The President's Emergency Plan for AIDS Relief

FY 2012

COUNTRY OPERATIONAL PLAN GUIDANCE APPENDICES

Table of Contents

Appendix 1: Acronyms 4

Appendix 2: Partner Performance and Pipeline Analysis Reviews 8

Appendix 3: Core Principles for the Continuum of Response (CoR): from prevention to care and treatment 9

Appendix 4: Building Partner Capacity and Sustainability – Guidance for Program Acquisition and Assistance 10

TBD Partners 12
Funding of TBD Partners 112
Approval of Identified TBD Partners 13
Local Partners 13
Definition of "Local Partner" for PEPFAR 13
Implementation Guidance for Local Partner Definition 14
Strengthening Local Partners 17
Single-Partner Funding Limit 18
Overview 18
Exceptions 19
Umbrella Award Definition 20
Justifications 21
Successful Practices for Encouraging Engagement with Local Partners and Faith- and Community-Based Organizations 21

Appendix 5: Setting Targets 23

National Level Indicators and Targets 23
Technical Area Summary Indicators and Targets 24
Implementing Mechanism-Level Indicators and Targets 24

Appendix 6: Instructions for Writing Technical Area Narratives and Budget Code Narratives 28

Technical Area Narrative Instructions 28
1. Governance and Systems TAN 28
2. Prevention TAN 34
3. Care TAN 39
4. Treatment TAN 46
Guide to Determining How to Apply Budget Code(s) to an Implementing Mechanism 54
Prevention 54
Budget Code: Prevention of Mother to Child Transmission (MTCT) 54
Budget Code: Abstinence/Be Faithful (HVAB) 55
Budget Code: Other Sexual Prevention (HVOP) 56

Budget Code: Blood Safety (HMBL) 57
Budget Code: Injection Safety (HMIN) 57
Budget Code: Injecting and Non Injecting Drug Use (IDUP) 58
Budget Code: Voluntary Medical Male Circumcision (CIRC) 59
Budget Code: HIV Testing and Counseling (HVCT) 60
Care 61
Budget Code: Adult Care and Support (HBHC) 61
Budget Code: Orphans and Vulnerable Children (HKID) 62
Budget Code: TB/HIV (HVTB) 63
Budget Code: Pediatric Care and Support (PDCS) 64
Treatment 65
Budget Code: ARV Drugs (HTXD) 65
Budget Code: Adult Treatment (HTXS) 65
Budget Code: Pediatric Treatment (PDTX) 66
Other 67
Budget Code: Health Systems Strengthening (OHSS) 67
Budget Code: Laboratory Infrastructure (HLAB) 68
Budget Code: Strategic Information (HVSI) 68
Cross-Cutting Attributions 70
Key Issues 73

Appendix 7: Small Grant Program 76
Proposed Parameters and Application Process 76
Eligibility Criteria 76
Accountability 77
Submission and Reporting 77

Appendix 8: Strategic Staffing 77
Position Management 78
Engagement and Support of Host Country Nationals (HCNs) 78
Coordination with Embassy and Agency Management Teams 79
Hiring PEPFAR Coordinators 80

Appendix 9: Operating Unit Team Staffing Data and Agency Information – Additional Resources 81
Staffing Tools Overview 81
Whom to Include in the Database 81
Staff Information Instructions 83
AGENCY COSTS OF DOING BUSINESS 87
Country Team Functional and Agency Management Charts 92
Functional Staff Chart 93
Agency Management Chart 94

Appendix 1: Acronyms

A – Bureau of Administration (State Department Bureau)

A&A – Acquisition and Assistance

AB – abstinence and be faithful

ABC – abstain, be faithful, and, as appropriate, correct, and consistent use of condoms

AF – African Affairs (State Department Bureau)

AIDS – Acquired Immune Deficiency Syndrome

ANC – antenatal clinic

APR – Annual Program Results

APS – Annual Program Statement

ART – antiretroviral therapy

ARV – antiretroviral

CBO – community-based organization

CCM – country coordinating mechanism

CDC – Centers for Disease Control and Prevention (part of HHS)

CN – Congressional Notification

CODB – Costs of Doing the USG's PEPFAR Business

COP – Country Operational Plan

CoR – Continuum of Response

CP – Combination Prevention

CQI – Continuous Quality Improvement

CSH – Child Survival & Health (USAID funding account; replaced by GHCS-USAID)

CSTL – Country Support Team Lead

CSW/SW – Commercial Sex Worker

DFID – Department for International Development (UK)

DOD – U.S. Department of Defense

DOL – U.S. Department of Labor

DOS – U.S. Department of State

EAP – East Asian and Pacific Affairs (State Department Bureau)

EUM – End use monitoring

EUR – European and Eurasian Affairs (State Department Bureau)

F - Office of the Director of Foreign Assistance

FBO – faith-based organization

FDA – Food and Drug Administration (part of HHS)

FJD – Framework Job Description

FP – Family Planning

FSN – foreign service national

FTE – full-time equivalent

FY – fiscal year

GAP – Global AIDS Program (CDC)

GFATM – The Global Fund to Fight AIDS, Tuberculosis, and Malaria (also "Global Fund")

GHAI – Global HIV/AIDS Initiative (funding account; replaced by GHCS-State)

GHCS – Global Health Child Survival funds (funding account)

GHI – Global Health Initiative

HCN – Host Country National

HCW – Health Care Workers

HHS – U.S. Department of Health and Human Services

HIV – Human Immunodeficiency Virus

HMIS – Health Management Information System

HQ - headquarters

HRSA – Health Resources and Services Administration (part of HHS)

HRH – Human Resources for Health

HTC – HIV Testing and Counseling

ICASS – International Cooperative Administrative Support Services

ICF – Intensified Case Finding

INR – Intelligence and Research (State Department Bureau)

IRM – information resources management

LCI – Local Capacity Initiative

LOE – Level of effort

LTFU – Lost to follow up

M&E – monitoring and evaluation

M&O – Management and Operations

MARPs – Most-at-risk populations

MC – Male Circumcision

MOA – Memorandum of Agreement

MOU – Memorandum of Understanding

NEA – Near Eastern Affairs (State)

NIH – National Institutes of Health (part of HHS)

OE – operating expense

OGA – Office of Global Affairs (part of HHS)

OMB – Office of Management and Budget

OS – Office of the Secretary (part of HHS)

OU – Operating Unit

OVC – orphans and vulnerable children

PASA – Participating Agency Service Agreement

PEPFAR – President's Emergency Plan for AIDS Relief

PLWHA/PLWA/PLHIV – People Living with HIV/AIDS or People Living with AIDS

PM – Political-Military Affairs (State Department Bureau)

PMTCT – prevention of mother-to-child HIV transmission

PPP – Public-Private Partnership

PR – Principal Recipient

PRH – Population and Reproductive Health

PRM – Population, Refugees, and Migration (State Department Bureau)

PSC – Personal Services Contract

PWID – People who inject drugs

PWUD – People who use drugs

QA – quality assurance

RFA – Request for Application

RFC – Request for Contracts

RFP – Request for Proposal

ROP – Regional Operational Plan

SAPR – Semi-Annual Program Results

SAMHSA – Substance Abuse and Mental Health Services Administration (part of HHS)

SCA - South and Central Asian Affairs (State Department Bureau)

SCMS – Partnership for Supply Chain Management

S/GAC – Office of the U.S. Global AIDS Coordinator (part of State)

SI – Strategic Information

TAN – Technical Area Narrative

TB –Tuberculosis

TBD – To Be Determined

TCN – Third Country National

TWG – Technical Working Group

UNAIDS – Joint United Nations Program on HIV/AIDS

UNDP – United Nations Development Programme

UNICEF – United Nations Children's Fund

USAID – U.S. Agency for International Development

USDA – U.S. Department of Agriculture

USDH – U.S. direct hire

USG – United States Government

UTAP – University Technical Assistance Project

VCT – voluntary counseling and testing

WHA - Western Hemisphere Affairs (State Department Bureau)

WHO – World Health Organization

Appendix 2: Partner Performance and Pipeline Analysis Reviews

Each OU team is expected to review both partner performance (i.e., timely expenditure of funds, achievement of programmatic targets) and overall programmatic pipeline as an interagency team while preparing its annual PEPFAR Operational Plan Teams may direct any questions to your Country Support Team Lead.

As in prior years, partner performance and pipeline analysis reviews are intended for COP/ROP planning purposes. Teams should carefully consider and, where applicable, discuss the interagency partner performance and pipeline review process utilized during FY 2012 COP/ROP planning in their submission.

The formal interagency review is programmatic and is separate and distinct from the acquisition and assistance performance review. The acquisition and assistance officials will consider the programmatic review. Partners should be advised through a grant term and condition of the annual programmatic performance review and the annual assistance review by the Grants Management Officer.

Partner Performance Reviews

Partner performance reviews are a standard and well-established management practice, informing interagency country teams' program planning, management, and oversight. They also contribute to PEPFAR's commitment to performance-based budgeting and are required by the Office of Management and Budget (OMB). It is critical to monitor and evaluate partner performance regularly to ensure the success of PEPFAR and remain accountable to Congress. In recognition of this, interagency country teams and headquarters personnel are required to monitor and evaluate partner performance on an ongoing basis throughout the year, especially as part of the Semi-Annual Progress Report (SAPR), Country Operational Plan (COP), and Annual Program Results (APR) processes. The collection of performance data also helps ensure consistency and allows teams to evaluate trends over time.

Pipeline Analysis

Monitoring and evaluating not only partner performance, but the country's financial performance overall is critical to the success of PEPFAR. Country teams are responsible for ensuring that funding is being spent at a pace commensurate with the requirements of the interagency Memorandums of Agreement (MOAs). PEPFAR Coordinators and/or their designates are required to use pipeline analysis in their COP planning and to engage with implementing agencies and partners based on the financial data available to them quarterly.

Appendix 3: Core Principles for the Continuum of Response (CoR): from prevention to care and treatment

The CoR approach is expected to:

- Assure and improve upon the sustainability of existing service systems;
- Improve access and distribution of services;
- Reduce HIV transmission;
- Improve retention and adherence of HIV+ clients in care/treatment programs; and
- Improve client, family and community health outcomes.

The primary goal of a Continuum of Response approach is to provide clients and their families with essential prevention, care/support, and treatment services to reduce HIV transmission and disease progression and to maximize health outcomes. In doing so, strategies are defined locally based on epidemiological and health and social needs data of target populations: such as, young women through pregnancy and motherhood with infants and young children; MARPs – PWIDs, CSW, and MSMs; and at risk adolescents and adults clients and their families.

The CoR approach addresses the lifetime needs of the target populations to assure adequate access to a wide range of prevention, care (acute and chronic care management), and treatment services and based on the changing needs and circumstances of these populations as clients and families. .

The CoR approach should be set within an organized and coordinated network system of community and facility based services and providers.

- Target populations should be routinely assessed for risk factors, and provided HTC and evidence-based prevention services to reduce risk of transmission or acquisition of HIV infection
- For HIV-infected clients, evidence-based services should be linked/integrated to maximize access, including the use of clinical and essential social services and providers
- Services should be affordable, evidence-based, and cost-effective
- Services sites may vary based on local resources and strategies, and can be provided at home, within communities, and/or at health care facilities

The CoR builds on existing public and private structures (including government, FBOs, NGOs, CBOs, private) to establish a functional network with active tracking and referrals procedures, and ideally collocated or closely linked service sites. The use of a multidisciplinary team of providers (professionals, community health care workers, expert clients, and family members) is an important component to assure efficiency in the use of providers and services.

National and local laws, policies and regulatory frameworks should be aligned in order to support a CoR approach. In doing so, the PEPFAR USG team will need to work in close collaboration with host governments and other international organizations/donors to leverage and build on existing services in order to establish an integrated, comprehensive system of sustainable services based on population based health and social service needs.

The CoR engages key stakeholders (government, civil society including public, private, FBO/NGO providers and organizations, PLWHA and families) to play a critical role in the design and planning, organization and monitoring of the services, and delivery of a full array of services.

Continuous Quality Improvement (CQI) should be a key element of a CoR.

Appendix 4: Building Partner Capacity and Sustainability – Guidance for Program Acquisition and Assistance

A central strategy of PEPFAR is to engage new and/or local partners to strengthen and ensure the sustainability of the response to HIV/AIDS. This appendix provides techniques and best practices for increasing the number of new and local partners, including faith-based (FBOs) and community-based organizations (CBOs), that are actively engaged in carrying out service delivery or technical assistance activities.

Local partners can be engaged through assistance (grants and cooperative agreements) and contracts. A local partner may gain experience as a subcontractor or sub grantee or may serve as a prime contractor or prime grantee. Local partner expertise can be expanded through issuing contracts or grants to international or other organizations to provide technical expertise to train and develop the local partner or through implementing agency personnel providing that development expertise. Regardless, the objective should be to develop local capacity so the ownership of the PEPFAR solution becomes country-centric.

Contracts and assistance agreements (grants and cooperative agreements) are issued under the rules and policies of the implementing Federal Agency, which determines when each instrument is appropriate, and the authorities of the individuals signing the documents. Questions regarding these policies and procedures should be directed to the appropriate Agency contracting and assistance policy offices. All procurement actions must be coordinated with the appropriate agency's procurement office(s).

PEPFAR policies that encourage the use of local partners include:

- use of "umbrella awards" (see definition below) to an experienced local or international organization who can identify potential local partners and engage and mentor them through sub awards;

- setting limits on the percentage of country funding to individual organizations under assistance agreements to encourage broader participation (see single-partner funding limit guidance below);
- targeted programs such as *PEPFAR Small Grants* and the *New Partners Initiative* that reserve funding specifically for new participants;
- requiring USG implementing agencies to review non-local partner performance in strengthening local partners on an annual basis; and
- HHS requirement for Track 1 ART grantees to develop plans for transitioning to local partners.

OU teams are encouraged to contact members of the Health Systems Strengthening working group and their agency representatives with any questions regarding C/FBO strategies. In addition, countries are encouraged to share their experiences and best practices in engaging new and local partners.

Objectives:

As you continue to design FY 2011 programs and acquisition and assistance (A&A) plans and begin to formulate FY 2012 plans, please integrate (as appropriate) the following objectives:

- Local Partner Graduation/Local Primes: As a part of a long-term sustainability strategy, experienced organizations should provide assistance to enable local partners to take on the responsibility of being prime implementing partners in place of international partner organizations. Having experienced organizations provide such assistance can reduce USG management burden while promoting the programs' success and organizations' sustainability.
- Engaging grassroots networks: Promote and maximize the effective use of local implementing partners, including both prime and sub-partners through strategic investments.
- Appropriate-to-country context: If the percentage of total PEPFAR partners that are identified as C/FBOs is substantially below the percentage of total HIV/AIDS service delivery activities through C/FBOs in a given country, examine reasons therefore and respond appropriately to address the imbalance.
- Diversity of service: C/FBO partners should not be concentrated all in one service area, as C/FBOs are active in almost every aspect of prevention, treatment, and care activities and often are uniquely positioned to sustain their services long term.
- New Partners: New partners should reflect a commitment to expanding to local partners through the establishment of national mentoring organizations, umbrella awards, or use of small grants.
- Local Umbrellas: The COP should reflect a long-term sustainability strategy that is committed to and invested in building organizational and technical capacity of local partners. Models include activities dedicated to establishing and/or

strengthening mentoring organizations and linking international or national organizations receiving umbrella awards to allow for eventual local ownership.
- Building linkages: The COP should reflect a priority for facilitating linkages between C/FBOs and national service networks, which are essential components to providing a continuum of service and care.

This appendix provides information on:
- TBD Partners;
- Local Partners;
  - Definition and
  - Guidance on Implementing the Local Partner Definition;
- Guidance on the Implementation of the Single-Partner Funding Limit;
  - Definition of Umbrella Awards; and
- Best Practices for Encouraging Engagement with Local Partners and Faith-Based and Community-Based Organizations.

TBD Partners

Consistent with its coordinating responsibilities, S/GAC will, from time to time, request information or provide further guidance during the A&A process. S/GAC may review directly, or request the implementing agency headquarters to review, the solicitation document before it is released to ensure that PEPFAR objectives are being pursued. On occasion, S/GAC may request to be the Source Selection Official for the action. S/GAC will notify the OU team and agency of these actions as early in the planning process as possible.

Do not list partners in the COP until they have been formally selected through normal A&A processes, such as Annual Program Statements, Requests for Application (RFAs), Requests for Proposals (RFPs), or Funding Opportunity Announcements (FOAs). Until a partner is formally selected, list the partner as To Be Determined (TBD).

Funding of TBD Partners

TBD activities programmed in the COP with a full 12-months of funding will not be approved unless a justification is provided in the obligation and outlay plan detailing the schedule for identifying and awarding the TBD.

In funding a TBD Partner, OUs should take into consideration the expected timing of the identification and award. Funding will be allocated to a TBD partner based upon the expected actual outlay needs during the 12-month period covered by the COP.

Approval of Identified TBD Partners

For all TBD activities to be funded through assistance mechanisms, the OU team will notify S/GAC once the partner has been identified but before the award. The timing of the notification between partner selection and award ensures S/GAC's COP approval process takes place prior to a final award. By reviewing TBDs prior to award, other factors can be considered such as the single-partner funding limit.

OU teams can name TBDs at any time by submitting the correct form to their CSTL. However updates will only be reflected in the FACTS Info – PEPFAR Module during formal update cycles.

Local Partners

Definition of "Local Partner" for PEPFAR

Under PEPFAR, a "local partner" may be an individual or sole proprietorship, an entity, or a joint venture or other arrangement. However, to be considered a local partner in a given country served by PEPFAR, the partner must meet the criteria under paragraph (1), (2), or (3) below[1]:

(1) an **individual** must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country served by the PEPFAR program with which the individual is or may become involved, and a **sole proprietorship** must be owned by such an individual; or

(2) an **entity** (e.g., a corporation or partnership):

(a) must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become involved;

(b) must be at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), or by other corporations, partnerships or other arrangements that are local partners under this paragraph or paragraph (3);

(c) at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted

[1] HHS will only implement paragraph 2 (entity) of the definition.

permanent residents of that same country, per sub-paragraph (2)(a), and at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; and

(d) where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country; or

(3) a **joint venture**, **unincorporated association**, **consortium,** or **other arrangement** in which at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the funding under the PEPFAR award is or will be provided to members who are local partners under the criteria in paragraphs (1) or (2) above, and a local partner is designated as the managing member of the organization.

Partner government ministries (e.g., Ministry of Health), sub-units of government ministries, and parastatal organizations in the country served by the PEPFAR program are considered local partners.[*] A parastatal organization is defined as a fully or partially government-owned or government-funded organization. Such enterprises may function through a board of directors, similar to private corporations. However, ultimate control over the organization rests with the government.

Starting with FY 2010, only partners that meet the definition criteria should be reported as local partners in the COP. A single partner can only be considered "local" in the country in which it meets the definition criteria; in other countries it should be listed as "international." The categories are international, local individual, local sole proprietorship, local entity, and local joint venture/association/consortium.

Implementation Guidance for Local Partner Definition

The definition sets the criteria by which an individual, sole proprietorship, entity (e.g., corporation or partnership), joint venture, unincorporated association, consortium, or other arrangement is considered a local partner under the PEPFAR program. Our goal is that the definition truly encompasses a local organization and, hence, does not include subsidiaries or franchises of non-local organizations. The definition is used or will be implemented in three primary ways:

(1) in the counting of local partners, which is required by law and reported to Congress;
(2) in the agencies' future grant and cooperative agreement solicitations where it makes sense for project goals to either limit competition to local partners or to include evaluation criteria that emphasize working with local partners; and

[*] USAID and its partners are subject to restrictions on parastatal eligibility for USAID funding. See 22 CFR 228.33.

(3) in overall PEPFAR policy guidance (i.e., COP guidance on engaging local partners).

The definition applies to both prime and sub-recipients, to grants and cooperative agreements, and, in certain contexts, to contracts. Because of applicable competition and source, origin and nationality rules, the local partner definition will not be used to limit eligibility unless S/GAC relies on "notwithstanding" authority as discussed below. Local contractors will be included as "local partners" for counting purposes.

In general, PEPFAR would like to see a greater number of sustainable, prime local partners – through either the graduation of local subs or the identification of new local primes.

Eligibility Determinations During Implementation: PEPFAR implementing agencies have the option of using any or all of the three sub definitions of a local partner (individual/sole proprietorship, entity, or joint venture) in its solicitations for grants and cooperative agreements, as appropriate for the intent of the award or in compliance with agency policies and regulations[2]. The agency will specify in the request for applications (RFA), request for proposals (RFP), or funding opportunity announcement (FOA) which types of partners may be considered for award as appropriate. Prior to issuing an RFA, RFP or FOA that limits eligibility to local partners, OU teams and PEPFAR implementing agencies shall consult with their contracting officer and legal advisor to resolve any competition and source, origin and nationality issues.

In order to qualify as a local partner in a given country, a partner must meet all of the criteria relevant to the particular type of entity under paragraph (1), (2) or (3) of the definition. For example, an "entity" under paragraph (2) of the definition, typically a corporation or partnership, must be legally organized in country, have its principal place of business in country (which restricts franchises of US-based organizations), and meet the percentage requirements for ownership and staff citizenship within the same country (i.e., 51%, 66% or 75%, depending on the fiscal year in which the award is made). Therefore, to be considered a local partner in Uganda, the organization must be legally organized in Uganda, have its principal place of business in Uganda, and the relevant percentage (51%, 66%, or 75%) of ownership and staff, including senior staff, must be Ugandans, etc.

Further, as appropriate for the intent of the award, an agency may choose to make the award available to partners who are local in other PEPFAR countries outside the one in which implementation of the award will occur. For example, a South African local partner could be deemed eligible for an award in Uganda, even if they are not a Ugandan local partner. In addition, if it makes sense for the purpose of the award to include organizations that are U.S. or third country-based, or that are local entities of

[2] HHS will only implement paragraph 2 (entity) of the definition.

international organizations, those organizations could be deemed eligible for award in the solicitation.

The percentages for determining local partners under the definition (51% in FY 2009-2010; 66% in FY 2011-2012; 75% in FY 2013) apply to new awards only based on the fiscal year in which the award is made (and without regard to the fiscal year of the funds supporting the award). Thus, for an award made in October 2010 (i.e., an award made in FY 2011), an entity would be required to meet the 66% local ownership and staffing criteria in order to be considered a local partner. Partners receiving incremental funding on existing awards would not be re-evaluated under the local partner criteria.

Notwithstanding Authority: Where necessary to implement local partner policies under this guidance, the Global AIDS Coordinator intends to rely on the notwithstanding authority for global HIV/AIDS activities using Global Health and Child Survival account funds (i.e., S/GAC funding) provided in Section 7060 of the Department of State, Foreign Operations, and Related Programs Appropriations Act, or similar authority provided in subsequent legislation, to overcome applicable competition and source, origin and nationality requirements.

Ownership and Percentage of Staff Who Are Citizens or Permanent Residents: The ownership and local staff requirements gradually increase for entities. In FY 2009-2010, the ownership and percentage of staff, including senior staff, who must be citizens or lawfully admitted permanent residents of the country, is set at a minimum of 51 percent. However, as we desire local partners to include a greater level of local participation, the percentage requirement increases over time. Thus, in FY 2011-12, these percentages will rise to 66 percent, and in FY 2013 will rise to 75 percent. This information may be shared with partners so that they understand the change in criteria over time. Again, the above percentages apply to new awards issued in the applicable fiscal year.

Excluding Individuals and Sole Proprietorships in Counting Local Partners: Only partners that meet the definition criteria should be reported as local partners in the COP. A single partner can only be considered "local" in the country in which it meets the definition criteria; in other countries, it should be listed as "international." There will be categories for local individual, local sole proprietorship, local entity, and local joint venture/association/consortium. See Section 7.5: Manage Partners and Manage Implementing Mechanisms.

However, although reported in the COP, individuals and sole proprietorships that qualify as "local" under the definition will NOT be officially counted as local partners. Most often, PEPFAR programmatic considerations are best served by grants and cooperative agreements to organizations rather than individuals. PEPFAR OU teams should carefully consider whether a grant or cooperative agreement to an individual or sole

proprietorship is the best use of PEPFAR resources and the most effective way to meet program objectives.

Guidance on Joint Ventures: To be considered a local partner, a joint venture must receive funding directly in the name of the joint venture, whether as a prime or sub-recipient. If the principal recipient or sub-recipient of record is solely a non-local (i.e. US-based, third country, or international) partner, the arrangement will not be considered a joint venture or counted as a local partner. For example, if Harvard forms a joint venture with local partners but the grant award is in Harvard's name, the joint venture will not be considered official or counted as a local partner until the grant award is renewed and awarded legally to the joint venture. To be a local partner, the joint venture must meet the applicable percentage of funding (51%, 66% or 75%) to members who are "local partners" under the criteria in paragraphs (1) or (2), and have designated a local partner as the managing member of the organization. If the joint venture meets the criteria, then it should be listed as a new entry in the COP under the joint venture's name.

Strengthening Local Partners

Good measures of "strengthened" and "sustainable" local partners include:

- *Strategic Planning* - organizations that have a Board of Directors[3], mission statement, and strategies for the short- and long-term (5-10 years), including diversification of funding sources and ability to write their own grant proposals;
- *Registration* - organizations that are registered with USG agencies or as legal entities in their own country;
- *Financial Management* - organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets;
- *Human Resource Management* - organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization;
- *Networks* – organizations that are linked to local networks that deliver prevention, care and treatment services, monitor implementation, and report results;
- *Monitoring and Evaluation/Quality Assurance* - organizations that have institutionalized the capacity to collect, enter, store and retrieve program data for use in planning, monitoring, reporting, and improving quality, and are able to fulfill USG and other international partner reporting requirements;
- *Commodities, Equipment and Logistics Management* - organizations that have established a system to assess commodity needs, account for donated product,

[3] Oversight Committee/ Task Teams/ Leadership Group

ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services;
- *Facilities* – organizations with laboratories, clinics, and classrooms capable to provide HIV/AIDS training or services; and
- *Fundraising* - organizations that develop plans for raising funds from non-USG sources.

Examples of how OU teams and PEPFAR partners can work to strengthen the technical capacities of local partners for service provision include:
- Developing, disseminating, and implementing appropriate treatment and care protocols and prevention programs;
- Developing and strengthening health infrastructure;
- Improving laboratory capacity to perform HIV testing;
- Implementing monitoring and evaluation systems and fostering data use;
- Promoting collaboration and coordination among partners providing prevention, care and treatment services;
- Linking local partners to international policy and service delivery networks;
- Developing, disseminating and sharing curriculum; and
- Building human capacity through training.

One particularly important gap for local partner organizations is technical expertise in accounting, managerial and administrative skills, auditing practices and other activities required to receive funding directly from the USG. The use of umbrella awards to mentor organizations can assist in providing this expertise. Wherever possible, efforts should be made to support and provide technical assistance to assist local partner organizations in 'graduating' to full partner status and enable them to be direct recipients of PEPFAR funds.

Single-Partner Funding Limit

Overview

The single-partner funding limit diversifies the PEPFAR partner portfolio, and expands partnerships with local partners, all with the goal of promoting the long-term sustainability of HIV/AIDS programs in our partner countries. For FY 2012, the limit on funding to a single-partner is no more than 8 percent of a country's PEPFAR budget, excluding U.S. Government OU team management and operations costs, or $2 million, whichever is greater.

Exceptions

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

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

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

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

C. **Umbrella Agreements**[4]**:** The grants officer will determine, in consultation with the OU team, whether an award is an umbrella for purposes of exception from the cap on an award-by-award basis. This determination may be made at the time the announcement is written based on the statement of work or at the time of award based on the applicant's work plan. The following criteria apply to decisions about umbrella status:
   - Awards made with the intent that the organization make sub-awards with at least 75 percent of the grant (with the remainder of the grant used for administrative expenses and technical assistance to sub-awardees) are umbrellas and exempted from the cap.
   - Awards that include sub-awards as an activity under the grant but do not meet the above criteria are not exempt, and the full award will count against the cap.

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

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

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

Umbrella Award Definition

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

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

The following are "best practices" for umbrella awards:

- Where local organizations are strong, umbrella grant programs hire a strong local or international organization whose role is to run a grant making and administration program by using a relatively small percentage of the funds (usually around seven percent) in the overall grant for these purposes.

- Where local organizations are weak, umbrella grant programs include significant technical assistance, either as part of the responsibilities of the grant-making organization or of a separate organization. The best examples again spend a relatively small proportion of the overall grant (typically 20 to 30 percent) on these services and are quite specific as to the responsibilities of the prime grantee in strengthening local partners. Such awards must move to the seven

percent level on a rapid timeframe as the technical capacity of local partners increases.

- To qualify for exemption from the single-partner funding cap, an umbrella award may not spend more than 25%of the overall grant for administrative expenses and technical assistance. Where a grant has characteristics of an umbrella award but administrative costs and technical assistance exceed 25 percent, the OU team may consider requesting that S/GAC authorize an exception to the cap on a case-by-case basis.

- An organization that receives umbrella awards may separately have other grants or contracts in which it engages in direct program implementation activities. However, awards containing such activities are not considered umbrella awards and are subject to the 8% single-partner cap. An award that includes both direct implementation and sub-grant-making activities will not normally count as an umbrella award for the purposes of that grant, but S/GAC may permit exceptions on a case-by-case basis.

Justifications

You will be asked to submit a justification for any partner that exceeds the single-partner funding limit, after excluding organizations (host country government organizations, parastatals) and funding (umbrella awards, drug and commodity purchases) exempted under the exceptions noted above. No justification is required for partners that would exceed the 8% limit only if procured commodities were included; however, the dollar amount of funding the partner will use for commodity procurement should be included with the implementing mechanism information.

Successful Practices for Encouraging Engagement with Local Partners and Faith- and Community-Based Organizations

The following guidance focuses on identifying organizations that already serve local populations, have expertise in programmatic areas, and would further benefit from USG partnership through technical assistance and capacity building.

PEPFAR has yielded examples of creative program designs that successfully integrate FBOs, CBOs, and local partners into Country Operational Plans. Recommendations and examples include:

- Avoid duplication of resources programmed by different USG agencies to the same implementing organization for the same purposes (e.g., two USG agencies funding the same partner to provide the same assistance to orphans or

antiretroviral treatment). This will minimize the burden on the partner as well as USG staff.

- Select Annual Program Statements (APSs), or other funding instruments, directed entirely at local partners or set aside a portion of funding for new partners that are local with an existing in-country presence or relationship.

- The language used in funding announcements, such as Requests for Application (RFAs) and APSs, is critical in determining what types of organizations respond. Word choices can encourage the participation of FBOs, CBOs, and local partners. A useful practice is to issue a draft solicitation for comment or hold a country pre-bidders conference to determine if there are impediments to participation by FBOs/CBOs.

- The dollar values and size of grants may also influence which organizations apply. Statements indicating dollar value awards "up to $5 million" may discourage local CBOs because they are often viewed as "set-asides" for international organizations. Language such as "small awards to local organizations will be a priority" may encourage local C/FBOs to apply for the grants.

- Ensure within all solicitations a level playing field for all potential bidders, including those with limited previous experience working with the USG. Posting solicitations on the web for comment is a best practice in this regard. In addition, as part of the review process, new procurements may be identified as requiring a review of the scope of work at headquarters.

- Consider using umbrella awards, small grant programs, and linking and graduating partners throughout varying levels of funding mechanisms.

- Many solicitations now include specific objectives for capacity building within statements of work and assign points for capacity-building plans as part of review criteria and scoring systems. (Examples will be posted on the PEPFAR Extranet.) During implementation, all USG implementing agencies are required to review partner performance annually to strengthen local partners and PEPFAR partners. Additionally, PEPFAR partners are required to address their plans for, and results of, capacity building within their annual work plans and annual program performance reports.

- In the acquisition arena, if an international organization is essential to provide technical leadership and oversight, use all available tools in award evaluation criteria and performance assessments to encourage use of local partners. The award evaluation criteria can include points for including local partners as sub-contractors or implementing partners. The evaluation of how broadly and

effectively a contractor utilized and included local partners during the performance assessment of that contractor has been effective when done rigorously.

Some of these practices will increase demands on A&A and other staff. We have therefore provided funding to our USG implementing agencies to allow them to increase human capacity in the field and at headquarters (including a Twinning Center that can help support local organizations). We are open to, and supportive of, innovative approaches to address this issue.

Appendix 5: Setting Targets

National Level Indicators and Targets

National targets are the expected national achievements inclusive of all stakeholders in a country, and are based on a reporting timeframe and host country projections defined by the partner national government. These are required for submission to headquarters for selected indicators.

All national-level indicators should be pulled from the national set. In some instances, PEPFAR teams may need to negotiate indicators into the national set if they are not already collected and to support activities that build the national systems to collect the data needed to report on these indicators. PEPFAR teams should be working to integrate existing parallel PEPFAR systems fully into the host country government's national M&E system.

Particularly relevant to this process is that while many countries and regions have developed the capacity to scale-up services in particular programs, the current economic environment requires that the rate of scale-up be considered in light of program cost and available funding from all sources (PEPFAR, national budgets and other donors). In this context, PEPFAR teams will want to support partner governments in their efforts to ensure national targets represent realistic funding levels, inclusive of USG, host government, GFATM, and other donors.

PEPFAR OU teams working in the context of Partnership Frameworks or PEPFAR Strategies should be supporting five-year targets for each goal and five-year and annual targets for each of the applicable national-level (or sub-national depending on the scope of the Strategy) indicators. For target data submitted, these figures should be reviewed each year and revised, if necessary, to reflect the most recent programmatic trends.

Timeframe for National Level Targets

The data reported should represent the most current (and complete) 12-month timeframe available based on the host country government reporting cycle.

The 12-month timeframe used for target setting (and results reporting) should remain consistent for the duration of this phase of PEPFAR so data will be comparable across years and trends can be analyzed accordingly.

Technical Area Summary Indicators and Targets

PEPFAR teams are required to set technical area summary targets on all of the "Essential/Reported" indicators that are "applicable" to the PEPFAR program. Annual technical area summary targets should be based on USG support and should feed into the national program 5-year goals set through a strategic planning process led by the host country government and supported by key stakeholders.

The expected accomplishments at the summary level are not simply the sum of the targets for a given indicator across individual partners. It is expected that some double counting will occur. When estimating targets the PEPFAR team should identify and resolve double counting issues. The targets should be an accurate reflection of the total de-duplicated reach of programs during the fiscal year period. Therefore, summary targets will need to be adjusted for double counting prior to submitting the COP to S/GAC.

Timeframe for Technical Area Summary Level Targets

The targets should reflect the expected direct program results in a given fiscal-year **time period** regardless of the fiscal year monies used to reach targets. By setting targets based on expected results within a given-year time period rather than based on a given-year funding, we will be able to make comparisons between targets and the annual results reported in Annual Progress Report (APR).

Implementing Mechanism-Level Indicators and Targets

Implementing Mechanisms targets represent the expected achievements of a partner for a given indicator(s) within the defined period. This information is important for management in country, but *is 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). For each Implementing Mechanism, country teams should consider setting at least two years of targets (FY 2012 and FY 2013). Where longer contracts or agreements exist, country teams may want to request additional year targets.

Each Implementing Mechanism's indicator set should represent a comprehensive set of measurements that provide the information needed by the partner and the PEPFAR team to manage the program activities. Minimally, partners will be expected (by the OU team) to set targets for all "essential/reported" indicators that are applicable to the work they are doing.

The PEPFAR OU teams will determine which additional Implementing Mechanism indicators are to be reported based on PEPFAR indicator guidance. Each partner's indicator set should represent the expected outputs (i.e. people served or other defined deliverables) or outcomes of the partner's activities.

Two Methods for Setting Implementing Mechanism Targets

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

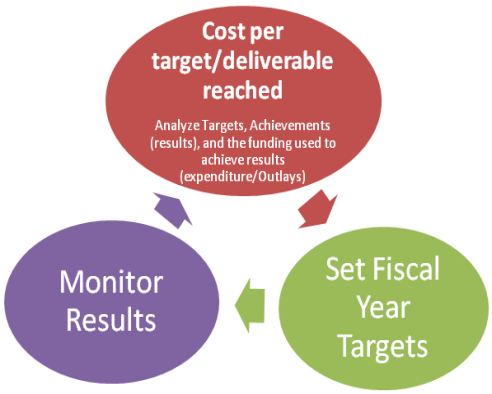
- The first method involves setting targets for the expected program achievements for the defined reporting period based on anticipated fiscal year expenditures.

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

Both methods to setting Implementing Mechanisms targets have been used as the basis for the PEPFAR planning process. Both approaches also use the same fiscal year timeframe as the Technical Area Summary targets. Targets can be aggregated and de-duplicated to produce a summary target. All Implementing Mechanisms will need to set Fiscal Year Targets so that this aggregation can be done.

Reporting results when using the first method for target setting:
In this case, targets are based on the same time period as performance results reported by Implementing Mechanism and provide a direct comparison between what a partner expects to accomplish (target) and what they actually accomplished (result), allowing country teams to monitor performance.

Considering budget information when using the first method to target setting:
Targets are based on the financial expenditures that are expected to be outlaid during the defined reporting period. Therefore, targets (and results) should be compared against financial records of expenditures or outlays to get an estimate of the cost per target reached. Targets, results and financial expenditures/outlays can be analyzed to provide PEPFAR country teams with a better



understanding of the cost, pipelines, and the relationship between dollars and outputs.

The information developed through these types of analyses should be fed into each round of target setting and can help to identify program efficiencies.

Example of Target Setting with the First Method – <u>New</u> Implementing Mechanism:

A new partner receives money for the first time in FY 2012 to provide treatment in a rural area that had no access to service delivery in past. Based on the expected date that the partner will receive funding, the partner doesn't expect to reach any patients with services in FY 2012. Once funding is received, they will have some infrastructure and procuring commodities work to do. They expect they will be up and running approximately 4 to 6 months following receipt of funding. The community has approximately 500 known patients ready to start treatment. The partner estimates that they will be able to get all 500 patients on ART before end of FY 2014 and will continue to enroll new patients as identified.

<u>The following indicator was chosen to demonstrate this example:</u>

Example Indicators	FY12	FY13	FY14
Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	0	250	500

Example of Target Setting with the First Method – <u>Existing</u> (continuing) Implementing Mechanism:

In this scenario, the partner has an existing treatment program continuing from the previous year. At the end of FY 2012, they expect to have approximately 2500 patients on the books. They are scaling up at a net gain of approximately 5 to 10 patients/month, taking into account death, transfers out, and other loss to follow-up. They have dollars in pipeline from FY 2011 and will continue service uninterrupted until receipt of FY 2012 funds.

<u>The following indicator was chosen to demonstrate this example:</u>

Example Indicators	FY12	FY13	FY14
Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	2500	2620	2740

***2014 targets are notional based on continued funding at the same FY2010 level.**

The second method involves setting targets based on the anticipated results that are tied to planned funding in this budget cycle (i.e., with FY 2012 funds), regardless of when the results will be achieved. Only HHS Implementing Mechanisms are required to set these targets in this way. The targets and results are generally analyzed from a budgetary perspective to help monitor contractual agreements.

Reporting results when using the second method to target setting:
This method to target setting will not allow comparison of targets to results, but will allow assessment of targets for the funds requested.

Considering partner requests for funds when using the second method to target setting:
This method to target setting allows project officers and procurement and grants officials to specifically evaluate the requested funding and targets described in partners' applications for annual funding in light of what was approved in the COP for the same fiscal year's funds. These targets will provide PEPFAR country teams with an understanding of the costs per target estimated by the partner for the funds requested that year.

There are a few key differences when applying the second method for setting Implementing Mechanisms to the example described above.

Example of Target Setting with the Second Method:

In this scenario, the partner has an existing treatment program continuing from the previous year. Planning for a target using FY 2012 funds only, they expect to scale up at a net gain of approximately 4 to 6 patients per month, taking into account death, transfers out, and other loss to follow-up.

The following indicator was chosen to demonstrate this example:

Example Indicators	FY12	FY13	FY14
Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	2500	2560	2620

***2014 targets are notional based on continued funding at the same FY2010 level.**

Appendix 6: Instructions for Writing Technical Area Narratives and Budget Code Narratives

As described in Section 7 of the FY 2012 COP Guidance, there are specific questions that need to be addressed in your technical area and budget codes narratives. In an effort to continue the move to a less burdensome COP, there are only four Technical Area Narratives (TANs) for the FY 2012 COP. It is expected that these TANs will give a strategic overview of the technical area and the country's priorities under the strategy. There are more questions that can be addressed in a ten page document, so please prioritize your responses to the questions most relevant to your country context.

Technical Area Narrative Instructions

1. Governance and Systems TAN

One of the key principles of the Global Health Initiative is to *"build sustainability through health systems strengthening."* Health systems strengthening efforts are important to ensure that USG investments are utilized to produce a lasting impact. Sustainable public health programs require an inclusive approach across public and private sectors to strengthen essential partner country capacities, institutions, infrastructures and systems. This comprehensive approach to sustainability supports the Global Health Initiative and allows activities supported by PEPFAR to facilitate a continuum of response across HIV programmatic areas, as well as the lifespan and range of health and development issues.

In the Governance and Systems technical area narrative, country teams will demonstrate how their PEPFAR programs promote sustainability through strengthening the host country health system and contributing to the partner country's capacity to lead, manage and sustain the national HIV/AIDS response over time. The Governance and Systems technical area narrative focuses on cross-cutting systems activities and their linkages to the activities described within the Prevention, Care and Treatment TANs.

OUTLINE FOR 10-page GOVERNANCE AND SYSTEMS TAN

- **Introduction:** Country teams should begin with a brief analysis of the major actors and constraints that are faced within the health system. The introduction will describe the context from which the country team engages with the health system and strategically implements programs to improve both the system

building blocks and the linkages between them. Please refer to the HSS Technical Considerations for further guidance.

- **Technical Area Descriptions:** The sections outlined in the table below include key priority areas for PEPFAR programs in FY 2012. Responses should address those areas that are relevant to the country program, and prioritize the selected technical areas according to the country context. Responses should address technical areas in sufficient detail to describe activities planned in the immediate and middle term. Each area is meant to represent broad, cross-cutting country program components, as opposed to specific programmatic activities. Country teams should apply the GHI lens of sustainability through health systems strengthening when crafting their responses to the following technical area questions and discuss how linkages between the building blocks leverage overall HSS efforts. Responses should address: (1) what is the current state of the activities in the area; (2) what are the key priorities in this area in the short- and longer-term; and, (3) how might activities in this area contribute to program sustainability. To provide clarity and context to these sections, country teams are encouraged to employ specific examples in their responses.

Technical Areas to be included and questions to answer:

AREA	QUESTIONS
Global Health Initiative	• Describe how PEPFAR is supporting the GHI goals through systems efforts. If your country has developed a GHI strategy, please discuss the governance and systems inputs to the GHI strategy that will be jointly or solely funded through PEPFAR. For example - discuss engagement with the private sector; describe the approach to strategic integration of programs and leveraging of existing platforms (PMI, PEPFAR, MCH, FP/RH).
Leadership and Governance and Capacity Building	• Describe how PEPFAR is strengthening 1) government; 2) private sector; and 3) civil society capacity to design, manage, and monitor HIV programs at the national, regional, and local levels a. How are we assisting the partner Government and civil society to take over greater responsibility and accountability for decision-making and priority setting, policy making and regulatory reforms? b. How does the PEPFAR program coordinate and leverage both existing and new programs of

	government, private sector and civil society to develop the capacity of relevant actors to manage operational and fiduciary functions, as well as the evaluation and monitoring (including quality improvement) for the HIV response at the community, facility, and national levels? c. How does the PEPFAR program promote an enabling policy environment for an effective Continuum of Response?
Strategic Information	• How is the PEPFAR country program advancing national HIV Strategic Information capacity (individuals, institutions, systems) to plan for, collect, manage, and use integrated data from different sources to inform HIV prevention, care and treatment programs? Please highlight key successes and challenges of the past year and describe your strategic priorities to meet the long-term goal of sustainable, integrated, country-led systems, personnel, and data, with special attention to improved execution of these essential functions: Support the overall integration and interoperability of national health information systems: Strengthen national efforts to develop and implement a strategic approach for national information system architecture. In addition, support efforts to standardize data collection tools and data elements and to interpret and utilize data originating from different sources – for example, from systems such as laboratory, pharmacy, ART monitoring, prevention of mother-to-child transition, blood safety, community-based programs, etc. Also describe efforts to transition and/or integrate PEPFAR-specific monitoring systems into national ones. • KNOW YOUR EPIDEMIC: Strengthen country capacity in surveillance of HIV epidemic trends and associated morbidity and mortality (e.g., prevalence, incidence, survival rate, mortality, etc.). This includes the individual, institutions, and systems capacities to design and implement censuses and surveys, surveillance systems, vital registration systems, and special studies, and to use the resulting data to inform HIV prevention, care and treatment programs. • KNOW YOUR RESPONSE: Strengthen country capacity to

	monitor clinical and community-based HIV programs including HIV program inputs, costs, activities, outputs, and outcomes collected through routine monitoring, and with special attention to data quality and data use for strategic planning and decision-making. Where applicable, also describe how PEPFAR is working to strengthen country capacity for monitoring integrated health programs (e.g. TB, MCH, malaria) which achieve broader health system goals (such as those specified under GHI). Developing the capacity of partner country governments and institutions to conduct evaluation, research and analysis, to build the necessary evidence base for HIV programs, and to use evidence to inform effective scale-up, efficient programming, and improvement of interventions.
Service Delivery	• Describe the continuum of response (CoR) in the country (refer to Appendix 3 for a description of the key features of a CoR approach). Describe how the country will implement a process to: a. Use epidemiologic and population-based, behavioral, and other health and social services data to design CoR programs that target the prevention, care and treatment service needs of target populations, including for example: adolescent girls and women prior to pregnancy, pre- and post-natal periods and during infancy and early childhood mother-stages; at-risk and HIV infected adults with affected family members; and MARPs populations including MSM, PWIDs and CSWs. b. Establish sustainable, comprehensive CoR programs through the use of existing government service sites and programs at the facility and community level, with established mechanisms to link/integrate and leverage NGO/FBOs, civil society, and private services and providers. Describe how CoR programs leverage public, private, and donor resources. c. Demonstrate ability to link/integrate essential and evidence-based prevention, care/support and treatment services that address client needs through a lifespan approach and within the context of family units. Explain the integration of quality assurance/quality improvement activities within the CoR approach. d. Develop the capacity of partner country governments and institutions to plan, implement and monitor effective and

	efficient delivery of services.
Human Resources for Health	• Describe how PEPFAR is working to increase the density, balance the distribution, and improve the performance of the health workforce. Describe how your planned activities align with your country's national HRH plan and the Partnership Framework Implementation Plan. Note where your HRH efforts are coordinated and leveraged with other donors, and, under the GHI, where efforts will leverage other USG HRH investments. Additionally, please summarize your efforts to: a. Improve pre-service education and contribute to the 140,000 target in a way that is specific to your country needs b. Strengthen MOH human resources management and planning, including efforts to develop a national human resource information system and the use of data in decision-making and policy change? c. Advance in-service training and continuing education that is nationally standardized and coordinated at a national and local level? d. Support capacity building of regulatory bodies and professional associations? e. Improve recruitment and retention of health workers, especially in rural or underserved areas f. Transition any PEPFAR supported staff to local ownership, where appropriate? g. Support improved models of service delivery, including through task-shifting, introduction of new cadres, integration of community health workers in the continuum of response, etc.
Laboratory Strengthening	• Describe current state of activities, your priorities and strategy to encourage and support the development of a national strategic laboratory plan for improving integration of laboratory services to meet the long-term goal of establishing a national integrated quality-assured network of tiered laboratory services that addresses the following components: a. The development of national laboratory policy, quality management systems and practical accreditation schemes, assurance programs, and standardized training and testing across major disease programs. b. The establishment and on-going reinforcement of local

	referral networks both within and among implementing partners c. Assuring an adequately trained laboratory work force that ensures quality of laboratory services for HIV and other diseases of public health importance.
Health Efficiency and Financing	• Describe the current state of activities, your priorities and strategy for assuring efficient use of PEPFAR funds for maximum program impact and your strategy and priorities for contributing to the long-term sustainability of the national HIV programs, focusing especially on the following areas: a. The use of economic analyses—such as cost and cost-effectiveness analyses, expenditure analyses and resource tracking— to guide program design, assure efficient program implementation and inform resource-allocation decisions b. Strategic leveraging to increase the impact and reach of PEPFAR funds, and supporting national partners to identify financing options and innovative funding schemes to support long-term sustainability and growth of programs c. Developing country capacity to conduct cost and other economic analyses and to use these data to guide program decisions
Supply Chain and Logistics	• Describe how PEPFAR is working to support and strengthen the national health supply chain system to ensure continued availability of key health commodities. For example, describe the approaches to: a. Support/encourage the development and implementation of a national strategic plan for supply chain. b. Contribute to an adequately trained and well-performing supply chain workforce, including capacity building activities and transitioning roles and responsibilities to partner government counterparts. c. Coordinate with other donors, and leverage other donor inputs, for supply chain system strengthening activities. d. Improve the availability and use of information within the supply chain system for decision making.
Gender	• Please describe any Gender Assessments you have conducted (or plan to conduct) that highlight gender issues in the context of health systems and human

	resources; please also note if you have developed a Gender Strategy (or plan to do so) and have designated Gender Expert or Focal Point. • Please describe approaches and programming to address capacity building of individuals, with an emphasis on women, and institutions to promote gender equality and improve gender-related outcomes, including: - Retention, recruitment and training strategies for women as health care workers, community health workers, and administrators in the health system. - Promote pre-service and in-service training in gender, gender-based violence and promotion of gender equality in health centers and health-related institutions. - Support host-country governments to develop and enforce policies to eliminate workplace gender violence and discrimination. - Strengthen and build capacity of national/regional/provincial levels of government responsible for gender and women issues (including but not limited to the ministry of health). • Please describe how the effectiveness of planned gender-related programming will be obtained through program monitoring, program evaluation, and/or implementation science.

2. Prevention TAN

Outline: Overview of the epidemic from the perspective of HIV Prevention (No more than 5 pages)

- Key populations, their geographic location, incidence and prevalence, disaggregated by age, sex
- Population size estimates (if they exist) of MARPs as defined by your epidemiology, and contributions of those populations to overall HIV incidence.
- Where relevant, what is the prevalence of male circumcision?
- Most recent DHS, AIS, BSS, etc. Please also describe any Gender Assessments you have conducted (or plan to conduct)
- Key risk factors

    - Influence of gender issues
    - Influence of other social/cultural factors
- Sources of the next 1,000 infections
- How is the prevention team using epidemiological data to support its decisions around prevention portfolio investments?
- Overarching Accomplishments in Last 1-2 Years
- Key Priorities & Major Goals for Next Two Years, including any shifts in the portfolio to reflect new priorities, new evidence or changes in policy.
- Alignment with Government Strategy and Priorities
- Contributions from or Collaboration with Other Development Partners
- Policy Advances or Challenges (identified in PF/PFIP, as well as others either new since PF or unable to be addressed in that document)
- Efforts to Build Evidence-Base –At the portfolio level, how does the USG team plan on evaluating the success (either outcome/impact level) of its strategic mix of interventions?
    - Please describe any ongoing impact evaluation.

AREA	QUESTIONS
PMTCT ***Please note that if you submit a new or revised PMTCT acceleration plan with your FY 2012 COP (for FY 11 or FY 12 funds), you should not answer these specific PMTCT questions in your TAN. You should briefly refer to the acceleration plan in your comments on the overall Prevention strategy however.**	• Briefly describe your current PMTCT program status, recent trends and accomplishments (include necessary background info, e.g. epidemiology, coverage and which,- WHO Option A or B or others, etc) • What are your priorities for scaling up and improving the quality of your PMTCT program by 2013 (and by 2015)? How will you use program efficiencies to achieve these gains in coverage and quality? • What are the major challenges in reaching these targets and what is the plan to address them and periodically measure progress? • How are you integrating PMTCT into MNCH, treatment and care services and other prevention programs including prevention with people living with HIV? • What are ongoing program evaluations? What efforts are in place to evaluate impact of PMTCT program?
HTC	• How are HIV testing and counseling resources (HVCT budget code) programmed across HTC approaches, geographic regions, and target populations, and what is the basis for these decisions? Please explain how decisions are made around programming of HTC resources. How will these planned approaches increase the number of people who receive HTC? • What strategies are you employing to ensure that

	persons who receive HIV testing and counseling services are linked to, and enroll in, other HIV prevention, care, and treatment services? What strategies are you employing to follow-up with HIV-positive persons who do not enroll in HIV care and treatment services? Please describe these approaches to ensure linkages, and provide any data you have on % HTC clients/patients who access other HIV prevention, care, and treatment services.
Condoms	• Please briefly describe any existing coordinating structures for managing condom supply and distribution within the country, key donors, and the USG's role. • What is the current coverage of male condoms for the country/region? Female condoms? • If availability and supply of condoms fall short of targets, please briefly outline the key barriers and problems (e.g. poor forecasting, procurement, supply chain, distribution, programming etc).
Voluntary Medical Male Circumcision	• Please quantify the national MC targets for 2012 (calendar year) and the PEPFAR MC targets for 2012 (fiscal year). If there is a gap, are other funding sources available to the partner country government to address the unmet need? What proportion of the unmet need could be alleviated by the proposed 2012 PEPFAR funding if greater service efficiencies were adopted? What efficiencies are currently being piloted or implemented (forceps guided, electrocautery, outreach/mobile services, campaigns, task shifting/sharing, MC kits)? • PEPFAR's support of MC in government facilities--often with requirements for refurbishment/renovation--should be predicated upon the dedication of staff and space for full-time service delivery. Within government health facilities, are PEPFAR funds supporting full-time equivalent MC Service teams working in spaces dedicated to full-time MC services? If PEPFAR supports government health facilities offering less than full-time MC services, what is the plan in 2012 to remedy the situation?

Positive Health Dignity and Prevention (formerly PWP)	• What HIV prevention services are delivered to PLHIV as part of their routine care? Please describe how risk reduction (sexual and alcohol), condom promotion and distribution, partner testing, adherence counseling, family planning/safer pregnancy counseling, and STI management are integrated into the regular care of PLHIV. What services are offered to discordant couples? • What prevention services for PLHIV are delivered through community programs such as home-based care, PLHIV support groups, etc.? • Are there bidirectional linkages and referrals between facility/clinic and community settings? • Is prevention with PLHIV part of your national prevention strategy or national care and treatment guidelines?
MARPs	• How is your country program addressing the prevention needs of most at risk populations? Does your country program provide the minimum package of services for MARPs? a. Please address the question specifically for the individual MARPs –e.g. PWIDs, MSM, and SWs. • How are your prevention programs for MARPs linked to appropriate, accessible and friendly HIV care, support, and treatment services for MARPs? How is your country program advocating for supportive policies or addressing legal barriers to provide services to MARPs and creating an enabling environment for MARPs accessing services?
GENERAL POPULATION	• Adult programs ▪ What strategic mix of interventions and approaches are being used to address the needs of key populations and/or geographic regions? How are these various interventions and approaches linked? ▪ At the portfolio level, how does the USG team plan on evaluating the success (either outcome/impact level) of this strategic mix of interventions? • Youth programs ▪ School based: briefly outline the status of HIV education in school settings in the country/region. What percentage of schools is covered? Is there a standard curriculum? What, if any, is PEPFAR's role?

	▪ Out of school based: briefly outline the status of HIV education for young people out of school. What percentage of these young people is covered? What, if any, is PEPFAR's role?
Cross Cutting Areas	
HSS/HRH	• What strategies are in place to sustain the existing volunteer and non-professional cadres of the prevention workforce? How is task shifting being implemented to expand the capacity of this workforce? What systems (training, supervision, policy, etc.) are in place to ensure the quality of services delivered by volunteer or non-professional cadres? • How is PEPFAR building the capacity of local, community-based organizations to strengthen and sustain their role in providing prevention services?
MEDICAL TRANSMISSION	• How is the prevention of medical transmission of HIV (including blood safety, injection safety, universal precautions, waste management) addressed across the portfolio and among partners, i.e., in care, treatment, lab, PMTCT, HTC, MCH, etc.? How do PEPFAR-supported activities maximize linkages with other USG efforts (e.g. blood donor messages with Peace Corps health and youth programs)? • How does the team ensure quality and evaluate the success of medical-transmission prevention as implemented in the context of other technical interventions (e.g., care & treatment, HTC)? • How does the team promote sustainability of medical-transmission prevention in terms of commodity (safety boxes, blood bags, etc.) security, policies, systems (training, supervision, metrics, workforce, health financing/e.g. cost recovery, etc.) and infrastructure (e.g., cold chain, mobile-collection vehicles, etc.)?
GENDER This section should highlight the priority gender issues affecting HIV prevention in the country and describe PEPFAR's overall approach to addressing them.	• Please describe gender-specific approaches and programming goals related to prevention and describe how the combination of approaches will be implemented. (Please see technical considerations section for illustrative activities for each strategy and for prevention programs). • Describe how evidence on the effectiveness of gender-related programming will be obtained through program monitoring, program evaluation, and/or implementation science.

Strategic Information	• Describe the key challenges and strategic responses to strengthen the prevention information base through integrated SI approaches, inclusive of surveillance and surveys, monitoring, evaluation, and health information systems. • Describe the key challenges and strategic responses to expand and strengthen prevention information use at all levels of implementation associated with national program strategies. • Describe the key challenges and strategic responses to strengthening nationals systems for prevention surveillance and surveys, monitoring, evaluation, and health information, while simultaneously integrating PEPFAR systems into these national developments.
Capacity Building	• What are the priority capacity building objectives for government, private sector, and civil society players in this technical area? • Are priorities determined by their potential effect on expected HIV/AIDS outcomes and impact? • What components of capacity building (individual, system, organization) are currently being addressed by in country activities? • What current or new partnerships with national government, , civil society, and/or other stakeholders will support the strategy? • How are capacity building activities aligned with other stakeholder efforts in the technical area? • What are the capacity development activities, outputs and outcomes and how will these be measured? Does the strategy integrate individual/workforce, organizational, and systems/policy approaches? • What measures are in place or will be developed to assure that quality standards remain as host countries take a greater role in leading and managing the response. What capacities will need to be enhanced to take on these roles?

3. Care TAN

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

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

The initial section of the TAN should describe the overall programmatic strategy for Care across all these areas, according to the outline below. Subsequent sections should describe strategies specific to the component technical areas, i.e., Adult Care and Support; Pediatric Care and Support; etc. When possible, the use of specific examples may be more useful for the OU to convey how strategies are made operational.

Following the outline below are questions common to each of the four required TANS, that TWGs- including the "cross-cutting" TWGs: Public-Private Partnerships, MARPs, Gender, and the Health Systems Strengthening (HRH, Lab, and SI) have suggested should be considered in describing PEPFAR's support. OU's need not feel compelled to address every question below; those deemed most important by each TWG have been designated by an asterisk. While it is not possible to answer every question listed, please share the questions with your implementing partners as well for use in the design of activities.

- **Outline - Overall Programmatic Strategy in Care: (5 pages)**
  - Major Accomplishments in Last 1-2 Years
  - Key Priorities & Major Goals for Next Two Years
  - Alignment with Government Strategy and Priorities
  - Contributions from or Collaboration with Other Development Partners
  - Policy Advances or Challenges (identified in PF/PFIP)
  - Efforts to Achieve Efficiencies
  - Efforts to Build Evidence-Base – How Evidence Informs Strategy & Priorities
  - Describe Cross-Cutting Program Elements
    - PPPs
    - Key Vulnerable Populations and Targeted Interventions (Gender, Children, MARPs)
    - Health Systems Strengthening elements
      - Human Resources for Health
      - Laboratory Strengthening

AREA	QUESTIONS
Adult Care and Support:	• Do PEPFAR-supported programs promote a minimum package of care and support services (i.e., a "preventive care package") for HIV-infected persons in care? What are the components? Is cotrimoxazole prophylaxis included? To what extent are they implemented? What

	are the obstacles, and what are the plans for overcoming them? • What HIV prevention services are delivered to HIV-infected persons as part of their routine care? Specifically, how are risk reduction, condom promotion and distribution, partner testing, adherence counseling, family planning/safer pregnancy counseling, and STI management integrated into their care? • Which HIV-infected persons are eligible to receive community-based services? What services are provided to persons in community-based programs? What percent of HIV-infected persons in care receive them? How are patients linked from facility-based to community-based programs, and vice-versa? • What strategies are in place to ensure that "pre-ART" patients (HIV-infected persons who have not been staged, persons who have been staged and are not yet eligible for ART, or those who are eligible but have not yet started), are retained in care? How have facility- and community-based programs been modified to address retention of these "pre-ART" patients? • What criteria are used to count persons receiving HIV clinical care? • What is the extent of coverage of HIV clinical care services (i.e., what percentage of persons who know they are HIV-infected are in care?) • What efforts, if any, are underway to optimize quality of care?
Pediatric Care and Support:	• How many children (0-15) are enrolled in care services (current, newly, ever) and targets for 2012 and 2013, and what is the retention rate over the past two years for children enrolled in care? • What were your major Pediatric HIV care and support accomplishments in the last two years, and what are your key priorities and goals for pediatric care and support for next two years, within the context of the existing government strategy and scale up plan? • How is access to cotrimoxazole, EID and PITC for infants, children and adolescents being instituted within context of broader MCH services, and what are existing measurement strategies and targets? • What is the capacity at national level to collect and analyze pediatric HIV care and support data (including

	costing data) for program use and policy-making, and how will the USG work with MoH and implementing partners to improve these data and their application? • How will the USG work to improve health care worker and community capacity to provide quality pediatric care and treatment services, including adherence, disclosure, and pain management for children? • How is the USG working to ensure that community and facility-based services are developed and linked to ensure the provision of a continuum of care within a district, region or province, and minimize LTFU? • What are the plans to expand capacity to prevent, diagnose and treat TB and other OIs in children, including procurement of drugs for OIs?
TB/HIV	• Based on the overall PEPFAR TB/HIV strategy and the current status of TB/HIV activities in your country, what are your key priorities and major goals to strengthen and expand TB/HIV activities in the next two years? • What are your plans to scale-up the Three I's: intensified TB case-finding (ICF), isoniazid preventive therapy (IPT) and TB infection control (IC) using PEPFAR-supported platforms? How do you plan to integrate PEPFAR TB/HIV indicators and WHO recommended indicators on the 3I's into national M&E systems? • Early initiation of ART for all people with TB who test positive for HIV regardless of CD4 count contributes to a significant reduction in morbidity and mortality. How do you plan to integrate this recommendation into your current HIV care and treatment strategy? • How do you ensure that partner and donor activities complement each other and are in alignment with government priorities to ensure adequate technical and geographic coverage of TB/HIV services? • What are your monitoring and evaluation strategies to measure progress in program implementation, assess the impact of TB/HIV activities and make program adjustments to improve outcomes? • How are you planning to improve the national TB laboratory diagnostic strategy to improve TB case-finding? If you are considering the use of Cepheid Xpert® MTB/RIF how do you plan to integrate it into your program and measure its impact?

Food and Nutrition:	• Describe existing PEPFAR strategies or plans to integrate nutrition assessment, counseling and support (NACS) within HIV/AIDS care and treatment programs per PEPFAR guidelines, including the use of NACS indicators (e.g. Technical Considerations for Food and Nutrition). Consider: how are these linked to national level food and nutrition coordination bodies, national strategies, and national M&E systems? How are quality improvement methods being employed to enhance data collection and analyses at the national, regional and program levels? What technical assistance partner (central or bilateral project) plays a leading role in food and nutrition work with the government and bilateral implementing partners at clinic and community levels? • Have the clinical and community partners been provided with funds specifically designated for NACS activities and included these within their budget and work plans? Consider: are therapeutic and supplementary foods being procured for provision within NACS? Are they procured locally? Is technical assistance being provided for food processing companies to meet quality and safety standards? Is there support for supply chain management for distribution of therapeutic and supplementary foods through NACS programs? • How are clinical and community partners linked/how are bi-directional referral systems maintained to support a continuum of care that includes food and nutrition? Specifically, consider: what assessments or programs exist that address household economic strengthening, livelihood and food security activities (ES/L/FS) linked to PEPFAR programs and are implementing partners linking PLHIV, their families and OVC to ES/L/FS support as a component of the continuum of care?
Orphans and Vulnerable Children:	• During the next two years, what are your primary goals for supporting children and their households affected by HIV/AIDS? [Please include supportive data and reference to host country priorities as well as relationship to other donor inputs] • What are the program's priorities for strengthening systems to support and protect vulnerable children and their families, including workforce development? [Please reference role of civil and community capacity building as appropriate]

	• What are the program's priorities for family strengthening [E.g. economic strengthening, food security, building parenting/caregiver skills]? • How are your programs supporting the needs of children across the age span from early childhood to transition to adulthood? [Please reference integration with other initiatives such as PMTCT or youth prevention as appropriate.]
Cross Cutting Areas	
Public-Private Partnerships:	• What role will the private sector play in advancing key priorities in provision of care? Please highlight specific public-public private partnerships that will advance major care goals. PPPs may be specific to one element of the care technical area (such as OVC, food and nutrition, pediatric care and support, etc) or may span multiple program areas.
Gender:	• Based on a review of the most recent APR results for males and females, are there gender disparities in delivery of care services? How will they be addressed? • Please describe gender-specific approaches and programming goals related to care, including for each of the 5 gender strategies and describe how the combination of approaches will be implemented and monitored.
MARPs:	• Based upon the best available data, what percentage of HIV-infected persons in the country are MARPs (sex workers, injecting drug users, and men who have sex with men)? What percent receive clinical care services? • How is your country program addressing the care needs of most at risk populations? Does your country program provide the minimum package of services for MARPs? Please address the question specifically for the individual MARPs – PWIDs, MSM, and SWs. • How are care programs for MARPs linked to appropriate, accessible and friendly HIV prevention and support services for MARPs? How is your country program advocating for supportive policies or addressing legal barriers to provide services to MARPs and creating an enabling environment for MARPs accessing services?
HRH	• How does the country support health workforce development to expand HIV care and how does your work align with the overall PEPFAR HRH strategy and national HRH plan as described in the "Governance and Systems" TAN? As part of this discussion, please include a

	description of: • Use of community health care workers, including training, mentorship and supervision, credentialing or other standardization, and compensation. Describe how CHWs are supported to assist in: 1) the early identification of HIV, TB and malaria, 2) the timely referrals of clients to health care sites for diagnosis and management, and 3) the support for client and family adherence and retention. • Efforts to support the role of social workers in HIV care activities, such as in the area of OVC care and support. Please include discussion of the policy, training, mentorship and supervision, credentialing, and compensation of such workers. • Use of "task-shifting/ task-sharing" efforts among HIV care staff, including work to change policy, training, and/or mentorship and supervision to support a task-shifted model of HIV care. Please include approaches to strengthen the use of multi-disciplinary teams and how task-sharing is implemented within these teams. • Approaches to update the knowledge and skills of health workers through continuous professional development on new or emerging HIV care issues, including the implementation of WHO guidelines, and/or new national guidelines
Laboratory	• What laboratory services are available in the country to diagnose TB and other HIV-related infections? Is there a tiered system of laboratory services? What quality assurance systems are in place to ensure accuracy of testing?
Strategic Information	• Describe the key challenges and strategic responses to strengthen the Care information base through integrated SI approaches, inclusive of surveillance and surveys, monitoring, evaluation, and health information systems. • Describe the key challenges and strategic responses to expand and strengthen Care information use at all levels of implementation associated with national program strategies. • Describe the key challenges and strategic responses to strengthening nationals systems for Care surveillance and surveys, monitoring, evaluation, and health information, while simultaneously integrating PEPFAR systems into these national developments.

Capacity Building	• What are the priority capacity building objectives for government, private sector, and civil society players in this technical area? • Are priorities determined by their potential effect on expected HIV/AIDS outcomes and impact? • What components of capacity building (individual, system, organization) are currently being addressed by in country activities? • What current or new partnerships with national government, civil society, and/or other stakeholders will support the strategy? • How are capacity building activities aligned with other stakeholder efforts in the technical area? • What are the capacity development activities, outputs and outcomes and how will these be measured? Does the strategy integrate individual/workforce, organizational, and systems/policy approaches? • What measures are in place or will be developed to assure that quality standards remain as host countries take a greater role in leading and managing the response. What capacities will need to be enhanced to take on these roles?

4. Treatment TAN

In keeping with the principles of PEPFAR II, PEPFAR treatment programs should maximize access to antiretroviral care and treatment programs, while ensuring that quality services are delivered in a sustainable fashion. The Adult and Pediatric Treatment TAN should describe past year accomplishments, major challenges, and planned activities to address challenges and attain goals for the upcoming year. In developing this TAN for FY 2012, country teams should consider the following issues and provide an overview in the narrative provided:

ADULT TREATMENT SECTION (no more than 4 pages)
Please address the questions below on the OU adult treatment program.

I. Access & Integration:

- What is the status of treatment guideline revisions, and what is the anticipated impact on the national program (in terms of access, ARV regimens, and

laboratory monitoring protocols)? What is the timeframe for guideline implementation and how is progress being monitored?
- Given anticipated budgets for treatment and external donor support, what is the plan for scale-up, both nationally and with PEPFAR support?
- What efforts are being done to integrate treatment services with care, prevention and TB/HIV services? What activities are planned to foster greater integration or linkage with MCH and primary care services (e.g., family-centered approach, provision of pediatric ART)? Are TB screening and infection control practices in place at ART sites and is IPT available?

II. Quality & Oversight:

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

III. Sustainability & Efficiency:

- How are expenditure data and cost modeling activities being used to encourage long-term sustainability of treatment activities and forecast the impact of changes in national treatment guidelines (e.g., criteria for ART initiation, ARV regimens, and changes in lab protocols)?
- What efforts are being done to leverage/coordinate with GFATM and other funders?
- What activities are planned to streamline procurement efficiency through changes to national drug formularies, the registration and use of generic formulations, or improved drug forecasting and logistics protocols?
- What other activities are planned to identify opportunities for cost-savings and greater efficiency of treatment services?

PEDIATRIC HIV TREATMENT SECTION (no more than 3 pages)
Areas of focus for COP FY 2012-13 are: a) Improving pediatric HIV data collection, analysis and use at national levels and in USG-supported programs for program and policy improvement; b) continuing collaborative scale-up efforts to increase the number of children accessing treatment and improve AIDS-free survival in this population; c) increasing efforts to address the needs of the growing population of adolescents on treatment.

- **Background:**

Please describe:
  - What were your major pediatric HIV treatment accomplishments in last 1-2 years?
  - How many children (0-15; 0-<2; 2- <5; 5-<15) are currently, were newly and ever enrolled on ART?
  - What percent of all persons on ART is represented by children 0-<15 years?
  - What are the pediatric treatment targets for COP 12-13?
  - What percent of USG supported treatment sites offer services for children?

- **Key Priorities & Major Goals for Next Two Years:**
  - How will the USG evaluate the impact of pediatric HIV care and treatment programs?
  - What are the plans to conduct a comprehensive pediatric ART program evaluation?
  - What pediatric HIV surveillance activities are planned in your country?
  - What are the plans to better document outcomes of children enrolled in care or on treatment (retention rates, morbidity, mortality, HIV drug resistance, growth, etc.)?
  - What are your key priorities and goals for pediatric HIV treatment for next two years?
  - What approaches and strategies will be used to improve early treatment initiation in young infants?
  - What strategies and approaches will be used to expand quality treatment services for adolescents?

- **Alignment with Government Strategy and Priorities:**
  - Does the country have specific pediatric HIV scale-up plans, targets and operational plans?
  - How is the USG supporting the government's pediatric HIV strategy and scale-up plan?
  - How does the USG team work with the MOH to support pediatric HIV scale-up?
  - What are the contributions to pediatric HIV treatment from other donors?
  - What is the current capacity of the MOH to implement pediatric HIV treatment and how is the USG supporting capacity development at this level?

- **Policy Advances or Challenges (identified in PF/PFIP):**
  - Have the country guidelines been updated using WHO 2010 recommendations for treatment of children?
  - What approaches are being used to decentralize pediatric HIV treatment services?
  - What are the main challenges faced by the country and USG partners to expand pediatric HIV treatment services and what are the plans to address these

challenges?

- **Efforts to Achieve Efficiencies:**
  - What is USG supported pediatric HIV treatment doing to achieve efficiencies?
  - How is the pediatric HIV program being integrated into the broader MCH program?

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

- **Key Priorities & Major Goals for Next Two Years:**
  - What are the projected ARV drug needs for the pediatric population for the next two years?
  - What are your key priorities and goals to assure country government rationalizes its pediatric ARV drug list, and to secure procurement or quality drugs and improve forecasting of pediatric ARVs next two years?

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

- **Policy Advances or Challenges (identified in PF/PFIP):**
  - How will WHO 2010 pediatric treatment guidelines influence the procurement of pediatric ARVs in the next two years (estimates of number of children eligible for treatment; impact on ARV budget)?
  - What proportions of children are receiving FDCs? With AZT? With d4T?
  - What are the expected needs for lopinavir/ritonavir in the next two years, based on WHO 2010 guidelines for newly diagnosed children?

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

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

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

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

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

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

Guide to Determining How to Apply Budget Code(s) to an Implementing Mechanism

PEPFAR encourages comprehensive programs, and as described in the policy overview, promotes cross-cutting activities in key areas. As the COP tracks funding by technical areas, it is necessary, as appropriate and relevant, to distribute components of your program across the 18 technical area budget codes and eight secondary cross-cutting budget attributions. Many implementing mechanisms have components that should be described (with funding amounts) in several different budget codes. In some cases, you may decide to code activities differently than in previous years. If this is the case, please use your best judgment and be thoughtful about any potential consequences to results reporting.

Prevention

BUDGET CODE: PREVENTION OF MOTHER TO CHILD TRANSMISSION (MTCT)

PMTCT – activities (including training) aimed at preventing mother-to-child HIV transmission, including ARV prophylaxis for HIV-infected pregnant women and newborns and counseling and support for maternal nutrition. PMTCT-plus ART activities should be described under ARV Drugs and Adult Treatment. Funding for HIV counseling and testing in the context of preventing mother-to-child transmission should be coded under PMTCT and targets should be included in PMTCT. Early infant diagnosis should be included under Pediatric Care.

INSTRUCTIONS FOR WRITING MTCT BUDGET CODE NARRATIVE

Please concisely describe each implementing mechanism's activities in PMTCT. In particular, please address:

- Contribution to scaling-up PMTCT programs including current geographic PMTCT coverage, accomplishments, targets for next two years, and a detailed plan for achieving the targets and periodically measuring progress.
- Provide available information on unit cost per patient reached with PMTCT, and plans to decrease the unit cost and increase coverage and/ or quality by improving program efficiencies.
- Activities and strategies aimed at building the capacity of health care providers and facilities to provide PMTCT services at various health care levels (decentralizing PMTCT services.)

- Activities and strategies to build capacity at national, regional, district and clinical site level to supervise the program, routinely collect data and monitor the quality of services.
- Best practices to scale-up quality PMTCT interventions, including PITC, use of more effective ARV regimens, access to CD4 testing, retention and adherence of mother-infant pair, linkages and referral to treatment , care and support services.
- Activities that promote demand creation such as community mobilization, male involvement, couples CT services in order to increase PMTCT uptake.
- Activities supporting integration of PMTCT with routine maternal child health/reproductive health services, adult and pediatric treatment services, and broader prevention programs. If there are linkages with food and nutrition, or associated funding, please describe as well.

BUDGET CODE: ABSTINENCE/BE FAITHFUL (HVAB)

Sexual Prevention -- Abstinence/be faithful – activities (including training) to promote abstinence, including delay of sexual activity or secondary abstinence, fidelity, reducing multiple and concurrent partners, and related social and community norms that impact these behaviors. Activities should address programming for both adolescents and adults. For sexually active individuals, it is anticipated that programs will include funding from both HVAB and HVOP.

INSTRUCTIONS FOR WRITING HVAB BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in sexual prevention among the general population and youth. In particular:

- Clearly define the population(s) that will be targeted by age, sex, risk behavior or other relevant parameters. (Example: young adult men and women aged 18-30 who engage in concurrent partnerships);
- If possible, please provide a concise description of the type, mix and dosage (e.g., number of sessions) of intervention(s) for each specific target population, including the basis for selecting these interventions; (Example: 14 session, evidence-based "Stepping Stones" curriculum for small-group skills-based HIV/AIDS education);
- Explain how the intervention(s) target(s) the key drivers in the specific epidemic context, including relevant gender dynamics
- Describe the geographic and/or population coverage of the intervention(s);
- Specify mechanisms to promote quality assurance (e.g. supportive supervision training, standardized materials);

- Describe how sexual prevention activities are integrated with and/or linked to other services/platforms including condom programming, counseling and testing, etc.
- Describe evaluation and monitoring plan.

BUDGET CODE: OTHER SEXUAL PREVENTION (HVOP)

Sexual Prevention: Other sexual prevention - other activities (including training) aimed at preventing HIV transmission including purchase and promotion of condoms, STI management (if not in palliative care settings/context), messages/programs to reduce other risks of persons engaged in high-risk behaviors. Prevention services should be focused on target populations such as alcohol users; at risk youth; men having sex with men (MSM); mobile populations, including migrant workers, truck drivers, and members of military and other uniformed services (e.g. police); and persons who exchange sex for money and/or other goods with multiple or concurrent sex partners, including persons engaged in sex work and/or transactional sexual partnerships. Prevention of sexual transmission for People who Inject Drugs (PWIDs) should be included in the IDUP budget code.

INSTRUCTIONS FOR WRITING HVOP BUDGET CODE NARRATIVE

Please complete the summary table below for each implementing mechanism with HVOP funding. Further details of populations, activities, geographic coverage etc, should be discussed in narrative format below the table.

Target Population	Approx Dollar Amount	Coverage – number to be reached by each intervention component	Activity
CSW			
MSM			
Please specify			

- Clearly define the population(s) that will be targeted by age, sex, risk behavior or other relevant parameters. Refer to the estimated size of the population if known.

- Provide a concise description of the type, mix and dosage of intervention(s) for each specific target population, including the basis for selecting these interventions.
- Describe the geographic and/or population coverage of the program, refer to the estimated size of the population if known.
- Specify mechanisms included as part of the intervention(s) to promote quality assurance and supportive supervision
- Describe how activities are integrated with and/or linked to other services/platforms.

BUDGET CODE: BLOOD SAFETY (HMBL)

Blood safety – activities supporting a nationally-coordinated blood program to ensure an accessible, safe and adequate blood supply including: infrastructure and policies; donor-recruitment activities; blood collection; testing (transfusion-transmissible infections, group, and compatibility); component preparation; storage and distribution; appropriate clinical use of blood; transfusion procedures and hemovigilance; training and human resource development; monitoring and evaluation; and development of sustainable systems.

INSTRUCTIONS FOR WRITING HMBL BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in blood safety thoroughly yet concisely. In particular please address:

- The basic objectives and approaches being applied in policy development, blood collection (donor recruitment, donor clubs, mobilization), processing (including component preparation), testing, M&E, quality assurance (quality systems/control), training, infrastructure development (procurement system etc), blood utilization, and distribution (including expansion to rural areas).
- How activities integrate with other HIV/AIDS services (e.g., counseling and testing, lab, care and treatment, PMTCT, etc)
- The coverage and scope of the activities including geographic coverage
- How activities foster country ownership and sustainability.

BUDGET CODE: INJECTION SAFETY (HMIN)

Injection safety includes the programs, policies, training, advocacy, and other activities to reduce medical transmission of HIV and other bloodborne pathogens, reduce unnecessary injections and promote the safety of necessary medical injections and related procedures. Injection safety also encompasses infection prevention and control, standard precautions, supply chain management, health care waste management, needle stick management/post-exposure prophylaxis (PEP) and safe phlebotomy.

INSTRUCTIONS FOR WRITING HMIN BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in injection safety thoroughly yet concisely. In particular please address:

- Objectives and approaches with respect to injection safety, other related procedures (e.g., phlebotomy and lancet procedures), management of HCW occupational exposure to bloodborne pathogens and waste management
- Coverage and scope of activities
- Integration of injection safety and waste management into HIV services, such as treatment and care, HTC, PMTCT, MC, etc.
- Promoting country ownership and sustainability
- Partnerships/collaboration
- Assuring quality improvement in injection safety programming
- Monitoring success (M&E) of injection safety activities, especially in HIV services
- Commodity security, i.e., ensuring sustained availability of single-use syringes and needles, lancets and blood drawing equipment, safety boxes, gloves, etc.

BUDGET CODE: INJECTING AND NON INJECTING DRUG USE (IDUP)

Prevention among people who inject and use drugs (e.g., methamphetamine users) – activities including policy reform, training, message development, community mobilization and comprehensive approaches including needle and syringe access programs and medication assistance therapy to reduce injecting drug use. Procurement of methadone and other medical-assisted therapy drugs should be included under this program area budget code. Programs for prevention of sexual transmission within People who Inject Drugs (PWIDs) should be included in this category.

INSTRUCTIONS FOR WRITING IDUP BUDGET CODE NARRATIVE

- Clearly define the drug use epidemic and the specific PWID and PWUD population(s) that will be targeted by age, sex, other HIV risk behavior or other relevant parameters.
- Provide a concise description of the core interventions that will be implemented to provide a comprehensive and integrated package of prevention, care and treatment services for each specific target PWID and PWUD population, including the basis for selecting these interventions.
- What is the geographic and/or population coverage by intervention (MAT, NSP)
- What mechanisms for monitoring, quality assurance and supportive supervision does each intervention include?

- Describe how these activities are integrated with the existing and planned service platforms of other international donors, government agencies, and nongovernmental organizations.

BUDGET CODE: VOLUNTARY MEDICAL MALE CIRCUMCISION (CIRC)

Voluntary Medical Male Circumcision (VMMC) – UNAIDS/WHO issued normative guidance in March 2007, stating that VMMC should be recognized as an important intervention to reduce the risk of male heterosexually acquired HIV infection. In response to the normative guidance and under the leadership of host country governments, Emergency Plan funds can be utilized to support the implementation of safe VMMC. All VMMC services should include a minimum package of prevention services which include routine counseling and testing for all men and, where possible, their partners attending MC services; age-appropriate sexual risk reduction counseling; and counseling on the need for abstinence from sexual activity during wound healing; and promotion of correct and consistent use of condoms. VMMC should be implemented in accordance with national standards and international guidance with active linkages with other HIV prevention, treatment, care and support services as needed. VMMC encompasses a focus on policy, training (task-shifting/sharing), outreach, development of tools for communications, efficient and accessible service delivery, quality assurance, and equipment /commodities related to male circumcision.

INSTRUCTIONS FOR WRITING CIRC BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in male circumcision thoroughly yet concisely. In particular, please address:

- Number of male circumcisions to be performed
- Coverage either in the geographic area or among the target population
- Activities for supportive supervision and quality assurance
- Communications activities for male circumcision as they relate to males and females
- Provision of TC onsite
- Inclusion of MC as part of a comprehensive prevention package
- Training programs and materials being used
- Demand Creation Activities
- Linkages to care and treatment

BUDGET CODE: HIV TESTING AND COUNSELING (HVCT)

Counseling and testing – includes activities in which both HIV testing and counseling are provided through provider-initiated or client-initiated approaches in a range of health-facility and community-based settings.
Funding for testing and counseling in the context of preventing mother-to-child transmission can be included under PMTCT or Counseling and Testing; targets should be included in PMTCT. Funding for testing and counseling in the context of TB services should be included under the TB budget code; targets should be included under HVCT. For other technical areas where HTC is part of the minimum package including: medical male circumcision, prevention with positives, MARPs services, adult treatment, care and support, and pediatric treatment, funding should come from HVCT and targets should be included under HVCT.

INSTRUCTIONS FOR WRITING HVCT BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in HIV testing and counseling (HTC). In particular, please address:

- The mechanism's target population (couples, MARPs, pregnant women, etc.) and their HIV prevalence (if known), coverage (% tested in past 12 months) either in the geographic area or among the target population
- Approaches (client-initiated, provider-initiated) to HIV testing and counseling undertaken, and settings in which HTC services are provided, (health facilities – ANC settings, TB clinics, Outpatient depts., etc; home-based HTC; outreach/mobile, voluntary counseling and testing (VCT); special events or campaigns, etc.)
- Targets for each approach and results achieved (as per PEPFAR indicators) in the past one year for each approach. Number of people trained or receiving refresher trainings this year, including the areas in which they were trained (i.e. re-testing recommendations, couples HTC, quality assurance, etc.)
- For HTC undertaken outside of PMTCT and TB settings, describe the proportional allocation of HTC funding to each of the other technical areas (MC, MARPs, PWP, Tx, Care/Support) and how HTC links with these other services.
- The testing algorithm used, if different from the national algorithm
- Activities to strengthen/ ensure successful referrals and linkages, including tracking or follow-up of HIV-positive individuals not enrolling in care or treatment services
- Activities for monitoring linkages from HTC to appropriate services, or systems to evaluate or otherwise measure successful linkages.
- Activities for quality assurance of both testing and counseling
- Activities for monitoring and evaluation of HTC, including incorporation of couples HTC indicator and other new PEPFAR recommended indicators where appropriate.

- Promotional activities around HTC for demand creation and target markets/audiences (Gen Pop, ANC, MARPs, Couples, etc.)

Care

BUDGET CODE: ADULT CARE AND SUPPORT (HBHC)

Adult Care and Support – All facility-based and home/community-based activities for HIV-infected adults and their families aimed at extending and optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness through provision of clinical, psychological, spiritual, social, and prevention services. Clinical care should include prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria and diarrhea (including provision of commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services); nutrition assessment, counseling and support (NACS); and pain and symptom relief. Psychological and spiritual support may include group and individual counseling and culturally-appropriate end-of-life care and bereavement services. Social support may include vocational training, income-generating activities, social and legal protection, and training and support of caregivers. Prevention services include partner/couples HIV testing and counseling, risk reduction counseling, adherence counseling and support, STI diagnosis and treatment, family planning counseling, and condom provision. The purchase of OI drugs (excluding TB drugs) should be included under Adult Care and Support. ARV drugs should be coded under Adult Treatment and ARV Drugs.

INSTRUCTIONS FOR WRITING HBHC BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in care and support thoroughly yet concisely. In particular, please address:

- The types of HIV care and support services, location/s of service delivery sites (facility, community, home based) and target audience/s (adolescents, adults, women, MARPs, others).
- Coverage in the geographic area and among the target population/s—how it fits with the overall PEPFAR and country strategy.
- Mechanisms to address client retention and referrals, including the use of outreach and bi-directional referral systems.
- Linkages between program sites with other HIV care, treatment and prevention sites within jurisdiction and linkages and/or referrals between program sites and non-HIV specific services (at a minimum food support, IGA, RH/FP and PLHIV support groups).
- Methods of program monitoring and evaluation, monitoring the quality of care and support services, and program evaluations and research studies to advance

program approaches and/or fill gaps in knowledge on priority care and support issues.

BUDGET CODE: ORPHANS AND VULNERABLE CHILDREN (HKID)

Orphans and Vulnerable Children – are defined as children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects—as stated in the Hyde-Lantos Act that reauthorized PEPFAR in 2008.

Support for orphans and vulnerable children and their households, is integral to the efforts of the President's Emergency Plan for AIDS Relief (PEPFAR). To support vulnerable children, programs should prioritize family strengthening approaches that reinforce families 'long-term caring capacities as the basis of a sustainable response to children affected by HIV/AIDS. Included under the rubric of "family strengthening" are interventions that boost household economic and food security, improve child/family access to health care and schooling, and encourage healthy parent-child relationships.

Families in turn rely on safe and supportive communities to thrive. Therefore HKID funds also support building the capacity of local community structures to respond to children and families in need. Such interventions include, for example, mobilizing multi-sectoral child protection committees at district and sub-district level and sharing and modeling best practices for local communities in working with vulnerable children and families. HKID funds also play an important role in strengthening social services systems. Social service systems (also referred to as social development or welfare) are chiefly responsibility for coordinating the multi-sectorial response to children and families and for providing a vital safety net for those who are most vulnerable. Examples of such interventions include helping governments to assess and expand the number and quality of social service workers, to enact regulation for the protection of children including those living in alternative care, and to improve capacity to monitor and evaluate the national OVC response. In addition to the above, programs should ensure that HKID funds are invested in the evaluation of OVC program impact and in building an evidence base of best practice.

The 10% budgetary requirement is for OVC programming only and is not to be used for pediatric treatment and care. In reports submitted by S/GAC to Congress, persons may be counted only once under each of the three global program areas of prevention, treatment and care. Thus, in reports to S/GAC, children may be counted only once under care but may <u>also</u> be counted under Pediatric treatment (treatment) and PMTCT (prevention).

INSTRUCTIONS FOR WRITING HKID BUDGET CODE NARRATIVE

For each Implementing Mechanism that receives HKID funds please include the following under the HKID budget code narrative:

1. Identify the type of partner it is (e.g. an International NGO, locally owned partner, government).
2. What are the goals of this project and how do they further national PEPFAR OVC goals and priorities (as described in the CARE TAN). Include target populations they will be addressing (age groups, gender, geographic coverage), if applicable.
3. Describe the strategies/activities this mechanism is using to achieve their goals and if these strategies are evidence based. If not, outline how they are contributing to building evidence through their program.
4. What successes and challenges has this partner had in their past performance? What efforts are being made to strengthen this partner's performance, if needed, and how are their strengths being used to build other partner capacity?

BUDGET CODE: TB/HIV (HVTB)

TB/HIV – includes exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis (including medications), as well as screening and referral of TB clinic clients for HIV testing and clinical care. The location of HIV/TB activities can include general medical settings, HIV/AIDS clinics, home-based care and traditional TB clinics and hospitals. Pediatric TB/HIV services should be included in this budget code.

INSTRUCTIONS FOR WRITING HVTB BUDGET CODE NARRATIVE

- Alignment of Partner Activities with Country Policy: Is the partner able to show that activities are aligned with host country national policies and strategic plans for TB and HIV?
- Coordination across Partners: Does the partner activity clearly demonstrate added value relative to other related partner activities that target similar technical and geographic areas?
- Human Resource Capacity and Sustainability: How does the partner activity ensure that there are sufficient trained personnel to carry out the proposed activities and sustain the program over time?
- Monitoring and Evaluation: Does the partner regularly review and report high-quality data using the national TB and HIV M&E framework and tools to track

progress toward stated objectives/targets? To what degree is the partner prepared to report on the revised TB/HIV indicators?
- Accomplishments: What were the key accomplishments and lessons learned since last year's COP and how do proposed activities take these into consideration?

BUDGET CODE: PEDIATRIC CARE AND SUPPORT (PDCS)

Pediatric Care and Support –all health facility-based care for HIV-exposed children aimed at extending and optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness through provision of clinical, psychological, spiritual, social, and prevention services. Clinical care should include early infant diagnosis, prevention and treatment of OIs and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide treated nets, safe water interventions and related laboratory services), pain and symptom relief, and nutritional assessment and support including food. Other services – psychological, social, and spiritual and prevention services – should also be provided as appropriate. Pediatric care and support services should be counted if they are provided at a facility, while community-based services should be included within programs for orphans and vulnerable children (OVC). It is important that funding for pediatric care activities is not double-counted in OVC. Pediatric TB is an important contributor to morbidity and mortality in HIV affected and infected populations. Please include all pediatric TB activities and efforts under the TB/HIV section.

INSTRUCTIONS FOR WRITING PDCS BUDGET CODE NARRATIVE

Please provide a succinct description of each implementing mechanism's activities in Pediatric Care and Support and a short narrative for each budget code in which they work. In particular, please address:
- The mechanism's target population and contribution to scaling up pediatric participation in treatment programs, including pediatric targets
- Activities that provide drugs, food and other commodities for pediatric clients (HIV exposed infants, HIV infected children and adolescents)
- Please describe activities to support the needs of adolescents with HIV (PwP, support groups, support for transitioning into adult services, adherence support)
- Activities for supervision, improved quality of care and strengthening of health services
- Activities promoting integration with routine pediatric care, nutrition services and maternal health services.
- Activities to strengthen laboratory support and diagnostics for pediatric clients.

Treatment

BUDGET CODE: ARV DRUGS (HTXD)

ARV Drugs – including procurement, delivery, and in-freight of ARV drugs. All antiretroviral Post-Exposure Prophylaxis procurement for rape victims should be included within this program area. Distribution/supply chain/logistics, pharmaceutical management and related systems strengthening inputs are to be included in the Health Systems Strengthening section.

INSTRUCTIONS FOR WRITING HTXD BUDGET CODE NARRATIVE

Please answer the following questions in the budget code narrative:

- What drugs will this partner procure?
- Does the partner support the national program in procurement strategic planning by participating in national quantification exercises and by providing estimates of the costs of proposed ART guideline changes?
- Has this partner experienced any stockouts in the last year? What is the partner doing to ensure that there will be no stockouts in FY 2012?

BUDGET CODE: ADULT TREATMENT (HTXS)

Adult Treatment - including infrastructure, training clinicians and other providers, exams, clinical monitoring, related laboratory services, and community-adherence activities. Clinical monitoring and management of opportunistic infections is classified under Adult Care and Support.

INSTRUCTIONS FOR WRITING HTXS BUDGET CODE NARRATIVE

Please answer the following questions in the budget code narrative:

- What type of training does the partner provide? Training activities may include pre-service and in-service training, mentorship, and preceptor programs.
- What level of on-site supervision does the partner provide?
- How does partner track and evaluate clinical outcomes and other performance data? What are their current clinical outcomes?
- How is performance measurement data used for quality improvement at the site level?
- What activities does the partner support to improve retention of patients initiated on ART? What are the outcomes of these activities?

- What adherence activities does the partner support? What are the outcomes of these adherence activities?
- What is the partner's target population(s) and coverage with a comprehensive care and treatment package, including ART provision, cotrimoxazole prophylaxis, and TB screening? In what ways has the partner improved programmatic efficiencies to allow for continued expansion of services?
- What activities of the partner promote transition to local ownership and sustainability of ART service delivery?

BUDGET CODE: PEDIATRIC TREATMENT (PDTX)

Pediatric Treatment – Support to the government to roll out updated pediatric treatment guidelines; infrastructure development, training clinicians and other providers, clinical and laboratory monitoring of children on treatment, adherence support and strategies to improve retention in the pediatric population, development of capacity to provide laboratory services for children and detect treatment failure. Building capacity to monitor, supervise and implement pediatric HIV treatment services; promote integrated approaches to improve outcomes.

INSTRUCTIONS FOR WRITING PDTX BUDGET CODE NARRATIVES

Please provide a succinct description of each mechanism's activities in pediatric HIV treatment. In particular, please address:

- Contribution to scaling up pediatric treatment for HIV infected children 0-15 years of age, including numbers of current, newly and ever enrolled on treatment and targets for the next two years.
- Activities and strategies aimed at building the capacity of health care providers and facilities to treat children.
- Activities and strategies to build capacity at national, regional, district and clinical site level to supervise the program, routinely collect data and monitor the quality of services.
- Activities to support adherence in pediatric populations, improve overall retention on treatment and establish functional linkages between programs and with the community to reduce losses to follow up and improve long-term outcomes.
- Activities promoting integration of pediatric HIV treatment services into MCH platforms of service delivery and linkages with nutrition support programs, linkages with community based activities, programs and services.
- Activities to expand capacity to provide early infant diagnostic services, rolling out PITC HIV testing in infants, children and adolescents. Describe efforts to

extend CD4 % availability and viral load monitoring of children in pre-ART or on ART.

- Describe activities to provide specific services for adolescents in treatment, including support to facilitate transitioning to adult services.
- Describe plans to improve capacity to collect, analyze and use pediatric HIV data in collaboration with the USG and national program.

Other

BUDGET CODE: HEALTH SYSTEMS STRENGTHENING (OHSS)

Health Systems Strengthening – include activities that contribute to national, regional or district level systems by supporting finance, leadership and governance (including broad policy reform efforts including stigma, gender etc.), institutional capacity building, supply chain or procurement systems, Global Fund programs and donor coordination. (Please note, as stated in the introduction, other activities will also contribute ultimately to reporting budget attributions to HSS. These calculations will be handled at HQ.)

INSTRUCTIONS FOR WRITING OHSS BUDGET CODE NARRATIVE

HSS is addressed under several other Technical Area Narratives (TAN), including Prevention, Care and Support, Treatment, and Governance and Systems TANs. These following areas need to be addressed concisely in the OHSS section: health delivery services, human resources for health, strategic information, health finance, governance/leadership, and medical products/ technologies and procurement systems.

1) What is the systems barrier/s that this mechanism/activity addresses?
2) How does mechanism/activity address this barrier?
3) Are linkages across functional areas, intentional spill-overs or leveraging identified?
4) If not, are there any missed opportunities?
5) For activities described as targeted leveraging, describe what funding inputs are coming from other donors, host government, and/or civil society.

BUDGET CODE: LABORATORY INFRASTRUCTURE (HLAB)

Laboratory infrastructure – development and strengthening of laboratory networks and facilities to support HIV/AIDS-related activities including purchase of equipment and commodities and provision of quality assurance, staff training and other technical assistance. Specific laboratory services supporting TB testing goes under TB/HIV. Laboratory services supporting counseling should go under Testing and Counseling or PMTCT. Laboratory services supporting care should go under Adult or Pediatric care and support. Laboratory services supporting treatment should be included under Pediatric or Adult Treatment Services.

INSTRUCTIONS FOR WRITING HLAB BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in laboratory infrastructure development thoroughly yet concisely using very clear goals and targets. In particular, please address:

- How the use of PEPFAR II indicators for measuring quality in laboratory services (number of testing laboratories, and the number of accredited laboratories) will provide critical information for more accurate forecasting, planning and budgeting for laboratory support for program activities.
- Coverage of laboratory testing either in the geographic area or among target populations.
- Development of training activities focused on laboratory management and quality assurance of laboratory testing.
- In line with the transition process for PEPFAR Track 1.0 implementing partners, the transition of laboratory services to local in-country partners; in particular, plans and activities that will result in sustainable accredited laboratory programs.

It is important to stress that when laboratory activities such as testing, services, and renovations are described in COP sections other than Laboratory Infrastructure the funding supporting these activities should be cross referenced, especially when assigned to implementing partners not specifically identified in the Laboratory Infrastructure section.

BUDGET CODE: STRATEGIC INFORMATION (HVSI)

Strategic Information – Aims to build individual, institutional, and organizational capacity in country for HIV/AIDS behavioral and biological surveillance, facility surveys, monitoring program results, reporting results, supporting health information systems, assisting countries to establish and/or strengthen national systems, and related analyses and data dissemination activities fall under strategic information. Program area-specific monitoring and routine evaluation should be incorporated under the specific program area.

INSTRUCTIONS FOR WRITING HVSI BUDGET CODE NARRATIVE

How to describe SI activities in the HVSI Budget Code Narrative:

- If working in more than one SI area describe the SI specific area of activity to be supported through this mechanism. For example, review the Technical Considerations Section for activities within HIS, M&E, and Surveillance & Surveys. Discuss in general terms the type and extent of work to be implemented within each SI area and how this work supports the national SI strategy. Notation also should be made with respect to the Partnership Framework if applicable.
- Describe how activities will provide support to national capacity building to collect, manage, analyze and use data.
- Describe how the proposed activities will support the broader technical program areas for monitoring, evaluation, surveillance, survey, or information systems
- If more than one implementing mechanism is being used for the same SI activity please explain how they will work together.

Deciding whether activities should be included in the SI budget code:
Country teams need to determine if an SI activity best fits in the SI (HVSI) budget code or within another budget code. Large scale SI activities that support multiple technical areas or national systems might best fit under the SI budget code.

This would include the following types of activities:

1. Activities that build capacity for and ensure the implementation of the collection, analysis and dissemination of HIV/AIDS behavioral and biological surveillance and monitoring information;
2. Supporting capacity building efforts and the implementation of facility and other surveys;
3. Build the capacity for the development of national program monitoring systems; and
4. Support the development of country-led processes to establish standard data collection methods.

Conversely, these types of activities might be more appropriate reflected in another budget code:

- Activities directly supporting one specific program area; and
- Activities that are integral components of a prevention, care, or treatment funding mechanism.

For example, suppose you are supporting PMTCT service delivery in 20 sites. A component of this program is to provide TA to set up facility-based health management information systems in the 20 PMTCT sites. This activity should be included in the PMTCT budget code, when the funding mechanism is entered and described within the narrative. If an HIS system is being installed, which will support all programs in the facility and is part of a national rollout, it might best fit in the SI budget code.

Cross-Cutting Attributions

Definitions

For each implementing mechanism, countries must estimate the amount of funding that is attributable to the following programming:

Human Resources for Health (HRH)

This cross-cutting attribution includes the following:

- Workforce Planning
- Human Resource Information Systems (HRIS)
- In-Service Training
- Pre-Service Education
- Task shifting
- Performance Assessment/Quality Improvement
- Retention
- Management and Leadership Development
- Strengthening Health Professional Regulatory Bodies and Associations
- Twinning and Volunteers
- Salary Support

Construction/Renovation

Construction refers to projects to build new facilities, such as a health clinic, laboratory, or hospital annex. Renovation refers to projects with existing facilities intended to accommodate a change in use, square footage, technical capacity, or other infrastructure improvements. PEPFAR-funded construction projects should serve foreign assistance purposes, will involve facilities that are provided to the partner government (or potentially to another implementing partner) as a form of foreign assistance, and are considered necessary to the delivery of HIV/AIDS-related services. PEPFAR-funded renovation projects may serve foreign assistance purposes, but may also be undertaken to repair or improve properties rented or owned by the USG. Note that the cost of renovating of USG-occupied rented or owned properties should be captured in the Cost of Doing Business.

Food and Nutrition: Policy, Tools, and Service Delivery

This secondary cross-cutting budget attribution should capture all activities with the following components:

- Development and/or Adaptation of Food and Nutrition Policies and Guidelines – The cost of developing or adapting guidelines that provide a framework for integrating food and nutrition activities within the care and support of people infected and affected by HIV/AIDS, including OVC. This includes policies and guidelines that foster linkages with "wraparound" programs that address food security and livelihood assistance needs in the targeted population. This also

includes activities that improve quality assurance and control for production and distribution of therapeutic and fortified foods for use in food and nutrition activities.

- Training and Curricula Development – The cost of training for health care workers, home-based care providers, peer counselors, and others to enhance their ability to carry out nutritional assessment and counseling. This includes developing appropriate nutrition-related curricula for inclusion in pre- and post-service training programs and development of appropriate job aids for health care workers.

- Nutritional Assessment and Counseling – The cost of providing anthropometric, symptom, and dietary assessment to support clinical management of HIV-positive individuals before and during ART as well as exposed infants and young children. This includes nutrition education and counseling to maintain or improve nutritional status, prevent and manage food- and water-borne illnesses, manage dietary complications related to HIV infection and ART, and promote safe infant and young child feeding practices. It also includes nutritional assessment, counseling and referral linked to home-based care support.

- Equipment – The cost of procurement of adult and pediatric weighing scales, stadiometers, MUAC tapes, and other equipment required to carry out effective nutritional assessment. This also includes more general procurement, logistics and inventory control costs.

Food and Nutrition: Commodities

This secondary cross-cutting budget attribution is meant to capture the provision of food commodities through food by prescription, social marketing, school feeding, OVC, PMTCT or other programs, including:

- Micronutrient Supplementation – The cost of micronutrient supplement provision according to WHO guidance or where individual assessment determines a likelihood of inadequate dietary intake of a diverse diet to meet basic vitamin and mineral requirements.

- Therapeutic, Supplementary, and Supplemental Feeding – The cost of facility- and community-based food support for nutritional rehabilitation of severely and moderately malnourished PLWHA, as well as supplemental feeding of mothers in PMTCT programs and OVC.

- Replacement Feeding and Support – The cost of antenatal, peri- and postpartum counseling and support to HIV-positive mothers concerning infant feeding options and vertical transmission; on-going nutritional and clinical assessment of exposed infants; replacement feeding support, including limited provision of

infant formula where warranted; and associated counseling and program support through at least the first year of life, per national policies and guidelines.

Please note that "safe water" is NOT included in this definition of food and nutrition. It is addressed separately, in the definition for Water.

Economic Strengthening

Countries should estimate the amount of funding for each activity that is attributable to economic strengthening activities, including:

- Economic Strengthening - The portfolio of strategies and interventions that supply, protect, and/or grow physical, natural, financial, human and social assets. For PEPFAR generally, this refers to programs targeting HIV-infected individuals in care and treatment programs, OVC due to HIV/AIDS, and their caregivers. These activities can include a variety of microfinance, vocational training and/or income generation.

- Microfinance - The range of financial products and services, tailored to meet the needs and demands of low-income or otherwise vulnerable populations. This includes group and individual lending, savings, insurance, and other financial products. Microfinance is distinguished from mainstream finance by its outreach to isolated and poor populations and its efforts to make financial services accessible and approachable to them, in terms of product design and delivery systems.

- Microenterprise - A very small-scale, informally organized business activity undertaken by poor people. Generally refers to enterprises with 10 or fewer workers, including the microentrepreneur and any unpaid family workers; many income generating activities fall into this category.

- Microcredit - A form of lending which involves very small sums of capital targeted towards microentrepreneurs and poor households. Microcredit can take the form of individual or group loans, and have varying terms, interest rates and degrees of formality. Microcredit is a *type* of microfinance.

- Market Development - A fundamental approach to economic development that recognizes and takes advantage of the fact that products and services are most efficiently and sustainably delivered through commercial systems. Market development encompasses more targeted strategies such as microfinance and microenterprise development.

Education

Efforts to promote effective, accountable and sustainable formal and non-formal education systems should be included in this secondary cross-cutting budget attribution.

In particular, activities focused on basic education, which is defined as activities to improve early childhood education, program area education and secondary education delivered in formal or non-formal settings. It includes literacy, numeracy and other basic skills programs for youth and adults. Activities related to life skills training and HIV prevention education within the context of education programs or settings should also be included in this cross-cutting budget attribution. Please see the *Technical Considerations* for what can be included as Education.

Water
Countries should estimate the total amount of funding from their country budgets, not including central funds, which can be attributed to safe water. Activities include support for availability, access, and use of products to treat and properly store drinking water at the household level or other point-of-use, and promotion of hand washing with soap.

Gender: Reducing Violence and Coercion
Activities for "Reducing Violence and Coercion" include:

- Screening and counseling for gender-based violence (GBV) within HIV/AIDS prevention, care, and treatment programs.
- Strengthening referrals from HIV/AIDS services to GBV services and vice-versa.
- Strengthening post-rape care services, including the provision of HIV PEP.
- Interventions aimed at preventing gender-based violence, including interpersonal communication, community mobilization and mass media activities.
- Programs that address societal and community norms that perpetuate violence against women and girls and other marginalized populations; that promote gender equality; and that build conflict resolution skills.
- Strengthening linkages between health, legal, law enforcement, and judicial services and programs to prevent and mitigate gender-based violence.
- Interventions that seek to reduce gender-based violence directed at children and related child protection programs.
- Support for review, revision, and enforcement of laws and for legal services relating to gender-based violence, including strategies to more effectively protect young victims and punish perpetrators.
- Research and program evaluation regarding the associations and interplay between GBV and HIV/AIDS, and HIV/AIDS services.

Key Issues

S/GAC uses these Key Issues tick boxes in responding to both Congressional and media inquiries and therefore it is critically important that they reflect the field reality as closely as possible.

You should ensure that each selection is justifiable according to the definition and that you would be able to support each selection in the event of an audit.

Definitions

For **each implementing mechanism**, countries must identify if programming has a component in one of the key issue areas defined below:

Health-Related Wraparounds: A wraparound activity wraps or links together PEPFAR programs with those from other health sectors to provide comprehensive program support and improve the quality of life to HIV/AIDS-affected and -infected communities and is a major focus of GHI. Wraparounds leverage resources, both human and financial, from entities with different funding sources in order to complement PEPFAR goals and maximize the effectiveness of programs. Wraparound activities may include other programs funded by the USG (e.g., USAID Development Assistance), the Global Fund, the UN (World Food Program, UNICEF, etc.), the private sector, or other partners. In general, wraparound activities are supported with a mix of funds, primarily from sources other than PEPFAR. However, wraparound activities that directly serve PEPFAR priority populations by supporting the prevention, treatment, or care of HIV/AIDS, and are in keeping with other PEPFAR guidance, may be supported with PEPFAR funds. In many cases the other sources of funding are used to provide the platform and PEPFAR funds are used to support those activities with our priority populations. In other cases, PEPFAR provides the platform (e.g. home-based care infrastructure) for wraparounds, such as delivery of bednets through the President's Malaria Initiative (PMI), immunizations, or medications for neglected tropical diseases.

- **Child Survival Activities**: The goal of child survival activities is to support the availability and use of proven life-saving interventions that address the major killers of children and improve their health status. Examples of wraparound services include care, routine immunization, polio eradication, safe water and hygiene, micronutrients, growth monitoring, improved infant and young child feeding, and treatment of life-threatening childhood illnesses.

- **Family Planning:** PEPFAR is a strong supporter of linkages between HIV/AIDS and voluntary family planning and reproductive health programs. 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 programs can work to expand access to family planning/reproductive health services through wraparound programming, i.e., providing counseling and referrals (linkages) to family planning programs for women and men in HIV/AIDS prevention, treatment, and care programs – ideally at the same site; providing family planning clients with HIV prevention including HIV testing and counseling, particularly in areas with high HIV prevalence and strong voluntary family planning systems – again, ideally at the same site; integrating family planning

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

- **Malaria:** Strengthening the interface between PEPFAR and PMI mutually benefits both programs and expands the platform of services to target populations. The goal of PMI is to strengthen malaria control programs and malaria research activities to reduce malaria-related mortality. Development of effective malaria vaccines, new malaria treatment drugs, and targeted operations research are key interventions that would also fall under this emphasis area. Relative to HIV, this would include wraparound activities that target people living with HIV/AIDS and OVC for malaria services.

- **Safe Motherhood:** The goal of safe motherhood programs is to reduce maternal mortality and disability by following a continuum of care through the postpartum period. Wraparound activities would support efforts such as improving pre- and postnatal care services with PMTCT programs to help improve maternal and child health outcomes. Wraparounds could also support facility-based and outreach services to improve the quality and equitable coverage of antenatal care, especially as PMTCT services are taken to scale. Delivery and postpartum care services, including periodic evaluation of the progress of pregnancy, labor support and active management of the third stage of labor, should be addressed in all PMTCT programming through such wraparound approaches.

- **TB:** The goal is to reduce the number of deaths caused by TB by increasing detection of cases of TB, and by successfully treating detected cases, as well as addressing issues of multi-drug resistant TB, TB/HIV, and investing in new tools for TB. In addition, if GHCS-USAID TB funds are being leveraged for this implementing mechanism, TB should be marked.

Gender: While there is one gender strategy assigned as a cross-cutting attribution (see above), the other four gender strategies should be captured through the key issue area:

- 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: This measurement uses quantitative and/or qualitative scientific methods and informs improvements in service delivery by measuring the effectiveness, efficiency, and/or quality of services that are delivered by a project. It may be conducted at specific times or throughout the life of a project.

Mobile Populations: Can include migrant workers, truck drivers, refugees/ internally displaced persons and professionals working in locations at a distance from their families among other groups as defined by country context and epidemiology.

Military Populations: Include Army, Navy, Air Force, Coast Guard, Peacekeepers, their families, employees and surrounding community using the military services.

Workplace Programs: Activities that encourage private business, public employers, unions, and professional associations (teachers, farmers, fishermen, coffee growers, etc.) to provide HIV/AIDS care, treatment and prevention for their members, employees and family members.

Appendix 7: Small Grant Program

Beginning in FY 2005, program funds were made available for all PEPFAR countries and regional programs that follow the criteria and reporting requirements listed below to support the development of small, local partners. The program is known as the PEPFAR Small Grants Program, and replaces the Ambassador's Self-Help Funds program for those activities addressing HIV/AIDS.

Country and regional programs should submit an entry for the PEPFAR Small Grants Program as part of their yearly operational plan (COP or F OP). The total dollar amount of PEPFAR funds that can be dedicated to this program should not exceed $300,000 or 5% of the country allocation, whichever is the lower amount. This amount includes all costs associated with the program, including support and overhead to an institutional contract to oversee grant management if that is the preferred implementing mechanism.

Proposed Parameters and Application Process

Eligibility Criteria

- Any awardee must be an entirely local group.
- Awardees must reflect an emphasis on community-based groups, faith-based organizations and groups of persons living with HIV/AIDS.

- Small Grants Program funds should be allocated toward HIV prevention, care and support or capacity building. They should not be used for direct costs of treatment.

Accountability

- Programs must have definable objectives that contribute to HIV/AIDS prevention, care and/or (indirectly) treatment.
- Objectives must be measurable.
- These will normally be one-time grants. Renewals are permitted only where the grants show significant quantifiable contributions toward meeting country targets.

Submission and Reporting

- Funds for the program should be included in the COP under the appropriate budget category.
- Individual awards are not to exceed $50,000 per organization per year; the approximate number of grants and dollar amount per grant should be included in the narrative. Grants should normally be in the range of $5,000 - $25,000. In a few cases, some grants may be funded at up to the $50,000 level for stronger applicants. The labor-intensive management requirements of administering each award should be taken into account.
- Once individual awards are made, the country or regional program will notify their core or regional team leader of which partners are awarded and at what funding level. This information will be added in the sub-partner field for that activity.
- Successes and results from the Small Grants Program award should be included in the Annual Program Results and Semi-Annual Program Results due to S/GAC. These results should be listed as a line item, like all other COP activities, including a list of partners funded with the appropriate partner designation.

Appendix 8: Strategic Staffing

Operating Unit teams should ensure that all management, operations, and staffing decisions are based on meeting PEPFAR programmatic goals, given legislative and budget constraints, rather than agency-specific needs driving organization decisions. Staffing exercises should minimize duplicative efforts, maximize interaction with Embassy and agency management support offices, and follow rightsizing and good position management principles. OU teams should be working in a complementary, non-redundant fashion (e.g. all technical staff working as a team, shared team

responsibility for the entire USG program rather than just one agency's portfolio, new technical staffing needs considered by the team rather than just one agency, etc.).

Position Management

Position management is a systematic approach for determining the number of positions needed, the grouping and duties among positions, and the required knowledge, skills, and abilities of all positions.

Good position management ensures managers can adjust positions and organization structures to meet local conditions, the mission can be accomplished effectively, the available labor market can be used effectively to staff the mission, employees can use their full capabilities, and employee morale and motivation can improve. The characteristics of sound position management are:

- A logical balance exists between employees needed to carry out the major functions of the organization and those needed to provide adequate support.
- Employees understand the mission and responsibilities of the organization.
- The organization is designed to effectively utilize and develop capabilities its employees.
- Lines of authority are clear from the top to the bottom of the organization.
- Responsibility is coupled with corresponding authority.
- The number of levels of authority is kept at a minimum.

Agency human resources offices are available to help OU teams implement good position management. For more information, please see the Fast Fact I - Position Management and training video on position management available on the PEPFAR Extranet Human Resources page: https://www.pepfar.net/C15/C9/Human%20Resources%20Issues/default.aspx:

Engagement and Support of Host Country Nationals (HCNs)

The recruitment, retention, and empowerment of Host Country Nationals (HCNs), formerly known as Locally Employed staff (LE Staff), are crucial to accomplishing our goals; approximately 75% of our field-based workforce is local. OU teams should look for opportunities to train, engage, and empower HCN/LE Staff. Good practices include promoting additional leadership roles, such as naming HCN/LE Staff to be TWG chairs, creating an interagency HCN/LE Staff advisory council for PEPFAR in country, and providing training and international travel opportunities.

Compensation and position grades often are identified as key obstacles to recruiting and retaining HCNs. The PEPFAR Interagency Working Group on Issues Affecting HCN (HCN WG) continues its efforts to assist teams in addressing such issues. The group

includes headquarters and field staff from State, USAID, CDC, and DoD who have programmatic, management, and human resources expertise and are available to assist and advise OU teams. The HCN WG has created a number of tools to help OU teams, including Framework Job Descriptions (FJDs) HCN positions. FJDs are standardized position descriptions for common PEPFAR HCN positions that can help supervisors to (1) describe new positions more accurately, (2) update and reclassify previously established positions, and (3) complete the required classification paperwork (including the local position description and Job Discussion Help Sheet). The overall goal is to ensure all positions working under PEPFAR are properly classified. The FJDs cover specific duties and responsibilities of the more common PEPFAR-funded positions. They allow for flexibility to make the job more mission-specific (80% is predetermined; 20% is post specific). The FJDs can be used "as is" or as guides for local positions. As of July 25, 2011, 22 FJDs have been approved for senior- and mid-level technical, management, and administrative LE Staff positions.

The HCN WG also has created 14 "fast facts" (1-2 page desktop references) and 9 training videos on important topics. Those resources, and others, are available on the Extranet Human Resources page at: https://www.pepfar.net/C15/C9/Human%20Resources%20Issues/default.aspx. OU teams can contact work group chair Sara Allinder for more information (sara.allinder@gmail.com).

In addition, it is important that OU teams submit data on HCN recruitment and retention challenges related to compensation in the mission's annual compensation questionnaire, which is distributed in the spring of each year.

Coordination with Embassy and Agency Management Teams

PEPFAR programmatic staff should consult with non-program offices, such as human resources, management, and general services/procurement, to ensure sufficient support to facilitate PEPFAR activities. Teams should ensure the accuracy of agency workload counts when provided to the ICASS Council in April each year and consult with financial management staff to project ICASS charges for each fiscal year based on the previous year's workload. Operating Unit teams should look for creative solutions to challenging management burden issues without creating duplicative positions or processes.

On May 14, 2009, the State Department issued a cable to all Chiefs of Missions (COM) advising them to "ensure all elements under their authority establish and maintain consolidated support platforms under the International Cooperative Administrative Support Services (ICASS) program. No Executive Branch agencies or sub-agencies with

staffs operating under COM authority, including State elements, should plan to establish new administrative systems or expand existing support operations outside of the ICASS framework, nor should COMs allow them to do so." Operating Unit teams should ensure that management support positions are not duplicated during FY 2012 COP planning.

In addition, OU teams should work in concert with agency acquisition and assistance (A&A) staff, as appropriate, when considering any changes to existing contracts or awards and in the planning of new procurements for the upcoming fiscal year. The agency A&A staff can advise on legal, policy, and procedures that must be followed. It is also important to consult with A&A staff from a workload perspective. Consulting with A&A teams early in the process allows them to plan for workload burden during the fiscal year. The same is true for Human Resources and other management support staff.

Hiring PEPFAR Coordinators

A standardized position description (PD) for the interagency PEPFAR Coordinator position with defined roles and responsibilities was approved in April 2008 and can be found at: https://www.pepfar.net/C15/C9/Human%20Resources%20Issues/default.aspx or through your Country Support Team Lead (CSTL). The PD should be used when recruiting new Country Coordinators. A key element of the PD is the delegation of day-to-day supervisory authority and performance review to the Ambassador or the DCM. Example PDs incorporating the roles and responsibilities have been developed by several OU teams and are posted on the PEPFAR Extranet.

There are several options for hiring in-country PEPFAR Coordinators:

- **U.S. Citizen Direct Hires (USDH).** Obtaining an FTE position for a country PEPFAR Coordinator is often challenging. State positions are exceptionally rare, as are those from agencies such as HHS and USAID. We expect this option will only be available in exceptional circumstances. S/GAC is unable to offer USDH FTE slots for this purpose.

- **Local Hire Contractors (PSAs).** To hire a Coordinator locally (Americans resident in country only) the preferred mechanism is State's PSA authority.

- **U.S. Based Personal Services Contractors (US PSCs).** The most common means is to recruit U.S. citizens as PSCs through USAID or CDC with the understanding that the agency hiring mechanism is for administrative purposes only and that day-to-day in-country supervision of the position will be exercised by the Ambassador or the DCM.

Regardless of which agency hires or contracts with the individual, the position will report to the Chief of Mission and coordinate the interagency PEPFAR team.

If the agency hiring the PEPFAR Country Coordinator is not State, an MOU between the agency and State must be completed to designate the Ambassador or DCM as the day-to-day supervisor. There is an existing MOU between USAID and State to cover Coordinators hired using USAID's PSC mechanism.

Appendix 9: Operating Unit Team Staffing Data and Agency Information – Additional Resources

Staffing Tools Overview

As a part of the COP, OU teams are asked to update their staffing data annually within the FACTS Info PEPFAR Module (pre-populated with the latest available staffing data).

The purpose of the staffing tool is to assist each OU team with strategic staffing – during the COP planning process and throughout the year – by organizing and managing the demographic information and expertise of each team member working at least part of his/her time on PEPFAR. The information should assist each OU team in assessing their current and proposed PEPFAR staff, from interagency and functional perspectives and for the purposes of program design and oversight. See the section on Position Management in Appendix 8.

The annual revision of staffing data should support each USG agency in ensuring that sufficient staff is in place for effective fiscal management and ensure that better information on staffing composition and needs is communicated to headquarters as part of the COP. Staffing data should be integral to COP planning and reporting, staff planning, and position and program management. In both management and technical areas, review of staffing data by USG agency may help to identify gaps and areas of overlap, as well as support Chiefs of Mission in managing the PEPFAR team while engaging in agency headquarters-driven management exercises such as "rightsizing" and "managing to budget."

Whom to Include in the Database

The database should include all U.S. government (USG) employees hired via direct-hire, personnel services contract (PSC), and personal services agreement (PSA) hiring authorities, as well as individuals employed by non-personal contractors (also known as commercial, third party, or institutional contractors). USG employees include U.S.-based direct hires and PSCs, locally employed direct-hires, PSCs, and PSAs (including

locally-recruited Eligible Family Members and Foreign Service Nationals). U.S. law does not consider Peace Corps' PSCs to be USG employees; however, all Peace Corps staff should be included in the staffing data. Peace Corps Volunteers are NOT USG employees or staff and should NOT be included in the staffing data.

Please include in the database:

1. Any partially or fully PEPFAR-funded (i.e. GHCS, GAP, or other PEPFAR fund accounts) positions (program or non-program);
2. All staff whose PEPFAR percentage of time is combined to equal one FTE; and
3. Any *remaining* non-PEPFAR-funded (i.e. agency core funds) program position in which the incumbent is expected to work at least 30% of his/her average annual time on PEPFAR.

Program staff : Those who work directly on PEPFAR programs or who provide leadership, technical, and/or management support for PEPFAR and program staff. Program staff includes the Ambassador, DCM, Mission Director, CDC Chief of Party, legal, contracts, financial, and Public Affairs/Public Diplomacy staff. Administrative staff who provide direct support to the program team also should be included.

Non-Program staff: Those who provide valuable administrative support to the PEPFAR team, including travel staff, drivers, and gardeners, but not direct program support.

Aggregate Entries: OU teams have the option of including in the database an aggregate entry for program staff who individually contribute less than 30% of their average time on PEPFAR, but are one of the same position who in aggregate work 30% or more. In order to aggregate staff into one entry, the positions must have the same answer for "Funding Agency," "Agency Position Title," "Type of Position," "Employment Citizenship," "Employment Type," "Funding Type, "Schedule," and "Location." Enter the number of staff included in the entry in the "Number of Individuals" data field. In the "% Time Devoted to PEPFAR by Each Individual" data field, enter the aggregate amount of time that the positions spend working on PEPFAR annually. See more information on the data fields below.

Inclusion of non-PEPFAR-funded and non-program staff: While optional, you may also elect to include non-PEPFAR funded program or non-program staff in the database. However, do not include any staff that work on PEPFAR on a temporary or seasonal basis, such as during the COP season. Do not include those working in ICASS-funded offices (e.g. motorpool, GSO, FMO, EX, HR, etc.); staff working in ICASS offices and paid by ICASS contributions should be removed from the staffing data.

Inclusion of Global Fund Liaisons: As in past years, Global Fund Liaison positions (whether centrally-funded or cost-share) should be included in Staff Information. For centrally-funded Liaisons, enter the record into the staffing database as "Non-PEPFAR Funded" (i.e. centrally or non-COP funded). As Missions pick up the funding of the

Liaison position (full or cost share), enter the record as "PEPFAR Funded," or "Partially PEPFAR Funded" as relevant.

As a part of the cleaning and review process, HQ will review the submission to ensure that positions are actually marked as non-PEPFAR funded where appropriate to avoid skewing staffing analysis. If and when a Mission picks up the position – it can then be marked as either partially or fully PEPFAR-funded.

All staff that are partially or fully funded by PEPFAR should be included in the database. This includes all previously agency-appropriations-funded (e.g. OE) staff who will be funded by PEPFAR program funds in FY 2012. Each position's entry should reflect the amount of time spent working on PEPFAR and whether the position is partially or fully PEPFAR funded. The funded costs for all positions should be reflected in the USG Salaries and Benefits CODB category budget entry for direct hire, PSC, and PSA staff, and in the Institutional Contractors CODB budget entry for non-PSC/PSAs.

Staff Information Instructions

Enter staff demographic information in the following fields (data field definitions are included below):

Operating Unit: This field is important for analysis across countries. The appropriate OU will be pre-populated by the system.

Number of Individuals: Captures the number of staff represented by the entry (typically a value of one). However, if you have aggregated several staff who together work 30% or more of their time on PEPFAR into one entry, please enter the number of staff included in the entry in the Number of Individuals field.

Time Devoted to PEPFAR by Each Individual: Refers to the annual staff time the person in the position spends on PEPFAR (10-100%). This is one of the key fields in determining the position's FTE. Enter the average percentage (10-100%) in the data field. If you have aggregated several staff, please enter the average percentage each person spends on PEPFAR (e.g. enter 10% if all three drivers devote this amount of time to PEPFAR).

Staffing Status: Refers to whether a position is currently staffed or not. Select whether the position is Filled, Vacant (previously approved in COP 2011 or prior), or Planned (new request for COP 2012):

- Filled refers to currently encumbered positions;
- Vacant refers to positions that have been previously approved in a COP, but are currently empty; or

- Planned (new requests) refers to positions that are new for COP 2012 and have not been approved in previous COPs. All new planned positions will need to have a new staff justification narrative completed.

Last Name: If desired and the position is filled, enter the staff member's last name. *If there are multiple positions included in one entry, enter "multiple" in the last name field.*

First Name: If desired and the position is filled, enter the staff member's first name. *If there are multiple positions included in one entry, enter the positions' title in the first name field.*

Funding Agency: Select the agency the staff person is employed by from the drop-down menu. For contractors, select the agency that supports the position.

Agency Position Title: OU teams should use a detailed functional title appropriate for each position or use official titles. For example, "Senior Technical Advisor for PMTCT" or "M&E Advisor," or "Management and Program Analyst" and "Public Health Advisor." Teams should be as specific and consistent as possible in their titling methodology.

Type of Position: This field includes five categories that have been condensed from previous years. Select the type of position from the following list:

a. **Technical Leadership/Management** includes positions that head up the health/HIV team within the agency; e.g., Health Officer, CDC Chief of Party, and Deputy. This could be the head of the agency (as is usually the case with CDC) or could be someone who oversees all USG health activities and spends only part of the time on the Emergency Plan (for example the head of the PHN Office under USAID). A U.S. Direct Hire Foreign Service officer filling an HIV/AIDS advisor position and thereby leading an HIV/AIDS team would also be placed in this category.
b. **Technical and Programmatic Oversight and Support** includes the technical staff within the health/HIV team who spend most of their time implementing or managing programs in technical areas, including Agreement Officer Technical Representatives (AOTRs), Project Officers (POs), and Public Health Advisors. Please also include here any entry and mid-level staff providing direct public health programmatic activities in this category (this is most relevant for CDC staff). Programmatic support positions within the health/HIV team or non-health/non-HIV staff who provide support to the health/HIV team not captured in another category (e.g. Education, Reproductive Health, TB, Food & Nutrition) are also included in this category.
c. **Contracting/Financial/Legal** includes acquisition (contracts) and assistance (grants and cooperative agreements) officers and specialists and

their support staff. A contracting officer represents the U.S. Government through the exercise of his/her delegated authority to enter into, administer, and/or terminate contracts, grants, and cooperative agreements, and make related determinations and findings. Contracting officers and specialists usually support an entire agency in country or will support an entire regional portfolio. If an agency utilizes the contracting officer services of another agency, include the position only in the contractor's home agency. This category also includes the financial management officer or specialist for the agency. These staff members support financial and budget analysis and financial operations functions. Legal includes any staff who provide legal advice and support to PEPFAR.

d. **Administrative and Logistics Support** includes any secretarial, administrative, drivers, and other support positions.
e. **US Mission Leadership and Public Affairs/Public Diplomacy** (PA/PD) include any non-health/HIV staff who provide management and leadership support to PEPFAR, such as the Ambassador, Deputy Chief of Mission, USAID Mission Director, or Political or Economic Officers, and any PA/PD staff.

Employee Citizenship: Select the citizenship of the staff member:

a. **US-based American citizen:** Direct hire or PSCs hired in the U.S. for service overseas, often on rotational tours. They are paid on the U.S. Foreign Service or Civil Service pay scale or compensated in accordance with either scale. The USG has a legal obligation to repatriate them at the end of their USG employment to either their country of citizenship or to the country from which they were recruited.
b. **Locally Resident American Citizen:** Ordinarily resident U.S. citizens who are legal residents of a host country with work permits. USG agencies recruit and employ them as Locally Employed Staff (LE Staff) under Chief of Mission (COM) authority at Foreign Service (FS) posts abroad often as PSAs. They are compensated in accordance with the employing post's Local Compensation Plan (LCP).
c. **Host Country National (or legal permanent resident):** Citizens of the host country or ordinarily resident foreign nationals who are legal residents of the host country and hold work permits. They are employed as LE Staff at FS posts abroad and compensated in accordance with the LCP of the employing post.
d. **Third Country Citizen:** Foreign Service Nationals (FSNs) who are recruited from a foreign country other than where they are employed with whom the USG has a legal obligation to repatriate them at the end of their USG employment to either their country of citizenship, or to the country from which they were recruited.

Employment Type refers to the hiring authority by which the staff member is employed or engaged:

a. **Direct Hire:** A U.S. government position (AKA billet, slot, ceiling, etc.) authorized for filling by a Federal employee appointed under USG personnel employment authority. A civilian direct-hire position generally requires the controlling agency to allocate an FTE resource.
b. **Personal Services Contractor (PSC**): An individual hired through USG contracting authority that generally establishes an employer/employee relationship. Peace Corps uses PSCs to obtain services from individuals.
c. **Personal Services Agreement (PSA):** An individual hired through specialized Department of State contracting authority that establishes an employer/employee relationship.
d. **Non-Personal Services Contractor (non-PSC/PSA):** An individual engaged through another contracting mechanism by a non-USG organization that does not establish an employer/employee relationship with the U.S. Government.

Funding Type: Select the appropriate choice for the position:

a. **PEPFAR Funded:** Any position funded by GHCS-State, GHCS-USAID, GAP, or other PEPFAR fund accounts.
b. **Partially PEPFAR Funded:** Any position partially funded by GHCS-State, GHCS-USAID, GAP, or other PEPFAR fund accounts.
c. **Non-PEPFAR Funded:** Any position funded by agency core (State, Defense, and Peace Corps positions; CDC and USAID positions should be partially or fully PEPFAR funded).

Schedule: Refers to whether the position is a full-time or part-time position. It does NOT refer to how much time the position spends working on PEPFAR. Do not include any staff who works on PEPFAR on a temporary or seasonal basis, such as during the COP season.

a. **Full-time:** Considered to be ≥ 32 hours/week for FTE calculations.
b. **Part-time:** Considered to be <32 hours/week for FTE calculations.

Note: The FTE box will auto-calculate the full time equivalent (FTE) of the staff's overall time based on:

- Full-time (= 1) vs. Part-time (= .5),
- % Time Devote to PEPFAR by Each Individual (10% = 0.1; 100% = 1).

Comments: OU teams are required to provide additional details for specific vacant or planned records (Justify Vacant and Proposed New Positions). For existing positions, OU teams may opt to add comments on an individual position that will aid in institutional memory for the team.

AGENCY COSTS OF DOING BUSINESS

The purpose of the Agency CODB section is to provide detailed budgetary information for each implementing agency working in country in order to better quantify specific costs to PEPFAR stakeholders. Additionally, this section includes narrative information for important costs categories to better assess the costs of doing PEPFAR business across OUs and across agencies.

If there is any funding requested for the following CODB categories, then you must complete the "Item Description" field associated with the category and planned amount. The narratives should be no more than 500 characters.

- **Non-ICASS Administrative Costs:** Please provide a detailed cost breakout of the items included in this category and their associated planned funding (e.g. $1,000 for printing, $1,000 for supplies). If a vehicle is necessary to the implementation of the PEPFAR program and will be used solely for that purpose, purchase or lease information needs to be justified and dollar amount specified.

- **Institutional Contractors:** Describe the institutational contractor (IC) activities and why these activities will be conducted by an IC rather than a U.S. Direct hire or PSC/PSA. Where possible, please provide the contracting company name and the technical area(s) which the IC(s) will support.

Once you have completed the steps for one agency, please repeat for all other agencies working in country.

There are ten USG CODB categories. The following list of CODB categories provides category definitions and supporting guidance:

i. **USG Staff (Direct Hire, Personal Services Contractor [PSC], Personal Services Agreement [PSA]) Salaries and Benefits:** The required costs of having a person in country, including housing costs not covered by ICASS, rest and relaxation (R&R) travel, relocation travel, home leave, and shipping household goods. This category includes the costs associated with technical, administrative, and other staff.

   a. PEPFAR program funds should be used to support the percentage of a staff person's salary and benefits associated with the percentage of time they work on PEPFAR. The direct costs of PEPFAR, specifically the costs of staff time spent on PEPFAR, need to be paid for by PEPFAR funding (e.g. GHCS, GAP). For example, if a staff person works 70% on PEPFAR, PEPFAR program funds should fund 70% of that person's salary and benefits. If the percentage worked on PEPFAR is 10%, then PEPFAR funds should fund 10% of the person's salary and benefits.

b. For agencies that cannot split-fund staff with their agency appropriations (such as USAID's OE funds), multiple staff may be combined to form one FTE and one of the staff's full salary and benefits will be funded by PEPFAR. For example, if two staff each work 50% on PEPFAR, PEPFAR funds should be used to fund the salary and benefits of one of the positions. If three staff each work a third of their time on PEPFAR (33% + 33% + 33%), PEPFAR funds should be used to fund the salary and benefits of one of the positions. If multiple staff work on PEPFAR but not equally (such as 10% + 20% + 70% or 25% + 75%), the full salary and benefits of the person who works the most on PEPFAR (in the examples, either 70% or 75%) should be funded by PEPFAR. This split should be reflected in the staffing data.
c. If the agency is paying for host country citizen fellowships and is going to only train the fellows, then the funding can remain in an implementing mechanism. If the agency is going to be getting a work product from the fellows, then this cost should be counted in M&O. Similarly, if agencies are paying for trainers who are USG staff, then the costs associated with these staff should be reflected within M&O. If the mechanism is paying for the materials and costs of hosting training, then the funding should be reflected in an implementing mechanism.

ii. **Staff Program Support Travel:** The discretionary costs of staff travel to support PEPFAR implementation and management does NOT include required relocation and R&R travel (those are included in USG Salaries and Benefits). This category includes the costs associated with technical staff travel and travel costs associated with the provision of technical assistance. All costs associated with technical staff time should be reflect within M&O; other TA funding (e.g. materials) should be reflected in an implementing mechanism

In FY 2012, technical assistance-related travel costs of HHS/CDC HQ staff for trips of less than 3 weeks will be included in the PEPFAR Headquarters Operational Plan (HOP) and funded centrally. Under this model, costs for short-duration technical assistance travel by HHS/CDC staff should not be included in the countries' COPs.

iii. **ICASS (International Cooperative Administrative Support Services):**

a. ICASS is the system used in Embassies to:
    i. Provide shared common administrative support services; and
    ii. Equitably distribute the cost of services to agencies.
b. ICASS charges represent the cost to supply common administrative services such as human resources, financial management, general services, and other support, supplies, equipment, and vehicles. It is a generally a required cost for all agencies operating in country.

c. Each year, customer agencies and the service providers present in country update and sign the ICASS service "contract." The service contract reflects the projected workload burden of the customer agency on the service provision for the upcoming fiscal year. The workload assessment is generally done in April of each year. PEPFAR OU teams should ensure that every agency's workload includes all approved PEPFAR positions.
    - ***i.*** ICASS services are comprised of required cost centers and optional cost centers. Each agency must sign up for the required cost centers and has the option to sign up for any of the optional cost centers.
    - ***ii.*** More information is available at http://www.state.gov/m/a/dir/regs/fah/c23257.htm.

d. ICASS charges must be planned and funded within the country/regional budget (COP). However, ICASS costs are typically paid by agency headquarters on behalf of the OU team from their budgeted funding. Each implementing agency, including State, should request funding for PEPFAR-related ICASS costs within its M&O budget.
    - ***i.*** It is important to coordinate this budget request with the Embassy Financial Management Officer, who can estimate FY 2012 anticipated ICASS costs. This FY 2012 ICASS cost estimate, by agency, should then be included as the planned ICASS funding.
    - ***ii.*** It is important to request all funding for State ICASS costs in the original COP submission, as it is difficult to shift funds at a later date.
    - ***iii.*** The Peace Corps subscribes to minimal ICASS services at post. Most GSO and all financial management work (except FSC disbursing) are carried out by Peace Corps field and HQ staff. In order to capture the associated expenses, Peace Corps will capture these costs within the indirect cost rate.

iv. **Non-ICASS Administrative Costs:** These are the direct charges to agencies for agency-specific items and services that are easy to price, mutually agreed to, and outside of the ICASS MOU for services. Such costs include rent/leases of USG-occupied office space, vehicles, shipping, printing, telephone, driver overtime, security, supplies, and mission-levied head taxes.

In addition to the budget data field, an "Item Description" field will be included for the agency to describe which costs are included in their figure, including a dollar amount breakout by each cost category (e.g. $1,000 for printing, $1,000 for supplies). If a vehicle is necessary to the implementation of the PEPFAR program and will be used solely for that purpose, purchase or lease information needs to be justified and dollar amount specified.

v. **CSCS (Capital Security Cost Sharing):** Non-State Department agencies should include funding for CSCS, except where this is paid by the headquarters agency (e.g. USAID).

a. The CSCS program requires all agencies with personnel overseas subject to Chief of Mission authority to provide funding in advance for their share of the cost of providing new, safe, secure diplomatic facilities (1) on the basis of the total overseas presence of each agency and (2) as determined annually by the Secretary of State in consultation with such agency.
b. It provides steady funding annually for multiple years to fund 150 secure New Embassy Compounds in the Capital Security Construction Program.
c. More information is available at http://www.state.gov/obo/c30683.htm.
d. OU teams should consult with agency headquarters for the appropriate amount to budget for in the COP.

vi. **Computers/IT Services:** Funding attributed to this category includes USAID's IRM tax and other agency computer fees not included in ICASS payments. If IT support is calculated as a head tax by agencies, the calculation should transparently reflect the number of FTEs multiplied by the amount of the head tax.

a. CDC should include the ITSO (IT support) charges on HIV-program-funded positions; these costs will be calculated at CDC HQ and communicated to OU teams for inclusion in the CODB.
b. USAID should include the IRM tax on HIV-program-funded positions.

vii. **Management Meetings/Professional Development:** Discretionary costs of OU team meetings to support PEPFAR management and of providing training and professional development opportunities to staff. Please note that costs of technical meetings should be included in the relevant technical program area.

viii. **USG Renovation:**

a. OU teams should budget for and include costs associated with renovation of buildings owned/occupied by USG PEPFAR personnel.
b. In addition to the budget information, OU teams must provide a M&O narrative to describe the requested project, timeline, and justification (above).
c. Costs for projects built on behalf of or by the partner government or other partners should be budgeted for and described as Implementing Mechanisms (see Section 9 of the COP Guidance).

ix. **Institutional Contractors (non-PSC/non-PSA):**

a. Institutional and non-personal services contractors/agreements (non-PSC/non-PSA) includes organizations such as IAP Worldwide Services, COMFORCE, and all other contractors that do NOT have an employee-employer relationship with the USG.

b. All institutional contractors providing M&O support to the OU team should be entered in M&O, not as an Implementing Mechanism template.
c. In addition to the budget information, OU teams must provide a narrative to describe institutional contractor activities (above).
d. Costs associated with this category will be attributed to the appropriate technical program area within the FACTS Info PEPFAR Module.

x. **Peace Corps Volunteer Costs (including training and support):**

a. Includes costs associated with Peace Corps Volunteers (PCV) and Peace Corps Response Volunteers arriving at post between April 2012 and March 2013.
    i. The costs included in this category are direct PCV costs, pre-service training, in-service training, medical support and safety and security support.
    ii. The costs excluded from this category are: USG staff salaries and benefits, staff travel, and other office costs such as non-ICASS administrative and computer costs, which are entered as separate CODB categories. Also excluded are activities that benefit the community directly, such as VAST grants or training events where the number of HCNs is greater than the number of PCVs participating. These types of activities should be entered directly into the appropriate program area budget code in an Implementing Mechanism template.
b. Funding for PCVs must cover the full 27-month period of service. For example:
    iii. Volunteers arriving in June 2012 will have expenses in FY 2012, FY 2013, and FY 2014.
    iv. Volunteers arriving in September 2012 will have expenses in FY 2012, FY 2013, FY 2014, and FY 2015.
c. PCV services are not contracted or outsourced. Costs are incurred before and throughout the Volunteer's 27-month period of service. Starting in FY 2010, costs incurred by Peace Corps Washington and domestic offices, such as recruitment, placement and medical screening of Volunteers, will be included in the Headquarters Operational Plan (HOP). Costs such as living allowance, training and support will continue to be included in the COP.

Inclusion of Global Fund Liaison Costs (where applicable): For Global Fund Liaison positions that remain centrally-funded at this time, the funding should not be included in the CODB. As Missions pick up the funding of the Liaison position (full or cost share), the percentage of the position which is PEPFAR funded should be reflected in the COP and allocated to the above CODB categories.

Attribution of CODB to Technical Areas

In an effort to allow OU teams to attribute select CODB across technical program areas proportionate to staff working in those areas, the FACTS Info PEPFAR Module will attribute USG Staff Salaries and Benefits, Program Travel, and Peace Corps Volunteer costs to the relevant technical area budgets.

- For USG Staff Salaries and Benefits and Staff Program Travel, OU teams will update their staffing data and enter the top-line budget amount for each category, by fund account. Based on the calculated budget code FTE, a portion of the top-line budget amount will be attributed to relevant budget codes and to the M&O funding amounts.

- For Institutional Contractors, OU teams will enter the budget code planned funding amount for the appropriate technical areas, by fund account - i.e. the area(s) for which institutional contractors are providing personnel support on behalf of the USG.

- For Peace Corps Volunteers in COP 2012, OU teams should attribute all PCV funding to Management and Operations (budget code HVMS).

OU teams must budget for their FY 2012 estimated CODB by USG agency and by funding source in the country/regional (COP/ROP) budget. OU teams may update these costs as appropriate during opportunities to make updates to their operational plan. OU teams should work with their Financial Management Officer, Executive Officer, Budget Officer, and/or other local administrative staff to develop the M&O budget, and should consult with the appropriate agency contacts regarding the availability of prior year M&O pipeline (unexpended funds) to support management and staffing costs.

Country Team Functional and Agency Management Charts

OU teams are asked to submit charts reflecting the functional and management structures of the country team. The *functional staff chart* and *agency management charts* should be uploaded as required supporting documents to the FY 2012 COP, though he functional chart is not required of smaller country teams that do not have TWGs.

The functional staffing chart and agency management charts are not intended to replace or duplicate existing agency organizational charts depicting formal reporting relationships or existing administrative relationships between staff within agencies.

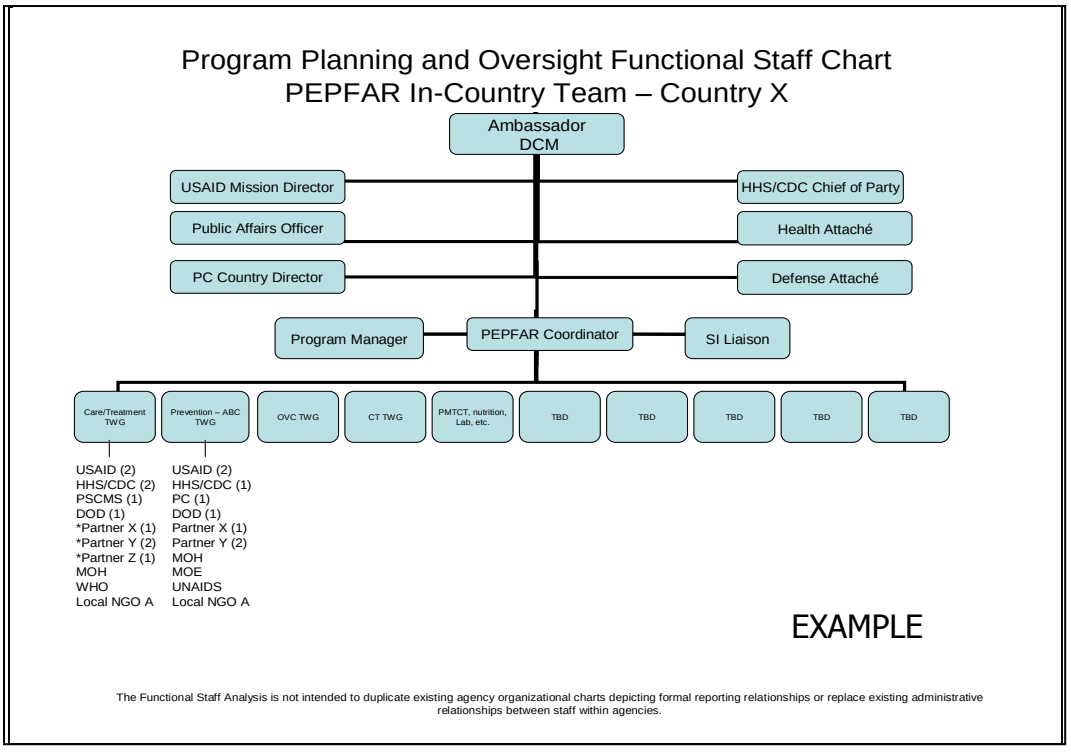
Functional Staff Chart

The "Program Planning and Oversight Functional Staff Chart" should reflect the PEPFAR OU team's leadership and TWG organization. Only leadership position and TWG titles should be included; **do not include names of persons.**

Teams should chart as appropriate to reflect any organizational changes made to assist FY 2012 program implementation and management.

If creating a new chart, the following template may be used. To complete the chart:

- Edit the leadership boxes to reflect the positions that are currently occupied. Add "(vacant)" next to any leadership positions that are currently vacant.
- List in the TWG boxes all of the TWGs present in country. The TWGs represented should reflect what the PEPFAR team uses for its internal PEPFAR/COP planning, NOT any group of partners chaired by the host government.
- For each TWG, list each USG agency and USG-funded partner (if any) and the number of staff members from each that participate in the TWG.
- For each TWG, also list non-USG-funded partners (if any) that participate in the USG TWG; it is not necessary to list the number of staff members for these entities.
- Please note that this chart is illustrative, as each OU team has a different composition. Please adjust the table to reflect your current reality.
- In addition, please also note perceived gaps.



Agency Management Chart

Along with the functional staff chart, OU teams should also submit copies of each agency's existing country organizational chart that demonstrates the reporting structure within the agency. If not already indicated on those charts, please highlight the management positions within the agency organizations. One chart should be uploaded per each USG agency operating in country.