire (USDH) (includes CDC appointed staff, military, and public health commissioned corps),
- USDH-equivalents (e.g., PSCs),
- Institutional Contractors/Fellows, and
- Other (for which there should be very few entries) employment mechanisms.

As in past years, USG-funded Global Fund Liaison positions (whether centrally funded or cost-share) should be included in the staffing data.

Peace Corps Volunteers should not be included in the staffing data as they are not USG employees. However, Peace Corps staff should be included.

8.6 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, 2012;
- Peace Corps Response Volunteers on board as of September 30, 2012;
- New Volunteers proposed in the FY 2013 COP; and
- New Peace Corps Response Volunteers proposed in the FY 2013 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.

Transition Planning:
Below the table in the same excel sheet, please describe your overarching plan for transitioning PEPFAR-supported health care workers to local institutional ownership over time. This plan can include transitioning salaries and positions to the government payroll, NGOs, or other local institutions. The plan for each position does not need to included, but the overall strategy in your country should be described.

9.2 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 each agency estimate quarterly outlays for all non-TBD COP 2013 funding (including agency CODB funds) and upload this information in the Agency Outlay Plan supporting document. These estimates should not include any pipeline spending, but should project the spending of COP 2013 funds only. Please ensure that these projections do not include any COP 2013 To-Be-Determined funds as those will be reported on separately. Calculations should be based upon projected partner expenditures per quarter as well as projected procurement and granting actions. Further definitions of the terms and instructions will be provided on the supporting document.

It is also required that the expected obligation (award) date, whether this exact TBD has been TBD in a previous COP and the projected monthly outlays for the specific TBD

is entered in FACTSinfo for each new TBD requested. Upon the selection of a TBD as Prime Partner, an additional tab will be made available in order to complete this information. **The supplemental Agency Outlay table is available on PEPFAR Plan B's COP planning site and must be uploaded into FACTS Info as a part of each COP13 submission.**

9.3 HIV Medicines and Diagnostics

As country programs scale-up to meet the World AIDS Day targets, the availability of funding for commodities is essential and often comes from multiple sources including PEPFAR, The Global Fund and other bilateral and multilateral entities. To date, we have been collecting this information on an ad hoc, country-specific basis and through separate data call from CSTLs. However, given that the availability of funds for essential HIV commodities directly affects successful implementation of all other program areas, teams are asked to integrate this data request as part of the regular COP planning process.

The HIV Medicines and Diagnostics supplemental form is included in the FY 2013 Country Operational Plan Guidance Appendices and can also be found on the COP13 planning site on Plan B. The purpose of the form is to help country programs and Headquarters to get an overall picture of the availability of funding for essential HIV medicines and diagnostics, including RTKs, lab reagents, ARVs, and Cepheid Xpert® MTB/RIF, a new diagnostic test that greatly reduces the time to confirm a TB diagnosis as well as resistance to rifampicin.

Collected data will be utilized in the COP review process to assess the degree to which PEPFAR is complemented by other resources in support of the overall national response. These data will also assist with planning and resource projections for the Emergency Commodity Fund. We intend that these data, collected in a uniform format, will obviate the need for ad hoc requests during the year.

9.4 Proposals for Central Initiative Funding

1. Local Capacity Initiative

The Local Capacity Initiative (LCI) is a central initiative that will provide funding to PEPFAR country and regional teams for direct support to local civil society organizations in support of the second phase of PEPFAR (2009 – 2013) and the Global Health Initiative (GHI) to enhance country ownership. The Local Capacity Central Initiative is a follow-on program to the New Partners Initiative (NPI). All country and regional operational plan (COP/ROP) PEPFAR countries are eligible to apply for LCI funding through submission of a supplemental proposal document uploaded into the FACTS Info

document library as part of the 2013 country operational plan (COP/ROP) submission. Proposals will be reviewed by the Local Capacity Initiative Interagency Working Group and winning proposals will be awarded funding. LCI funding has been congressionally notified so the anticipated award date of funds is May/June 2013. **LCI Proposal Guidelines are included in the FY 2013 Country Operational Plan Guidance Appendices.**

2. Key Populations Challenge Fund

The Key Populations Challenge Fund is a central initiative that will provide funding to PEPFAR country and regional teams to leverage other funds to stimulate improved programming for key populations (PWID, SW, MSM and TG). The Key Populations Challenge Fund was announced during Secretary Clinton's plenary speech during the International AIDS Society conference held in Washington, DC in July 2012. All country and regional operational plan (COP/ROP/OP) countries who receive PEPFAR funds are eligible to apply through submission of a 2 page concept papers to the Key Populations TWG. Concept papers will be reviewed by the Key Populations TWG. A limited number will be selected and those teams will be asked to complete full 10 page proposals. Countries and regions with winning proposals will be asked to reflect matching funds in their FY 2013 COP budgets. **Key Populations Challenge Fund application guidelines are included in the FY 2013 Country Operational Plan Guidance Appendices.**

10 Change Table

Version	Date	Location of Change	Description of Change
2	Oct 12, 2012	Section 4.2 Pg. 27-28	Description of Country Ownership categories updated