The President's Emergency Plan for AIDS Relief

FY 2013

COUNTRY OPERATIONAL PLAN GUIDANCE APPENDICES

October 12, 2012

Version 2

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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 - The Office of U.S. Foreign Assistance Resources

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 their 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 2013 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. 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). No continuing mechanisms may have more than 18 months of pipeline. Overall country teams are expected to have 12 months of pipeline. Furthermore, outlays are expected to be equal or greater than COP 13 funding levels as to not increase pipeline. 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 and well-being 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 and well-being 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:
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 TBD outlay plan tab 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 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

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

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
(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.

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

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 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

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

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, 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;

[3] Oversight Committee/ Task Teams/ Leadership Group

- 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 2013, 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.

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.

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

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 partner 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:

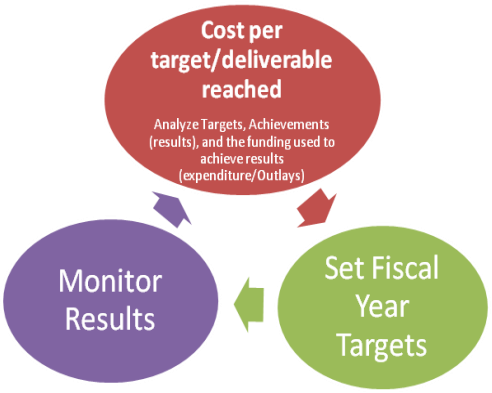
1. The first method involves setting targets for the expected program achievements for the defined reporting period based on **anticipated fiscal year expenditures**.

2. The second method involves setting targets for the expected program achievements for the defined reporting period based on **the planned fiscal year COP budget** (i.e., with FY 2013 funds).

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 FY2013 level.**

Appendix 6: Treatment Calculator

Country:

Instructions

This tool was designed to assist country teams in justifying their FY 2013 treatment allocations, and to ensure that treatment budgets align with treatment targets. To use the tool, complete boxes 1 through 4. Boxes 5 through 7 will then calculate the required outputs. Please explain any factors that contribute to a change in average spending per patient (either increases or decreases) in box 8. Note that information from prior years has already been provided, and that boxes in gray automatically calculate based on previously entered values.

All teams that report direct treatment targets should return this completed form to Lara Stabinski (StabinskiLL@state.gov) no later than December 31, or as soon as your team determines treatment allocations & targets.

1) Number of adults and children who received ART in FY 2011 and FY 2012 (indicator T1.2.D)

	T1.2.D	Change from prior year
FY 2011		-
FY 2012		0

2) Treatment targets for FY 2013 and 2014 (indicator T1.2.D)

	T1.2.D	Change from prior year
FY 2013		0
FY 2014		0

3) Treatment budget codes for FY 2010, FY 2011, FY 2012, and FY 2013

	HTXD	HTXS	PDTX	Total Tx budget
FY 2010				$0
FY 2011				$0
FY 2012				$0
FY 2013				$0

4) Enter the amount of pipeline funds your program spent or plans to spend on each budget code

	HTXD	HTXS	PDTX	Tx pipeline spending
FY 2010				$0
FY 2011				$0
FY 2012				$0
FY 2013				$0

5) Total amount spent per budget code (sum of boxes 3 and 4)

	HTXD	HTXS	PDTX	Total Tx spending
	$0	$0	$0	$0
FY 2011	$0	$0	$0	$0
FY 2012	$0	$0	$0	$0
FY 2013	$0	$0	$0	$0

6) Average amount spent per patient (prior year's total Tx spending divided by given year's treatment targets)

FY10 budget/ FY11 results	FY11 budget/ FY12 results	FY12 budget/ FY13 results	FY13 budget/ FY14 results
#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

7) Yearly change in amount spent per patient (percent decrease in average spending per patient from prior year to given year)

FY10 to FY 11	FY 11 to FY 12	FY 12 to FY 13
#DIV/0!	#DIV/0!	#DIV/0!

8) If there is a substantial decrease or increase in the average cost per patient, please explain any factors that contribute to this

Appendix 7: Instructions for Writing Budget Code Narratives

As described in Section 7 of the FY 2013 COP Guidance, there are specific questions that need to be addressed in your budget code narratives in NEW implementing mechanisms.

Guide to Determining How to Apply Budget Code(s) to a NEW 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)

MTCT – Includes activities aimed at preventing mother-to-child HIV transmission, such as ARV prophylaxis and treatment (ART) for HIV-infected pregnant women and newborns, counseling and support for maternal nutrition, and related training. Funding and targets for provision of ARVs for prophylaxis and/or treatment for HIV-infected pregnant women and newborns should be coded in the ARV Drugs and Adult Treatment budget code and cross-referenced to activity descriptions in MTCT. Funding for HIV counseling and testing in the context of preventing mother-to-child transmission should be coded under PMTCT. Targets set for this funding should be set under both NGI P1.1.D (Number of pregnant women with known HIV status) and P11.1.D (Number of Individuals who received Testing and Counseling services for HIV and received their status). 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 (in non-hierarchical order):

- 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 mother-infant pair 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 health facility level to supervise the program, routinely collect data and monitor the quality of data and services.
- Activities to ensure initiation of ART for eligible HIV+ pregnant women, program retention, and ART adherence among mothers and infants in care and treatment programs.
- Activities to scale-up additional quality PMTCT interventions to increase HTC, including PITC of pregnant women at ANC, ANC attendance and facility deliveries, use of more effective ARV regimens, access to CD4 testing, and evidence-based interventions to reduce incident HIV infections during pregnancy, and improve care and support services at health facilities and in communities.
- Activities to support PMTCT program evaluation: 1) in real time using innovative approaches and tools (e.g., dashboards and mobile technology); and 2) through measurement of population transmission rates at national and/or subnational levels.
- Activities that promote demand creation such as community mobilization, action-oriented male involvement, couples CT services, including identification of discordant couples, in order to increase PMTCT uptake and improve PMTCT and health outcomes for women and their families.
- Activities supporting integration of PMTCT with ART and routine maternal child health/reproductive health services, especially family planning services, adult and pediatric treatment services, and broader prevention programs

PROGRAMMING FOR PREVENTION OF SEXUALLY-TRANSMITTED HIV INFECTIONS

Most programs to prevent sexual transmission of HIV should be budgeted under the HVAB (Abstinence and Be Faithful) and/or HVOP (Other Sexual Prevention) budget codes. The exception to this rule is voluntary medical male circumcision programs, which should be funded under the CIRC budget code. The choice of budget code will depend on the type of activities to be funded and the targeted population. In general, activities promoting risk avoidance, e.g. delay of sexual debut among youth and mutual

fidelity between stable partners of known HIV-negative status, should be funded under HVAB. Activities addressing risk reduction, e.g. condom promotion and distribution, as well as services for sexually-active persons, such as PEP and STI management, should be funded under HVOP.

In both generalized and concentrated epidemics, sexual prevention programs should adopt a comprehensive approach, i.e., reflect a combination of the strategies most relevant to the specific epidemic context and affected populations. Programs for sexually-active adults and young people in the general population, and for vulnerable sub-groups within the general population, should where appropriate and feasible be jointly funded from BOTH the HVAB and HVOP budget codes in order to make the full array of preventative options available. Exceptions might include pre-risk activities for very young teens, which may be appropriately funded only under the HVAB budget code, or sex worker programs, which should in most cases be funded exclusively under HVOP. Additionally, all prevention programming should incorporate proactive linkages to HTC and to relevant high impact services such as VMMC, PMTCT and ART.

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 influence these behaviors. Activities should address programming for both youth and adults.

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: Activities (including training) aimed at preventing HIV transmission through means other than promoting abstinence and fidelity. These may include: procurement, promotion, distribution and social marketing of male and female condoms and lubricants, both on a targeted basis to key populations and in high-risk venues, but also to make condoms more broadly available to the general population; STI management for key populations and PLHIV (if not in palliative care settings/context); comprehensive care for survivors of sexual violence including provision of post-exposure prophylaxis (PEP); and messages/programs to reduce other risks to persons engaged in high-risk behaviors, e.g. such as alcohol-related sexual disinhibition.

This budget code should be used both for programs addressing key populations and other especially vulnerable subgroups across all epidemic settings, as well as for comprehensive sexual prevention programs addressing the general population in high prevalence settings. The major exception is programming for people who inject drugs (PWID), which should be funded under the IDUP budget code.

INSTRUCTIONS FOR WRITING HVOP BUDGET CODE NARRATIVE

- 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/occupational 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. 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. PEPFAR teams should refer to the 2010 Technical Guidance: Prevention for People Who Inject Drugs.

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 partner 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. VMMC programs may encompass as needed policy efforts, training (task-shifting/sharing), outreach, development of tools for communications, quality assurance, and equipment /commodities related to male circumcision, with a focus on safe, efficient service delivery,

- PEPFAR funds may not be used to provide VMMCs that require sedation or general anesthesia. For more information, please see the VMMC Technical Considerations.
- PEPFAR-funded VMMC programs must have emergency equipment and supplies on site to manage the very unlikely life-threatening complications that may occur. Staff trained in the use of the emergency equipment and supplies must be on site at all times VMMC surgeries are being provided. For more information, please see the VMMC Technical Considerations.

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, quality assurance, and emergency preparedness
- Communications activities for male circumcision as they relate to males and females
- Provision of HTC onsite
- Coverage of HTC among MC clients/patients
- Inclusion of MC as part of a comprehensive prevention package
- Training programs and materials being used, including efforts to ensure staff that are trained are actually providing VMMC services post-training

- ❖ Demand Creation Activities
- ❖ Linkages to care and treatment

BUDGET CODE: HIV TESTING AND COUNSELING (HVCT)

HIV Testing and Counseling (HTC) – this budget code covers the provision of HIV testing and counseling across the range of community and facility-based settings including client- and provider-initiated approaches. Mobilization to support HTC as well as activities linking HTC-users to appropriate follow-on services and tracking linkages are also covered under this budget code.

Funding for HIV counseling and testing in the context of preventing mother-to-child transmission should be coded under PMTCT. Targets set for this funding should be set under both NGI P1.1.D (Number of pregnant women with known HIV status) and P11.1.D (Number of Individuals who received Testing and Counseling services for HIV and received their status). Funding for HTC in the context of TB services should be included under the TB budget code; targets should be set under P11.1.D. Funding for HTC in the context of VMMC services should be included under the CIRC budget code; targets should be set under P11.1.D. For other technical areas where HTC is part of the minimum package including: PHDP; services for key populations; adult treatment, care and support; early infant diagnosis; and pediatric treatment; funding should come from HVCT and targets should be set under P11.1D.

INSTRUCTIONS FOR WRITING HVCT BUDGET CODE NARRATIVE

Please describe the implementing mechanism's activities in HTC. In particular, please address:

- The approach used for setting the HVCT budget and how the current situation in country shapes HVCT budgeting decision (e.g. other funders/donors).
- How HVCT budget allocation is enough to cover testing requirements necessary to meet treatment, VMMC, and PMTCT acceleration targets, and ongoing programs you have both in community- and facility-based settings.
- The mechanism's target population(s), their HIV prevalence (if known), coverage (% tested in past 12 months) either in the geographic area or among the target population, and strategic prioritization of services.
- Promotional activities around HTC for demand creation and target markets/audiences
- Approaches to HIV testing and counseling undertaken (e.g. client-initiated, provider-initiated), and settings in which HTC services are provided. These could include health facilities (ANC, TB clinics, VMMC, Outpatient departments, etc), home-based HTC, outreach/mobile, voluntary counseling and testing (VCT), special events or campaigns, etc.

- Approaches to enhance coordination and linkages between HTC services across various settings to reduce repeat HIV testing and counseling (e.g. VCT and VMMC or home-based HTC followed by a repeat test in a clinic setting)
- Targets for each approach (PITC and CITC) and results achieved (as per PEPFAR indicators) in the past year.
- Target for number of people trained or receiving refresher trainings and results achieved in the past year, including the areas in which they were trained (e.g., PITC, couples HTC, quality assurance or improvement, rapid testing)
- Excluding HTC within PMTCT and TB, describe the proportional allocation of HVCT funding to each of the technical areas (VMMC, MARPs, PWP, Tx, Care/Support) and how HTC links with these other services. For example, testing client and/or partners, strengthening linkage interventions/systems.
- Activities and proportion of funds for strengthening and ensuring successful referrals and linkages to prevention, care, and treatment, using community based and facility based strategies. These strategies may include follow-up of HIV-positive individuals who have not enrolled in HIV care or treatment services following diagnosis.
- Activities for quality assurance of <u>both</u> testing and counseling
- Activities for monitoring and evaluation of HTC, including the essential/not reported and recommended PEPFAR indicators and linkages from HTC to care, treatment and other preventions services.

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. To assure access to the continuum of care and to support timely initiation and maintenance on ART, programs should attempt to optimize linkage and entry into care following HIV testing, and retention in pre-ART and ART care, Clinical care to reduce HIV-related morbidity and mortality should include evaluation for ART eligibility so that ART can be initiated at the appropriate time; prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria, diarrhea, and Cryptococcal disease (including provision of commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services); nutrition assessment, counseling and support (NACS); pain and symptom relief; and screening and treatment to prevent cervical cancer in HIV-infected women *(given specific funding considerations, please refer to FY 2013 Technical Considerations for further information regarding cervical cancer)*. 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-sectoral 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 also 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 isoniazid and drugs for treating active TB), 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. Laboratory investments for TB/HIV should be included under the HVTB 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 –Includes all health facility-based care aimed at extending and optimizing quality of life for HIV-infected children, adolescents, and their families throughout the care continuum 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 care and support 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. Infrastructural and construction activities should not be included under PDCS, but rather under HSS.

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 (in non-hierarchical order):

- 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)
- Activities to support the needs of adolescents with HIV (ALHIV) (PwP, support groups, support for transitioning into adult services, adherence support, reproductive health services, educational support for in and out of school youth)
- 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.
- Activities to ensure appropriate dispensation of CTX and INH, prophylaxis in infants, children and adolescents.
- Activities to address nutritional evaluation and care of malnutrition in HIV+ infants, children and youth.
- Activities to address psychosocial support of children and adolescents, including disclosure, adherence counseling, and support groups.
- Activities that will increase direct linkages to the community to improve communication between facilities and community services for HIV+ children and youth.

Treatment

BUDGET CODE: ARV DRUGS (HTXD)

ARV Drugs – including procurement, delivery, and in-freight of ARV drugs. Funding for all ARVs should be reflected under HTXD, including ART costs for adult and pediatric treatment and PMTCT. All antiretroviral Post-Exposure Prophylaxis procurement for rape victims and needlestick injuries 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. Country teams are expected to forecast, cost and fully budget for the PEPFAR supported cost of antiretroviral treatment and buffer stock. HIV drug resistance surveillance activities are classified under Strategic Information (HVSI).

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 2013?

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.

Country teams are expected to budget appropriately to meet treatment targets. In addition, regardless of their entry point (PMTCT or Treatment program) treatment for eligible pregnant women should be forecasted, costed and fully and adequately budgeted for in PEPFAR supported programs. The total cost supported by PEPFAR should be reflected as locally appropriate across PEPFAR budget codes including MTCT, HTXS, OHSS and others as needed. HIV drug resistance surveillance activities are classified under Strategic Information (HVSI).

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 – Includes support to the government to roll out updated pediatric treatment guidelines; infrastructure development; training clinicians and other providers; clinical and laboratory monitoring of children and adolescents on treatment; adherence support and strategies to improve retention in the pediatric population; development of capacity to provide laboratory services for children/adolescents and detect treatment failure; building capacity to monitor, supervise and implement pediatric HIV treatment services; and promoting integrated approaches to improve outcomes. Infrastructural and construction activities should not be included under PDCS, but rather under HSS. HIV drug resistance surveillance activities are classified under Strategic Information (HVSI).

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 (in non-hierarchical order):

- 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, family planning, educational and psychosocial support.
- Describe plans to improve capacity to collect, analyze and use pediatric HIV data in collaboration with the USG and national program.
- Activities to address increased access to treatment to pediatric-aged PLHIV and retention activities appropriate for ALHIV
- Activities to evaluate treatment failure in pediatric HIV+ patients and access to second and third line ARVs for these children and youth.
- Activities to address procurement and maintenance of adequate supplies of pediatric ARVs
- Activities to address simplification of pediatric formularies
- Activities to address the issues of disclosure to PLHIV and ALHIV

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. HIV drug resistance surveillance 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 a 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 or Renovation (two separate attributions)

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, if an OU is requesting PEPFAR funds for construction or renovation of facilities under an implementing mechanism, the appropriate cross-cutting attribution (see COP Guidance 7.5.1.3) should be identified and a Construction/Renovation Project Plan form screen (see Appendix 10) completed directly in the FACTS Info – PEPFAR Module **for each project**. There is no cap on the amount of funds to be included in the COP submission i.e., all projects, regardless of amount, need to be submitted for approval. For USG-occupied rented or owned properties, the cost of renovating should be captured in the Agency Cost of Doing Business (CODB) section and a USG narrative completed under Interagency M&O Narratives (Narrative 3).

Motor Vehicles: Purchased or Leased (two separate attributions)

Countries need to provide the total amount of funding by Implementing Mechanism, which can be attributed to the purchase and/or lease of motor vehicle (s) under an

implementing mechanism. The term Motor Vehicle refers to motorcycles, cars, trucks, vans, ambulances, mopeds, buses, boats, etc. that are used to support a PEPFAR Implementing Mechanism overseas.

Key Populations: Men who have sex with Men (MSM) and Transgender Persons (TG)

This cross-cutting budget attribution is meant to capture activities that focus on gay men, other men who have sex with men including male sex workers, and those who do not conform to male gender norms and may identify as a third gender or transgender (TG). These activities may include:

- Implementation of core HIV prevention interventions for MSM/TG that include community mobilization, peer outreach and education, targeted behavior change communication, risk reduction counseling and skills training, condoms and lubricant promotion and distribution, STI screening and treatment, HIV counseling and testing, and linkage to and provision of HIV care and treatment (including adherence support).

- Training of health professionals and providers of community-based HIV prevention services to increase the capacity for delivering high-quality prevention and health care services for MSM and TG that are affirming, free from discrimination and ensure the confidentiality of all people who receive these services.

- Collection and Use of Strategic Information such as assessments of laws, policies, regulations and barriers that impede the implementation of comprehensive HIV prevention programs and activities for MSM/TG in order to address such structural barriers; size estimation activities to help countries set targets for access to HIV prevention, treatment and care for MSM/TG; ongoing HIV/AIDS surveillance that provides data on MSM/TG; and rapid assessments using multiple qualitative and quantitative methods to better understand the behavioral and HIV transmission dynamics and estimate coverage needs and costs to have an impact on the HIV epidemic.

- Conducting Epidemiological, Social Science and Operational Research to better understand HIV risk and its prevention among MSM/TG and their sex partners; identify the most effective interventions for MSM/TG within each epidemic context; support delivery of high-quality services to clients; evaluate innovative strategies to improve and strengthen comprehensive HIV prevention services for MSM; promote the development and strengthening of MSM and TG organizations that provide HIV prevention and related health services; and support laws, regulations and policies that foster effective HIV prevention efforts for MSM/TG.

- Monitoring and Evaluation of programs and intervention through the use of standardized indicators, including those developed by WHO, UNODC and UNAIDS, for each core intervention component to monitor accessibility, availability, quality, coverage and impact.

- Commodity Procurement of condoms and condom-compatible lubricants and other commodities essential to the delivery of effective HIV prevention care, and treatment services for MSM/TG.

Key Populations: Female Sex Workers (FSW)

This cross-cutting budget attribution is meant to capture activities that focus on female sex workers. Relevant activities include:

- Implementation of core HIV prevention interventions for FSWs that include community mobilization, peer outreach and education, targeted behavior change communication, risk reduction counseling and skills training, condoms and lubricant promotion and distribution, STI screening and treatment, HIV counseling and testing, .and linkage to and provision of HIV care and treatment (including adherence support).

- Training of health professionals and providers of community-based HIV prevention services to increase the capacity for delivering high-quality prevention and health care services for SW that are free from discrimination.

- Collection and Use of Strategic Information such as size estimation activities to help countries set targets for access to HIV prevention, treatment and care for SW; ongoing HIV/AIDS surveillance that provides data on FSW; and rapid assessments using multiple qualitative and quantitative methods to better understand the behavioral and HIV transmission dynamics and estimate coverage needs and costs to have an impact on the HIV epidemic.

- Epidemiological, Social Science and Operational Research to better understand HIV risk and its prevention among FSW and their sex partners; identify the most effective interventions for FSW within each epidemic context; support delivery of high-quality services FSWs; evaluate innovative strategies to improve and strengthen comprehensive HIV prevention services for FSW; and promote the development and strengthening of FSW organizations that provide HIV prevention and related health services.

- Monitoring and Evaluation of programs and intervention through the use of standardized indicators, including those developed by WHO, UNODC and UNAIDS to monitor accessibility, availability, quality, coverage and impact.

- Commodity Procurement of condoms and condom-compatible lubricants and other commodities essential to the delivery of effective HIV prevention care, and treatment services for FSW.

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: Preventing and Responding to Gender-based Violence (GBV)
This secondary cross-cutting attribution should capture all activities aimed at preventing and responding to GBV, which results in physical, sexual, and psychological harm to either women or men, girls or boys. Forms of gender-based violence include, but are not limited to intimate partner violence; rape and sexual abuse; female infanticide; psychological or emotional abuse; sexual harassment or violence in the workplace or in educational institutions; and harmful traditional practices including female genital mutilation/cutting, and forced marriage.

Examples of activities for "Preventing and Responding to Gender-Based Violence" include:

- Collection and Use of Gender-related Strategic Information: assess differences in power and gender norms that perpetuate GBV as well as gender and societal norms that may facilitate protective actions against GBV and changes in attitude and

behaviors; analysis of existing data on different types of GBV disaggregated by sex, age and geography, and in relation the HIV epidemiology in order to identify priority interventions and focus in the context of PEPFAR programs; analysis of treatment, care and referral services data by sex and age to ensure the unique needs of actual and potential victims are being met; employ rapid assessment, situational analyses and other quantitative and qualitative methods to understand norms and inequalities perpetuating GBV

- Implementation: 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 GBV, 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

- Capacity building: capacity building for USG staff and implementing partners on how to integrate GBV into HIV prevention, care and treatment programs; capacity building for Ministry of Women's Affairs, Ministry of Health or other in-line Ministries to strengthen national GBV programs and guidelines; pre and in-service training on the identification, response to and referral for cases of intimate-partner violence, sexual violence and other types of GBV; assist in development and implementation of agency-, government-, or portfolio-wide GBV strategy

- Monitoring and Evaluation: strengthening national and district monitoring and reporting systems to capture information on provision of GBV programs and services, including HIV PEP within health facilities

- Operation Research: to better understand the associations and pathways between GBV and HIV/AIDS; identify promising practices in training and protocol for the effective delivery of GBV screening and services and of GBV prevention programs; evaluate the impact of comprehensive GBV programming on HIV and GBV outcomes of interest

Gender: Gender Equality

This secondary cross-cutting attribution should capture all activities aimed at ensuring that men and women have full rights and potential to be healthy, contribute to health

development and benefit from the results by taking specific measures to reduce gender inequities within HIV prevention, care and treatment programs. This would consist of all activities to integrate gender into HIV prevention, care, and treatment and activities that fall under PEPFAR's gender strategic focus areas:

- Increasing women's legal rights and protection
- Increasing gender equity in HIV/AIDS activities and services
- Engaging men and boys and addressing gender norms and behaviors
- Increasing women's access to income and productive resources

Examples of these activities include:

- Collection and use of Gender-related Strategic Information: Analysis of existing HIV prevention, care, and treatment portfolios and/or individual programs to understand and ensure appropriate response to: gender norms, relations and inequities that affect health outcomes; variation across populations and population subsets (by sex and age) in terms of gender norms, roles and resource needs; differences in power that affect access to and control over resources between women and men, girls and boys, which are relevant to health objectives; key gaps and successful programs in gender integration across HIV prevention, care and treatment; analysis of access and adherence to treatment includes analysis of data by sex and age and assessment of barriers to service by men and women; employ rapid assessment, situational analyses and other quantitative and qualitative methods to understand gender norms and inequalities in the context of HIV prevalence and programming

- Implementation of: HIV prevention interventions redressing identified gender inequalities; Legal, financial or health literacy programs for women and girls; programs designed to reduce HIV that addresses the biological, cultural, and social factors that disproportionately impact women's, men's or transgenders' vulnerability to the disease, depending of the setting and type of epidemic; a PMTCT or HTC program that implement interventions to increase men's meaningful participation in and use of services; specific programming for out-of-school adolescent and pre-adolescents who are often the most vulnerable, including males and married adolescent girls; male circumcision programs that include efforts to reach female partners, mothers and other women in the community and incorporate messages around gender norms in pre and post counseling

- Capacity building: assist in development and implementation of agency-, government-, or portfolio-wide gender strategy; conduct training for USG staff and implementing partners on women, girls, and gender equality issues, as well as capacity building on how to integrate gender into HIV prevention, care and treatment programs; capacity building for Ministry of Women's Affairs or the Gender Unit within a Ministry of Health; capacity building interventions for HIV-positive women to assume leadership roles in the community and programs; training for health service providers on unique needs and risks of specific sub-populations such as adolescent girls and older, sexually-active men

- Operational Research: to better understand gender-related barriers and facilitators to HIV prevention, care and treatment programs; identify HIV-related needs and risks specific to adolescent girls and young women; promote constructive male engagement strategies to increase uptake of male circumcision, other prevention strategies, HTC, treatment, and care among adult men

- Monitoring and Evaluation: of programs and services through the use of standardized indicators and strengthening monitoring systems be able to document and report on accessibility, availability, quality, coverage and impact of gender equality activities; ensure that data is disaggregated by sex and age

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: In addition to capturing funding data under the Gender Equality and GBV attributions, the other four gender strategic areas should be captured through the key issue area designation:

- Increasing gender equity in HIV/AIDS activities and services, including access to maternal and reproductive health services
- Engaging men and boys and reducing harmful gender norms
- Increasing women's legal rights and protection, and
- Increasing women's access to income, productive resources and education

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 8: 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.

Construction/Renovation:

- OU teams that have small grant applications for construction/renovation need to submit a ***Small Grants Program - Construction/Renovation Project Plan*** form for each construction/renovation project (under an already approved COP implementing mechanism) for review/approval throughout the year (there is no set time for submission, but is as needed based on the country's small grants award timeline).
- Please send the project plan form applications directly to your OGAC CSTL (copy Siri Dell, Sr. Management Analyst) throughout the year during your small grant proposal review periods. Note, all form fields need to be completed.
- The form(s) will be uploaded into the **FACTS Info – PEPFAR Module Document Library** as part of the COP Submission after it is reviewed and approved.
- Once the OU receives confirmation from OGAC that the small grant applications have been approved, the OU team needs to the upload the approved application forms (for construction/renovation only) into the **FACTS Info – PEPFAR Module Document Library** under the approved COP cycle (e.g., if the 'small grants program' implementing mechanism was approved in the FY 2013 COP, then the OGAC approved small grant applications need to be uploaded in the Facts Info Document Library under the FY 2013 COP cycle).
- N.B. Documents can be uploaded into the Facts Info Document Library throughout the year even after a cycle is closed.
- The ***Small Grants Program - Construction/Renovation Project Plan*** form template is located under ***PEPFAR Construction/Renovation*** on the **PEPFAR Plan B** website.

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 9: 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 that:

- 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 utilize and develop capabilities its employees effectively.
- 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 Locally Employed Staff (LE Staff)

The recruitment, retention, and empowerment of Locally Employed staff (LE Staff) are crucial to accomplishing our goals. LE Staff may be host country nationals, locally resident Americans, or locally recruited Third Country Nationals (TCNs). Approximately

80% of our field-based workforce is locally hired: 75% host country nationals, 3% locally resident American citizens, and 4% TCNs (unknown which TCNs were locally or internationally recruited).

OU teams should look for opportunities to train, engage, and empower LE Staff. Good practices include promoting additional leadership roles, such as naming LE Staff to be TWG chairs, creating an interagency LE Staff advisory council for PEPFAR in country, and providing training and international travel opportunities. Providing a work environment that fosters collaboration, respect, and professional development is an essential element in supporting the long-term retention of these staff who maintain critical relationships with the host government and partners and are essentially the institutional knowledge for our programs.

The PEPFAR Interagency Working Group on Issues Affecting LE Staff (LE Staff WG) continues its efforts to assist teams in addressing LE Staff recruitment, retention, and empowerment. 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 LE Staff WG has created a number of tools to help OU teams, including Framework Job Descriptions (FJDs) LE Staff positions. FJDs are standardized position descriptions for common PEPFAR LE Staff 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 August 5, 2012, 27 FJDs have been approved for senior- and mid-level technical, management, and administrative LE Staff positions:

Approved Senior-Level FJDs

- Senior Public Health Specialist
    - Prevention,
    - Care,
    - Treatment,
    - TB/HIV,
    - Surveillance,
    - Monitoring and Evaluation,
    - Health Management & Information Systems,
    - Lab Liaison,
    - Lab Advisor,
    - PMTCT/pediatric AIDS

- Public Health Administrative Management Specialist (LE Staff Deputy for Operations)
- Sr. Public Health Specialist (LE Staff Deputy for a branch/office)
- Senior Orphans and Vulnerable Children (OVC) Specialist
- Senior Human Resources for Health (HRH) Specialist
- DoD Program Manager

*Senior Public Health Specialist for Emerging Infectious Diseases also approved

Approved Mid-level FJDs

- Behavioral Scientist
- Public Health Administrative Management Assistant
- Public Health Administrative Management Specialist (Finance)
- Public Health Specialist for
    - Prevention
    - PMTCT/pediatric AIDS
    - Monitoring and Evaluation
    - Care & Support
    - HMIS
    - TB/HIV
- Agreements Administrator (CDC)
- PEPFAR Deputy Coordinator

Expected Mid-Level FJDs *(by end of 2012)*

- Public Health Specialist for
    - Treatment
    - Surveillance
    - Lab Assistant
    - OVC
- Voluntary Counseling & Testing Coordinator
- Public Health Specialist
- Human Resources for Health Specialist

The LE Staff 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 LE Staff recruitment and retention challenges related to compensation in the mission's annual local compensation questionnaire (LCQ), 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 2013 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 10: 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 breakdown of time dedicated to each budget code 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 (including appointed staff for CDC), 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/appointees and PSCs,and 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 2013. 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.

CHANGE IN DATA ELEMENTS FOR FY 2013: A change has been made under the **Employee Citizenship** element that splits "Third Country National" into "Locally Hired Third County National" and "Internationally Recruited Third Country National". This change will assist in identifying clearly which staff are locally hired.

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 2012 or prior), or Planned (new request for COP 2013):

- 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 (including military and public health commissioned corps), appointees (CDC), 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. **Locally Hired Third Country Citizen:** Foreign Service Nationals (FSNs) who are not citizens or permanent residents of either the host country or the United States and are hired locally in the country in which they are employed. They are compensated in accordance with the employing post's LCP.
e. **Internationally Recruited 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. NOTE: Host country nationals that are appointed by a USG agency should be listed as a Direct Hire.
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 GHP-State, GHP-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).

- **Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) 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).

v. **Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) and will be used solely for that purpose, purchase or lease information needs to be justified. For new requests in **FY 2013** please provide a brief narrative (few words) explaining the purpose of each vehicle (s) and associated cost (s). It is also a requirement that the total number of vehicles purchased and/or leased under Non-ICASS (Motor Vehicles) costs to date **(cumulative through FY 2012 COP)** are provided in this category. In addition to the budget data fields, please complete the "Item Description" field.

vi. **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. The State Department uses a portion of the CSCS amount for the Major Rehabilitation Program (MRP).
c. It provides steady funding annually for multiple years to fund 150 secure New Embassy Compounds in the Capital Security Construction Program.
d. More information is available at http://www.state.gov/obo/c30683.htm.
e. OU teams should consult with agency headquarters for the appropriate amount to budget for in the COP.

vii. **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.

viii. **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.

ix. 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 (see COP Guidance Section 8.2) to describe the requested project, timeline, and justification.
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 Sections 7.5.1.3 and 7.5.1.6 of the COP Guidance).

x. 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.

xi. 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 <u>excluded</u> 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.

Appendix 11: Construction and Renovation

7.5.1.6 Construction/ Renovation for HIV/AIDS Assistance Projects ONLY (not for USG- Occupied projects 5)

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

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

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

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

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

whether such entities could manage construction efficiently with grant funding from the USG. Country teams should also carefully consider individual agency policies on construction when identifying the USG implementing agency before requesting COP funding for construction to be managed by a USG agency.

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

Host Country MOU (and MOU Amendment) on Construction and Facility Handover

All OUs with construction/renovation funding in their COP that use direct contracting/in-kind mechanisms must conclude with the host government a Memorandum of Understanding (MOU) on PEPFAR construction and renovation. The goal of the MOU is to improve coordination with host government officials on construction needs in-country, to facilitate the planning and tracking of projects, and to establish appropriate host country responsibilities for facilities following transfer. PEPFAR countries must also sign a MOU Amendment when adding projects after the original MOU (that includes the original list of projects) is signed. The MOU Amendment document template references the originally signed MOU and includes the new list of approved projects. The MOU provides a simplified form for transfer of completed projects (Annex A, *Project Handover Acceptance Form*). A model MOU, MOU Amendment and related template forms are located under Construction/Renovation on the PEPFAR Plan B website. It is a requirement that all PEPFAR countries use the above mentioned documents for direct contracting/in-kind transfers. Substantive departure from the templates should be cleared by S/GAC and the Office of the Legal Adviser.

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

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

In cases where OU teams are entering into contracts, grants or cooperative agreements with partners who will undertake construction activities under the terms of the award, but the intent is not to provide the completed facility to the host country government as a form of in-kind assistance, a host country MOU is not required. In such cases, the assistance instrument governs the terms of the project.

Construction/Renovation Project Plan form screen in Facts Info

If an OU is requesting FY 2013 PEPFAR funds for construction or renovation of facilities under an implementing mechanism where the intent is to provide the completed facility as a form of foreign assistance, the appropriate Construction/Renovation cross-cutting attribution (see 7.5.1.3) should be identified and a Construction/Renovation Project Plan form screen (see below for details) completed for each project directly in the FACTS Info – PEPFAR Module. All fields on the Construction/Renovation Project Plan form screen must be completed. In submitting proposed construction projects, country teams should consider the most appropriate implementing agency option as noted above.

Procedural Steps When DOS is the USG Implementing Agency

DOS has the authority to undertake overseas construction in support of PEPFAR programs. When State acts as the implementing agency, PEPFAR funding for projects remains within State (i.e., funds are allocated to relevant regional bureau for allotment to posts), and the country team must have adequate State Department capacity to implement construction and manage projects. Thus, the OU must have identified State Department personnel at Post who can act to requisition the project (i.e., through RPSO, which is the contracting mechanism for all State-implemented PEPFAR construction), certify to RPSO that funds are available, oversee and manage the project as necessary, and ensure all steps needed for orderly handover of the completed facility. Post also must have an individual available to serve on location as the COR for the project, though an appropriate non-State Department employee may be designated to serve as the COR (e.g., a CDC technical expert may be appropriate for medical facilities). Detailed procedural steps[6] for implementation are located under Construction/Renovation on the PEPFAR Plan B website.

End Use Monitoring (EUM)

An End Use Monitoring (EUM) report on all completed facilities/projects is due to S/GAC as part of the APR Submissions. Effective with the FY 2012 COP guidance, the requirements provide more uniform and comprehensive monitoring and reporting procedures. The purpose of the annual review is to ensure that all facilities provided through PEPFAR funding through construction/in-kind grants continue to be used in ways consistent with the purposes for which the property was made available. The EUM guidance includes reporting on facilities provided through all implementing document types, such as construction grants or cooperative agreements, as well as USG-occupied

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

rented or owned properties. This will ensure oversight of these facilities, and provide a full picture of PEPFAR support for the host country's health systems infrastructure.

The EUM report form screen must be completed for each facility/project in the FACTS Info – PEPFAR Module as part of the **Annual Program Results (APR)** Submission.

Semi-Annual Activity Reports
All construction/renovation projects are required to provide semi-annual project status reports to S/GAC for each facility/project (not for completed/transferred projects) as part of the **Semi-Annual Program Results (SAPR)** and **APR** submissions. The guidance includes reporting on facilities provided through other implementing document types, such as construction grants, cooperative agreements and USG-occupied rented or owned properties.

The *Semi-Annual Activity Reports* report form screen must be completed in the FACTS Info – PEPFAR Module as part of the **Annual Program Results (APR)** Submission.

Construction/Renovation Project Plan form screen in Facts Info

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

If an OU is requesting FY 2013 PEPFAR funds for construction or renovation of facilities under an implementing mechanism where the intent is to provide the completed facility as a form of foreign assistance, the Construction/Renovation tickbox should be selected on the Mechanism Details screen, and a Construction/Renovation Project Plan form screen completed for **each** project directly in the FACTS Info – PEPFAR Module. A Construction/Renovation tab will appear requesting the user to enter each proposed project. All fields on the Construction/Renovation Project Plan form must be completed. In submitting proposed construction projects, country teams should consider the most appropriate implementing agency option as noted above.

A construction/renovation project is made up of a group of interrelated work activities constrained by a specific scope, budget, and schedule to deliver an end goal (PEPFAR overseas renovation or new construction project). Projects are defined (and approved) by their scope, budget, and schedule. The schedule specifies a defined beginning and end. Projects go through a life cycle of phases: initiation, planning, design, construction, commissioning, closeout, project transfer to the host government, and end use monitoring.

The purpose of the *Construction/Renovation Project Plan* form screen in the FACTS Info – PEPFAR Module is to identify the scope and purpose of each PEPFAR construction/renovation project, where the intent is to provide the completed facility as a form of foreign assistance, estimate the cost and work involved, and create a project

schedule and timeline. There is no cap on the amount of funds to be included in the COP submission i.e., all projects, regardless of amount, need to be submitted for approval. The screen is located under implementing mechanisms in Facts Info.

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

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

2. If the Mechanism Details tab/Procurement Type field selected is **"Contract"** the following needs to be completed:

    a. **If this project is funded under a Contract, has a PEPFAR Construction MOU been signed with the Host Government?** [Yes, No]

    b. If Yes: **Enter the Construction MOU Date Signed**

    c. If No: **Describe Status**

3. **Project Name:** Enter the name of the construction/renovation project. Please be consistent from COP year to year (and in reporting).

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

5. **Location:** Provide the city name and location of the project facility.

6. **Funding Source:** Select the appropriate funding source from the drop-down list.

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

8. **USG Managing Agency:** Select the appropriate implementing USG Agency in country or region. If the project will be implemented by DOS through RPSO, the funding agency would be State Bureaus.

9. **Funding:** Enter the requested FY 2013 funding amount for the project. The amount should include all anticipated or actual costs, including cost for A&E, actual construction costs and any equipment necessary to make the building operational and ready for use. As noted above, there is no cap on the amount of funds to be included in the COP submission i.e., all projects, regardless of amount, need to be submitted for approval.

10. **In-Country Management Plan:** It is a DOS Inspector General (IG) requirement that the contact information for the following persons be included (All fields need to be completed. Incomplete fields will impact the approval of the project):

- person who will serve as the **Contracting Officer's Representative (COR)** or Contracting Officer's Technical Representative (COTR)
- individual **who will sign the requisition and transfer documents** (where applicable)
- person **who will provide technical assistance and oversight**
- **PEPFAR Coordinator/Officer responsible** for coordinating PEPFAR construction/renovation projects
- **post or HQ Financial Management Officer (FMO)** (depending on the procurement type)
- point of contact on the country team **responsible for overseeing the construction project**
- **post Management Officer** (where applicable).

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

12. **Timeline**: Select the appropriate date for the **Estimated Start Date**, **Estimated Completion Date**, and **Estimated Transfer to Partner Government**. For continuing projects, please provide the original and amended timelines.

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

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

Appendix 12: Donor Funding for HIV Medicines and Diagnostics

Part A: HIV Medicines and Diagnostics Funding Landscape

The purpose of this supplemental form is to help country programs and Headquarters to get an overall picture of the availability of funding for essential HIV medicines and diagnostics. As country programs scale-up to meet the World AIDS Day targets, the availability of funding for commodities is essential and often comes from multiple sources including PEPFAR, The Global Fund and other bilateral and multilateral entities. To date, we have been collecting this information on an ad hoc, country-specific basis and through separate data call from CSTLs. But it makes sense to integrate this data request as part of the regular COP planning process as the availability of funds for essential HIV commodities directly affects successful implementation of all other program areas.

The data collected on this form will be utilized in the COP review process to assess the degree to which PEPFAR envelope in support of our targets is complemented by other resources in support of the overall national response. These data will as well assist as well in our planning and resource projections for the Emergency Commodity Fund. We intend that these data, collected in a uniform format, will obviate the need for ad hoc requests during the year. Please add rows to the tables as necessary.

(1) Please list all funding sources (other than PEPFAR) that finance ARV medicines and diagnostics (including RTKs, lab reagents and ARVs), and the time period for which they are funded. Data sources may include PF/PFIPs as appropriately updated since finalized in addition to other in-country data sources

Funding Source	Amount (if known)	Commodity	Time period

(2) Does the country team believe that there is sufficient funding available from all sources through 2014 to finance the scale-up required to meet the world AIDS day targets (300 word limit)?

(3) If there is a gap, can the country team estimate the magnitude of the gap and for which product lines?

Estimated gap (eg in time, from xx date, amount)	Commodity affected	Reason for anticipated gap

Part B: PEPFAR investments in Gene XPert RIF/MTB:

As you know, in late 2010, WHO endorsed Cepheid Xpert® MTB/RIF, a new diagnostic test that greatly reduces the time to confirm a TB diagnosis as well as resistance to rifampicin. Interest in the roll-out remains high and coordination across partners is critical. Recognizing that this interest level is ongoing and will diminish as roll-out progresses, we are asking PEPFAR teams to provide the following data.

Reporting of these data will enable us:

1. To respond to the numerous high-level requests for aggregate data on PEPFAR investments in XPert without ad hoc data calls;
2. To coordinate resources and decision-making with other funding streams (eg UNITAID, USAID TB, TB Reach);
3. To inform allocation decisions for future potential supplemental resources.
4. To contribute USG-wide data to global roll-out monitoring efforts.

Inclusion criteria for this data collection include only PEPFAR-supported instruments and cartridges.

PEPFAR-funded Xpert® MTB/RIF instruments and consumables:

COP	Xpert 4 module		Xpert 8 module		Xpert 16 module		Xpert Infinity		$ Value	Cartridges	
	# planned	# placed	# planned	# placed	# planned	# placed	# planned	# placed		Tests kits 10 each	Value
FY10											
FY11											
FY12											
FY13											

Deployment	# Modules	Location (facility, city, etc if known)	Planned or in-place	Implementing partner	Funding: COP, HQ
Instrument 1					
Instrument 2					
Instrument 3					
Instrument 4					
Instrument 5					
Instrument 6					
Instrument 7					

Appendix 13: Local Capacity Initiative

The Local Capacity Initiative (LCI) will provide funding to PEPFAR country and regional teams for direct support to local civil society organizations (CSOs) in support of the goal of enhancing country ownership, as emphasized in the second phase (2009 – 2013) of PEPFAR and the Global Health Initiative (GHI). LCI is a follow-on program to the New Partners Initiative (NPI).

All country and regional operational plan (COP/ROP) PEPFAR countries are eligible to apply for LCI funding through submission of a supplemental proposal document (uploaded into the FACTSInfo document library) as part of their 2013 country operational plan (COP/ROP) submissions. Proposals will be reviewed by the LCI Interagency Working Group and winning proposals will be awarded funding. LCI funding has been congressionally notified. Accordingly, the anticipated award date of funds is May/June 2013.

LCI is under the central initiative category of sustaining and capacity. As a central initiative, LCI funding is intended to be an innovative fund that will provide one-time financial support for proposals lasting from one-to-three years. If COP/ROP countries find that LCI funded central initiative activities are having an impact on their HIV response future activities beyond the one-time funding should be funded through the COP/ROP. The assumption is that this funding will be used to either: a) financially support organizations that are sustainable but need further capacity building and funding to achieve the objectives related to advocacy listed below; or b) strengthen organizations' abilities to become more sustainable beyond PEPFAR funding in countries/regions that are targeted assistance under the PEPFAR Country Ownership Strategy (see Annex A).

LCI funding through the PEPFAR country and regional teams is targeted to support a variety of CSOs, including non-governmental local organizations and networks/coalitions –professional associations, faith-based organizations/FBOs, community associations, and not-for-profit organizations at national, district and local levels. Should a country or region propose to fund a local regional organization or organizations that will conduct activities in several countries, the program managing the funds will be responsible for oversight of the multi-country activities.

The LCI USG Interagency Working Group will consider proposals for supporting CSOs in annual amounts ranging from $250,000 - $750,000 over one-to-three years. Based upon the LCI goal of sustainability, it is recommended that all proposals be based on a declining or a reverse-tiered approach within their respective budget periods. (As an illustrative example, for a single country proposal: $350,000 Year One, $300,000 Year Two, and $250,000 Year Three). Deviation from this approach must have strong justification.

All countries and/or regions are encouraged to include local capacity initiative-type activities in support of country ownership as reflected in their annual COP/ROPs. Given that those PEPFAR countries with relatively small budgets have fewer resources, the interagency LCI working group may give higher priority to proposals from such countries.

LCI Objectives

With regard to country ownership, LCI focuses on the factors for strong country ownership as outlined in the 2012 *USG Interagency Paper on Country Ownership: Global Health Initiative (GHI).* Referring to the Country Ownership Assessment Tool (COAT) referenced in this document, this funding will support activities that are specifically aimed to promote stronger:

- Political leadership and stewardship
- Institutional and community ownership
- Capabilities, and
- Mutual accountability, including finance

Regarding CSOs in particular, LCI will also strongly focus on the issue of advocacy since, as the *Country Ownership* document states, "Civil society as an advocate for the health care needs of a country is a significant feature in country ownership."

LCI funding will support organizations that aim to enhance the effectiveness of local health systems in addressing the HIV response by:

1. Increasing accountability and transparency of a government's national commitments and planned results by advocating for transparency, evidence-based policies/regulations and civil society engagement in each stage of HIV program development and implementation

2. Reducing legal and policy structural barriers to a quality HIV response

3. Reducing stigma and discrimination for key populations, thereby creating greater access to HIV services

4. Supporting civil society networks/coalitions including those that advocate for key populations from both a policy and programmatic perspective

5. Promoting the ability of citizens to recognize and demand quality services in their community and acting as advocates for the HIV-related health care needs of a country to hold governments accountable for service delivery

6. Fostering sustainability of CSOs beyond the life of USG funding in targeted assistance finance PEPFAR countries

7. Ensuring there is an enabling environment for CSOs resulting in increased access and uptake of HIV services.

Examples of Programs to be Considered for Funding

Under LCI, the intended recipient of funding should be a local CSO(s) or CSO network/coalition receiving one-time funding to meet the LCI objectives listed above. With that in mind, examples

of the types of programs which LCI is seeking to fund include those of local CSOs as well as international NGOs; those referring to the latter are presented for illustration purposes only:

The Caribbean HIV/AIDS Alliance (CHAA)
PEPFAR funding has been provided to the Caribbean HIV/AIDS Alliance to build sustainable and evidence based programs. The Caribbean Alliance is managing the Eastern Caribbean Community Action Project which is working with key populations and communities to increase access to HIV and AIDS services in the project countries. The project is focusing on increasing the use of strategic information to promote sustainable, evidence-based HIV services in the Eastern Caribbean. Both USAID and HRSA have been involved in supporting CHAA, with the HRSA-sponsored Caribbean HIV/AIDS Regional Training (CHART) network providing technical assistance recently for development and piloting of a curriculum regarding confidentiality in health care as well as training regarding VTC, in particular.

The Tanzanian Advocacy Partnership Program (TAPP)
USAID funded the Tanzanian Advocacy Partnership Program (TAPP) that was designed to strengthen the capacity of CSOs to articulate and represent public interests to the government of Tanzania on selected health, environment and private-sector policy issues while fostering an enabling environment for CSO-government partnerships. CSO partners were provided with training and technical assistance in organizational development, governance and leadership, and advocacy. A Legislative Roadmap manual for CSOs was developed presenting the complexities of the policy-making and legislative processes in layman's terms. The Roadmap, published in Kiswahili and English, identified points in the legislative process that can serve as windows of opportunity for advocacy and offered a toolkit of possible actions.

USAID-FBO Collaboration in Asia
Through PEPFAR, USAID supported the FBO community in Vietnam to provide care and support services to key populations (IDUs and sex workers). This would not have been possible without the intensive advocacy from USAID's partners and sub-partners (Catholic dioceses and Buddhist pagodas), in cooperation with the government.

The prime partner was both an advocate and a provider of capacity building to its subs in, among other things, advocacy. It this case, prior to the start of the project, the subs did not exist as FBOs. They were individual, highly-committed nuns and monks from their respective religious institutions, which have a history in Vietnam of working on behalf of the less privileged. While the prime partner had built capacity in advocacy it also had to create organizational capacity. This capacity building included the development of sound administration, governance, financial management, monitoring and evaluation (M&E) as well as technical skills for service delivery to key populations.

As a result of this concerted capacity-building effort, newly-created FBOs had a platform to be effective advocates as well as service providers. The resultant advocacy efforts provided an enabling environment, the capacity building made the organizations more sustainable and the focus on key populations as well as the work of the FBOs addressed stigma and discrimination.

MSM Network Strengthening, Asia
In Asia, the International AIDS Alliance helped to create and strengthen several MSM networks through advocacy from individual MSM groups, all supported by PEPFAR funding. As a result, these networks were enabled to strengthen capacities in administration, financial management, planning, governance, and their HIV/AIDS technical response. By closely collaborating with the provincial and district governments, the project garnered government support, including receptivity to the concerns and needs of the MSM networks. The interventions carried out by these networks addressed stigma and discrimination and the creation of enabling environments for MSM.

Umbrella of People Living with Disabilities in the Fight Against AIDS (UPHLS), Rwanda
UPHLS is a voluntary association of disabled persons organizations (DPOS) in Rwanda, a country where it is conservatively estimated that three percent (300,000) of the population is disabled. For those who are disabled and are infected with HIV, stigma and discrimination is an especially challenging problem. While the government recognizes their plight—to the point of including PWDs as a "key population" in the national HIV/AIDS Strategy, the gap between policy and practice remains wide. As a result, UPHLS is working to become an ever-stronger advocacy voice on behalf of PWDs in Rwanda. In this effort, it has been aided by two HRSA grantees, Handicap International and ICAP, via capacity-building workshops as well as promoting its integration as a member body of a technical working group that advises the government on PWD-related issues.

Journalists Against AIDS (JAAIDS), Nigeria
In Nigeria, the local organization Journalists Against AIDS (JAAIDS) has received PEPFAR funding to equip gatekeepers in the media with accurate and up-to-date information in to ensure reliable reporting on issues, challenges and solutions regarding HIV/AIDS stigma and discrimination. The project has provided platforms for informed public discussion and debate on this issue and has built capacity among leaders of the Nigerian media in Lagos, Abuja, Ekiti, Enugu and Kano. As a result, these community-based leaders are receiving the skills needed to be effective advocates for change, addressing both policy makers and the public at large.

The Christian Health Association of Kenya (CHAK)
The Christian Health Association of Kenya joined forces with the Kenya Episcopal Conference and the Supreme Council of Kenya Muslims in developing a memorandum of understanding with the Kenya Ministry of Health to improve the quality of health service delivery, sustainability, and accountability for improved ARV delivery as well as care and treatment services to people with HIV/AIDS.

The Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL),
AMICAALL was created in 1998 out of the concern of African mayors about the impact that HIV/AIDS was having on their communities. Through this program, they have mobilized political commitment, engaging mayors, municipal leaders and other local government authorities to support them in working with citizens groups, private voluntary organizations, the private sector, national government and the international community—all to develop programs/services that address the needs of affected households and communities. An ever-

expanding organization, the Alliance currently has chapters in Burkina Faso, Ivory Coast, Mali, Namibia, South Africa, Swaziland, Tanzania, Uganda, and Zambia. Based in Windhoek, Namibia, the Alliance joined forces with the US Conference of Mayors from 2001 to 2003 to link sister cities in the US with three sister cities in Africa (Uganda, Swaziland, and South Africa). Model policy and program development ensued and two of these partnerships still existed in 2011.

Treatment Action Campaign (TAC), South Africa
Founded in Cape Town in 1998, this organization has mobilized a variety of individuals to successfully advocate for increased access to treatment, care and support services for people living with HIV and campaigns to reduce new HIV infections. With more than 16,000 members, 267 branches and 72 full time staff members, TAC has become the leading civil society force behind comprehensive health care services for people living with HIV&AIDS in South Africa. TAC has held the government accountable for health care service delivery, campaigned against official AIDS denialism, challenged the world's leading pharmaceutical companies to make treatment more affordable, and cultivated community leadership on HIV and AIDS.

Recommended Activities/Use of Funds In Support of LCI Objectives

LCI seeks both to maintain flexibility regarding the types of activities that will be supported and to be as supportive of country-specific needs as possible. Countries and/or regions are encouraged to propose country /regional ownership-related and sustainable activities that are not specifically articulated in the examples below, based on local needs and gaps in their current PEPFAR portfolios.

It is important to note that all proposals submitted need to clearly describe: a) how proposed activities address a stated need or problem in relation to the PEPFAR country/regional operational plan program; b) why there is need for funding outside of the annual country/regional budget and c) how the program will be sustained if it is not complete, once the LCI funding period is over.

The following list provides guidance and examples on the types of activities that may be supported, but is not an exhaustive list of activities that will be supported. Objectives and illustrative activities can be combined and proposals do not need to propose only one category.

1. Increasing accountability and transparency of a government's national commitments and planned results by advocating for transparency, evidence-based policies/regulations and civil society engagement in each stage of HIV program development and implementation.

For example, one activity that could be conducted under this objective is advocacy training and funding for select CSOs or networks/coalitions that aim to advocate for greater financing by host governments to meet currently unmet needs/gaps, such as increased treatment availability or other commitments made in national HIV/AIDS strategic plans and/or partnership frameworks or strategies. Another possible activity would be the funding of organizations to conduct HIV expenditure tracking at the district health level in countries with decentralized health systems

that locally deliver care or provide supportive services such as land, utilities, and/or transportation services that together enable better care. Yet another example would be enabling CSOs to develop with host government(s) a civil society engagement regarding a specific HIV response, in order to assure that governments have mechanisms in place for effective and formal feedback from civil society. Media training for journalists and media owners on HIV-related health care reporting might also fall under this activity. A program of advocacy efforts to eliminate corruption and greater stewardship of donor funding is another example, particularly in countries/regions that are either at risk of losing or no longer receive Global Fund HIV grants for life-saving treatment.

2. Reducing legal and policy structural barriers to a quality HIV response.

Examples of funding could be for civil society organizations to advocate for reduction of barriers including adopting or enforcing human rights based national policies so that all members of society can access HIV services including key populations and other vulnerable groups—prisoners, women, people with disabilities, LGBT, etc. For example, laws and legally condoned customs that fail to protect women and girls from violence deepen gender inequalities and increase their vulnerability to HIV. Laws that dehumanize those populations highest at risk of HIV – including MSM, sex workers, transgender people and injecting drug users—drive individuals in such groups underground and away from essential health services, thereby heightening their risk of HIV infection. Additionally, laws that criminalize HIV transmission and exposure or non-disclosure of HIV status discourage people from getting tested and treated.

3. Reducing stigma and discrimination for key populations creating greater access to HIV services.

Stigma is a powerful, discrediting and a dynamic, social process that radically and negatively affects the way individuals view themselves and the way they are viewed by others. Reinforced by underlying stigmatization, discrimination is a legal normative concept and is commonly manifested in the farm of laws, policies and administrative procedures. Examples of discriminatory measures related to HIV/AIDS include: compulsory screening and testing, compulsory notification of AIDS cases, forced eviction of PLHIV from their homes, restrictions on the rights of anonymity, prohibition of PLHIV from certain occupations, restrictions from health care access and medical examination, and even criminal prosecution. As mentioned in the PEPFAR *Guidance for the Prevention of Sexually Transmitted Diseases* (August 2011), stigma and discrimination against persons living with HIV/AIDS (PLWHA) and other "marginalized groups" present "barriers to increasing demand and access to (HIV/AIDS-related) services" resulting in the need for "efforts to overcome this obstacle."

Stigma and discrimination against members of certain key populations and other vulnerable groups—MSM, intravenous drug users (IDUs), commercial sex workers (CSW), persons with disabilities (PWDs), and others—are often heightened when access to HIV services are made difficult or denied for members of such groups. As an example, same-gender sexual activity is criminalized and transgender people lack legal recognition in more than 75 countries nations, according to a 2011 report by the World Health Organization (WHO). Such legal conditions

force members of this population to risk criminal sanctions, even if they simply try to discuss their level of sexual risk with a service provider.

Because they directly work with and represent various marginalized populations at the local level, CSOs have a unique potential for overcoming the barriers posed by stigma and discrimination, through education and advocacy efforts. As Secretary of State Clinton stated in her landmark remarks on Human Rights Day in December 2011, "Those who advocate for expanding the circle of human rights were and are on the right side of history, and history honors them." Through education and advocacy efforts, programs and activities funded under LCI will address stigma and discrimination at the individual, environmental and structural levels within the broader social, cultural, political and economic framework of a country(s) or region.

4. Supporting civil society networks/coalitions including those targeting key populations and other vulnerable groups from both a policy and programmatic perspective.

Effective engagement for a greater good often requires a collective and organized voice that can mobilize around a common issue or cause. Social movement theory assumes that people are driven into such movements out of a sense of deprivation or inequality, particularly in relation to others or in relation to their expectations. For example, in the history of the AIDS, one of the most famous social movements was the South Africa's Treatment Action Campaign (TAC). Since this network of unlikely partners first came together, it has effected positive change in that country and achieved sustainability. Indeed, among TAC's strategic objectives is to "campaign for an effective regional and global network comprising of organizations with similar aims and objectives."

Central to the viability of sustainable networks/coalition is the identification of common causes or practices that can lead to social movement and network/coalition development. As with the development of any civil society network/coalition, nascent HIV/AIDS-related networks/coalitions need to develop and implement a road map to affect policy and funding outcomes at a local, regional, and national level for PLHIV, key populations and other vulnerable groups, improved access to care and treatment programs, and strengthened prevention programs. This element of LCI will be targeted to non-governmental organizations (NGOs), CSOs, and existing networks/coalitions (professional, faith-based, community or regional associations, etc.). Key activities common to effective and sustainable HIV/AIDS-related civil society networks/coalitions must include: a) training and materials-development on how to work with policy makers at the local, regional, and national level; b) development of a policy action plan including using data for decision making, communications strategy, and use of social media; and c) training of policy makers and opinion leaders regarding relevant public health practices and model policies for impact.

5. Promoting the ability of citizens to recognize and demand quality services in their community and acting as advocates for the HIV-related health care needs of a country to hold governments accountable for service delivery.

It is important that CSOs and their leadership be as independent as possible, even as they develop key relationships with authorities and government leaders. CSOs have an important role

to play with government, particularly through participation in opportunities such as parliamentary committees and public hearings. As effective advocates, CSOs can strategically educate and inform those who hold governmental, political, economic or private power in order to effect lasting change. Activities or programs to be funded under LCI should strengthen and provide activity funding for a CSO or network/coalition of CSOs to provide a voice to the government or private sector for improving access to services necessary for the continuum of care within a national HIV response. An enabling environment in which there are effective partnerships between CSOs and the government/private sector will be an important element of successful advocacy efforts for key populations in many countries.

6. Fostering sustainability of CSOs beyond the life of USG funding in targeted assistance PEPFAR countries/regions (see Annex A).

Sustainability of CSOs is an issue for both the overall civil sector and for individual organizations. The ability of organizations to procure adequate funding depends on funds being available and accessible to them. For many HIV/AIDS organizations this has meant funding from the USG and, as this resource dwindles, there is a need to find resources elsewhere. Accordingly, options then include private sector, government and external donors.

LCI can be used to explore and help promote options for future funding both broadly for the sector and on behalf of individual organizations. In addition, organizations may need the technical competencies to be able to manage resource mobilization activities and strategies that lead to financial viability over time. LCI funds can be used to procure the necessary technical assistance to support organizations in these endeavors. The following is a list of illustrative activities that may be undertaken using LCI funds:

- Providing technical assistance to CSOs to develop resource mobilization strategies
- Working with the private sector to develop a funding strategy or mechanism for funding CSOs
- Advocating for a government-supported CSO grants program and technical assistance to the government for the development of such a program.

7. Ensuring there is an enabling environment for CSOs, resulting in increased access and uptake of HIV services.

One aspect of creating an enabling environment is to ensure that decision makers and key stakeholders from the government, communities and other sectors understand the need for and role of CSOs in providing services. This may be especially urgent in marginalized and remote populations where the public health infrastructure is weak or nonexistent. Another feature of an effective enabling environment for CSOs is the assurance of a legal framework that allows CSOs to operate—a framework that is workable, well understood and enforced. The types of enabling environment-related activities that might be funded under LCI include:

- Strengthening CSOs to work with government on the development and implementation of an effective legal framework

- Ensuring that CSOs train to strengthen other CSOs in working with government to ensure legal protection
- Strengthening advocacy for the promotion of civil society at the district/provincial and local levels to ensure that CSOs are supported (not necessarily financially) by local governments and communities
- Developing policy dialogue with stakeholders around the legal framework and issues affecting CSOs' abilities to operate

Indicators of Success

Each proposal funded will need to include some indicators of success. As suggested in the *USG Interagency Paper on Country Ownership: Global Health Initiative (GHI*), potential metrics of success include following:

- Increased domestic government health budgeting and spending over time
- Demand created at the community level which enhances accountability for government and/or local service delivery
- Number of effective CSOs with mechanisms in place for citizens to express views to government bodies (social responsiveness and accountability)
- Representation of community members and active participation of communities in governance structures
- Number of new prime partners per fiscal year who were sub-awardees in the past
- Increase in the percentage of USG funding that is awarded to local partners
- Number of new policies adopted by governments

Other indicators can be drawn from the PEPFAR *Capacity Building Framework* or the next generation indicators or other programs. Such indicators include the following:

Strategic Partnerships

Formal joint planning process aligned to country processes

- Leadership role of national/local partners defined
- Joint accountabilities defined

System/Policy

- New/updated strategic plans approved
- New/updated policies and/or standards approved
- New/updated national management systems implemented
- Official organized networks/coalitions supported

Organizational

- Assessed improvement in national/local partners technical and management capacity in targeted areas

As further illustration, the following are examples of specific organizational actions that would support these overall indicators:

- The organization is able to collect sound and persuasive data on the effects of the policy(s) sought to be changed
- The organization is able to analyze and document human rights implications of the current policy(s) and a proposed policy alternative(s)
- The organization is able to provide public education and to build public support (including through the use of media) for the proposed policy change
- The organization is able to build coalitions and networks/coalitions to enlist partners in joint action to secure the policy change
- The organization engages in direct action with the legislative and/or executive decision makers empowered to effect the policy change
- After a policy change is effected, the organization takes follow-up action to foster implementation of the policy change
- The organization demonstrates that it has institutionalized its commitment and capacity to follow-through on policy change and implementation

Resource Documents

The New Partners Initiative Resource Guide to Managing U.S. Government-Funded HIV/AIDS Programs, Second Edition. http//:www.npi-connect.net

The President's Emergency Plan for AIDS Relief FY 2012 Capacity Building and Strengthening Framework. USG Only.

U.S. Government Interagency Paper on Country Ownership: Global Health Initiative. http://www.ghi.gov

Civil Society and Advocacy: Expert Advocacy Manual. Tanzania Advocacy Partnership Program (TAPP). http://www.pactworld.org

Advocacy in Action—A Toolkit to Support NGOs and CBOs. International HIV/AIDS Alliance. http://www.aidsalliance.org

Strengthening and Measuring Advocacy Capacity of Civil Society Organizations Handbook, Pact Zimbabwe. http://www.pactworld.org/galleries/resourcecenter

Stigma, Discrimination and Human Rights, The Policy Project. Futures Group. http://www.policyproject.com/stigma.

Networks Capacity Analysis Toolkit (Rapid Assessment Guide). International HIV/AIDS Alliance. http://www.aidsalliance.org.

The TB/MDR-TB Advocacy Tool Kit, The Advocacy Partnership (March 2011). http://www.advocacypartnership.org

Integrating Stigma Reduction into HIV Programming- Lessons from the Africa Regional Stigma Training Programme, International HIV/AIDS Alliance (March 2011).
http://www.aidsalliance.org

Proposal Guidelines

All countries and regions that submit country operational plans (COPs) or regional operational plans (ROPs) are eligible to apply for LCI funding. Countries or regions can apply for funding for more than one local organization or network/coalition of organizations. Countries or regions can apply for a multi-country proposal, however the country or region proposing a multi-country proposal will need to be responsible for the program monitoring and reporting for all countries.

Proposals must be developed through an interagency process and submitted to OGAC in the FACTSInfo system as part of the COP 2013 submission through the country/region's PEPFAR Coordinator/PEPFAR Point of Contact (POC). The proposal should indicate which agency or agencies will be involved in the management of this project, what roles will be played by each and how funds will be allocated. This central initiative funding opportunity was developed to coincide with COPs so that it can be an integral part of the COP/ROP planning process and reviewers can review the proposals against the COP to assure that it increases the impact of the COP and addresses a gap(s) in the program.

As such, the final document will be due at the same time as the FY 2013 COP as an up-loadable document. It will not be entered into the COP 2013 database since these funds come from prior year appropriations and were notified separately from country/regional budgets.

The PEPFAR Coordinator or Point of Contact should notify Allison Campbell (CampbellAK@state.gov) once the submission is in the FACTSInfo system for tracking purposes.

TIMELINE	
October 1, 2012	LCI Proposal Guidelines Included in Supplemental Information in the COP 2013 Guidance
October – December 2012	LCI Working Group provides more information to the field
March 1, 2013	COP Submission with LCI proposals included as a supplemental document uploaded in FACTSInfo
March 1 – May, 2013	LCI Working Group reviews proposals and makes selections for funding
May 2013	LCI funds sent to the field

LCI one-time funding can cover up to a three-year period at a range of $350,000-$750,000 per year. Countries or regions are encouraged to propose a declining budget or reverse tiered approach budget over the program period with the goal of sustainability (i.e., $350,000 Year

One, $300,000 Year Two, $250,000 Year Three). The $750,000 annual level is anticipated for regional or multi-country proposals with country-specific proposals at smaller funding levels.

Proposal Organization

Proposals must be no more than 10 pages and must include the following sections:

- **Background**
  - Overview of the health sector addressed
  - Overview of the civil society sector in health and of advocacy within the health sector (strength of CSOs, what are the funding sources for CSOs and what are the prospects for future funding, government perception of CSOs, etc.)
  - Statement of the problem and funding gap
  - Information on why the proposed activities are not able to be funded through the COP/ROP

- **Overview of Proposed Intervention**
  - A brief description of the proposed interventions, including how they complement each other to reach the stated objectives and how they will positively impact on country's or region's PEPFAR program, in general
  - If multiple organizations are proposed for funding, description of the role(s), objectives and key activities for each organization

- **Objective(s)**
  - Listing of one to three objectives of the proposal that will address the overall LCI objectives described above
  - Description of how these objectives will lead to increased country ownership and sustainability

- **Description of Proposed Key Activities**
  - Key activities for each identified objective, including a description on how each activity will support its respective objective(s)
  - Specification regarding whether a proposed activity or one that is being expanded/scaled up through LCI
  - Identification of key assumptions that are critical to success of the activity
  - Brief explanation regarding why the combined set of activities proposed will be successful. (e.g., What evidence base is being used to determine the approach? Has this approach been successful previously or is this a new innovative idea?)
  - Description of how the proposed activities add value and increase the impact of the country's or region's current PEPFAR program

- **Identification of Technical Assistance Needs**
  While some countries may have access to technical assistance, others may find it relatively inaccessible or expensive. Accordingly, LCI will work with country offices to identify options (both through centrally and regionally funded mechanisms) to provide technical assistance to the field. Please include in the proposal specific TA needs and

identified mechanisms for addressing them—currently active local mechanism(s), locally procured, central mechanism(s), etc. This may include, but is not limited to, any or all of the following:

- Facilitating organizational assessments and developing capacity building action plans to further the objectives of the funded activity
- Providing technical assistance to CSOs in support of advocacy activities proposed
- Providing organizational development assistance to strengthen the sustainability beyond PEPFAR funding in Targeted Assistance countries (See Annex A)

- **M&E Plan**
  - Describe key indicators to be utilized based on PEPFAR Next Generation Indicators, country ownership metrics of success or *Capacity Building Framework* illustrative indicators. (If these indicators are not sufficient please explain and propose additional indicators.)
  - Describe how the LCI-funded activities will have a positive impact on the country or region's ability to achieve its annual PEPFAR targets—including World AIDS Day targets, if applicable
  - Describe evaluation components that will inform expansion of programming (if applicable) and contribute to the evidence- base for capacity building, specifically as it relates to advocacy

- **Sustainability Plan**
  - Describe which project activities are expected to continue beyond the life of the project and how they will be continued.

- **Management & Staffing**
  - Describe how the PEPFAR Country Team will manage the proposed LCI activities, including which agency(s) will be responsible and which USG or Host Country National staff member(s) will be dedicated to the LCI funded project(s)

- **Budget**
  - Cost of project activities (funding for each local organization)
  - Cost of technical assistance requested (there may be TA costs paid for through other sources

- **Organizational Background Information** (See attached template)

Review Criteria

Proposals will be reviewed by the LCI Interagency Working Group based on the following criteria:

1. Understanding of Need and Scope

Proposals will be evaluated based on the extent to which they:

- Address the stated gap or problem statement in relation to the local PEPFAR program

- Demonstrate the need for additional funding outside of the COP/ROPs
- Demonstrate an understanding of the civil society organization's need for technical assistance to be successful

2. Approach to Implementation

Proposals will be evaluated based on the extent to which they:

- Articulate clear objectives and proposed activities to meet them (including capacity building/TA needs)
- Explain the relationship between the proposed project and enhancement of country ownership and a sustainable civil society response in relation to the objectives of the LCI funding
- Provide a sustainability strategy if needed beyond the one-time funding

3. Project Management

Proposals will be evaluated based on the extent to which they:

- Present an appropriate timeline for project activities
- Demonstrate investment by the PEPFAR team in the form of complementary funding and/or dedication of staff time for activity monitoring
- Identify systems and procedures to effectively manage the proposed activities
- Identify each USG agency(s) to be involved, specifying key roles and responsibilities

4. Monitoring and Evaluation

Proposals will be evaluated based on the extent to which they:

- Present a plan for monitoring and evaluation that articulates methods for collecting, managing, analyzing and utilizing data
- Specify appropriate and relevant indicators for monitoring and evaluation
- Demonstrate the potential for improved access to health care services where applicable
- Demonstrate the potential for impact on the PEPFAR program in the country or region, especially in terms of its ability to meet annual targets

Annex A: PEPFAR Country Ownership COP/ROP Country Categories

<table>
<tr><td colspan="3">PEPFAR Country Categories</td></tr>
<tr><td>Long Term Strategy (LTS):
- Burundi
- Cameroon
- Cote d'Ivoire
- DRC
- Ethiopia
- Haiti
- Kenya
- Lesotho
- Malawi
- Mozambique
- Rwanda
- South Sudan
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zimbabwe</td><td>Targeted Assistance (TA):
- Asia Regional (Laos, Burma, Papua New Guinea)
- Cambodia
- Caribbean Regional (Antigua & Barbados, Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St Vincent & the Grenadines, Suriname, Trinidad &Tobago),
- Central America Region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama)
- Central Asia Republics (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan)
- Dominican Republic
- Ghana
- India
- Indonesia
- Ukraine
- Thailand</td><td>Technical Collaboration (TC):
– Brazil
– China</td></tr>
<tr><td colspan="3">Co-financing (Co-F) Emphasis</td></tr>
<tr><td>Long Term Strategy (LTS):</td><td>Targeted Assistance (TA):</td><td>Technical Collaboration (TC):</td></tr>
<tr><td>Nigeria</td><td>Angola, Botswana, Guyana, Namibia, South Africa Vietnam</td><td></td></tr>
</table>

Annex B: Local Capacity Initiative (LCI) Civil Society Organization Background Questionnaire

Directions: Complete form for each proposed prime recipient civil society organization proposed for funding under LCI.

Country(s) of Proposed Project:

Organization Name:

Amount of Funding Requested:

Length of Proposed Project:

Does the proposed CSO have sub-grants or subcontracts to other organizations?

Yes ☐ No ☐

If yes, list organizations names and proposed sub-grant amounts?

Please indicate type of Civil Society Organization:

Faith-Based Org (FBO):

Network/Coalition:

Academic Institution:

Community Based Org (CBO):

Professional Association:

National NGO:

Local Regional NGO:

Local District NGO:

Multi-country Regional Organization:

Other

Does your organization have legal status to operate in the country? Yes ☐ No ☐

What is your organization's approximate annual operating budget?

What is the number of staff members of your organization?

Does your organization have a board? Yes ☐ No ☐

Who is your organization's primary funder?

Is your organization currently receiving USG funds? Yes ☐ No ☐

If yes, please indicate which USG agency:

Appendix 14: Key Populations Challenge Fund

Background on the Key Populations Challenge Fund

At the International AIDS Conference held in Washington, DC in July 2012, Secretary Hillary Rodham Clinton announced the first Key Populations Challenge Fund (KPCF). The goal of the KPCF is to support a scope of projects that contribute to an evidence-based, sustainable HIV response for Key Populations in PEPFAR- supported country programs. For the purpose of this funding announcement, Key Populations include people who inject drugs (PWID), female sex workers (FSW), and men who have sex with men and transgender persons (MSM and TG), including those who sell sex.

Rationale

PEPFAR's authorizing legislation recognizes the importance of addressing HIV among Key Populations as an essential component of an effective HIV response. This commitment is articulated within PEPFAR technical guidance documents which are grounded in a rights-based approach to programming for Key Populations.
While PEPFAR has had a commitment to addressing Key Populations in its programs, it is clear from Country Operational Plan (COP), and Regional Operational Plan (ROP) reviews that programming for Key Populations would benefit from additional attention and funding. Furthermore, PEPFAR country teams have indicated that there is ongoing interest and commitment to improve and expand programs.

In response to these needs, an additional $20 million in funding has been designated as the "PEPFAR Key Populations Challenge Fund." This fund will catalyze the initiation, innovation, or expansion of strategic programming for Key Populations within PEPFAR programs, based on the comprehensive packages of services recommended for key populations (see technical considerations). The purpose of this document is to provide instructions for country and regional programs to apply for these additional resources.

Requirements

Funding will be distributed as matching funds to ensure that the country program is invested in the proposed project. Matching is defined as funds from PEPFAR (COP/ROP/OP) budgets. No fixed ratio of matching is required; however, the matching amount requested should be reasonably aligned with current budget and staffing of a country's PEPFAR program. The level of investment made by the PEPFAR program will be considered during the review of proposals; therefore it will be important to provide justification for the proportion of contribution from the country program.

In addition to single country proposals, multi-country regional proposals addressing common issues related to key populations, mobile key populations who cross borders, encouraging regional interventions, and engaging south-to-south collaboration, are acceptable. If country/regional programs propose use of funds from their PEPFAR budget, this must be reflected in the FY 2013 Operating Plans. These funds can be reprogrammed from prior year

budgets or dedicated in advance from the current operating plan. A minimum investment of 100,000 USD from the PEPFAR budget (prior to the KPCF match) is required. Programs must identify who will be responsible for financial and technical management in-country and what proportion of his or her time will be devoted to the proposed activities.

If an application proposes to leverage non-PEPFAR funding, proposals must describe how other donor activities may complement the proposed activity/ies. In addition, programs must provide an estimate of funding and describe how proposed activities will be integrated into host government or other donor activities. For example, if the Ministry of Health is funding a confidential clinic for sex workers with their funds, the challenge funds could be used to establish an improved monitoring system to measure and enhance referrals of HIV-positive persons to pre-ART and ART programs. The KPCF matching funds are disbursed as one-time plus up funds only and not incorporated into countries' base budgets for this or future funding years; rather the funds are intended to accelerate or complement country investments. While these are one-time funds, they may be used over more than one year, in certain cases. To have significant impact, activities to be funded through the KPCF may need longer term investments and consideration should be given to rolling long-term activities into future COPs/ROPs/OPs. It is important to describe your plan to sustain programming where needed and the time-frame for investments.

Guiding Principles for Proposal Development

Proposals should be consistent with PEPFAR's vision of "country ownership;" i.e., they should reflect substantive engagement of civil society and/or partner government at the national and/or sub-national level and, where appropriate, the private sector. If possible, proposals should be linked to Partnership Frameworks and Partnership Framework Implementation Plans, or to PEPFAR Strategies.

A. Proposed activities should be considered within the context of other USG activities in country. The KPCF provides an opportunity to fund innovative programs that build on other platforms.

B. The KPCF are to complement, not replace, current or future key populations funding and should be used to help establish, improve the quality, and/or increase the scope of programs through proposals that:.
   - support an enabling environment for Key Populations, i.e. an environment of laws, regulations, policies and social norms that support the implementation and scale-up of evidence-based interventions.
   - improve implementation of the comprehensive package of services for key populations (see technical considerations for more details on these services) by:
     a) increasing coverage of evidence-based prevention, care, and/or treatment services for Key Populations
     b) improving the quality of programs for Key Populations
     c) implementing quality assurance standards for Key Population programming
     d) improving linkage, entry and retention in care and treatment for Key Populations

e) identifying best practices for successful linkages between prevention to care and treatment for Key Populations
f) identifying best practices for co-locating services within the comprehensive package
g) increasing access to sexual and reproductive health services for Key Populations
h) strengthening the use of monitoring and evaluation of key population services, interventions and linkages into other HIV services

C. Implementing agencies and mechanisms will be determined in-country.

Eligibility

Proposals will be accepted from all PEPFAR countries. Factors to be considered are current epidemiology, funding and coverage of services for key populations, as well as quality, feasibility and merit of the proposal. However, preference will be given to programs with budgets lower than $10 Million USD per year. Country or regional programs with higher PEPFAR budgets may make a case for funding but are also encouraged to program/reprogram current resources and/or pipelines to address needs related to Key Populations. We anticipate funding at least one proposal per region.

Each country program or regional program may submit **only one application**. This application may include multiple activities and/or multiple agencies. The full application must be approved through an interagency process, describe potential implementing partners or mechanisms, and be submitted by the PEPFAR Coordinator or Point of Contact. Applications that do not meet these criteria will not be reviewed.

For guidance on programming for Key Populations, please see the FY2013 Technical Considerations as well as PEPFAR Guidance documents on Prevention for PWID, MSM, and Sexual Prevention (www.pepfar.gov/guidance).

Application Process

Application for the KPCF will take place in two phases:
1) Submission of 2 page concept paper
2) Submission of detailed proposals for selected concepts

I. REQUIRED CONTENT OF THE CONCEPT PAPER

Concept paper should be a maximum of 2 pages and shall include:
1. Brief Background Description, including available data on key populations, gaps in knowledge and/or services as well as information on the sociopolitical context (enabling environment) for key populations
2. Goals & Objectives of proposed activity(ies)
3. Description of activity(ies)
4. Monitoring and Evaluation Plan, including measurable outcomes/targets and formative assessments for new programs or new components of existing programs. This section

should be included as an Appendix, maximum of one page, and will not count toward the 2 page limit.
5. Sustainability Plan
6. Estimated total funding needed and timeline for implementation and spending

The Key Populations TWG will review concept papers and select a limited number for development of detailed proposals. Where needed, countries will be provided with technical assistance (TA) to prepare the detailed proposal. A request for TA from the TWG can be made by the PEPFAR Coordinator or Point of Contact to the Key Populations TWG by contacting Tonia Poteat at PoteatTC@state.gov.

II. REQUIRED CONTENT OF THE FINAL PROPOSAL

Proposals should be a maximum of 10 pages.

- Background:

a. Briefly describe the social, political, and epidemiological context and key population data where/if available for the country of interest.
b. Provide any pertinent information about your country's PEPFAR and USG work and capacity related to key populations and the rationale for your proposed activity(ies). This may include descriptions of some or all of the following, but may also expand beyond these suggested areas:

i. Staff expertise/experience with work related to key populations.
ii. Current integration of PEPFAR technical considerations for key populations into programming.
iii. PEPFAR country or regional strategy on key populations and/or knowledge of other key population strategies that exist locally or nationally in your country.

c. Describe the commitment of civil society, private enterprise, and/or government, etc. to work with key populations, and how the proposed activities fit into the overall USG and PEPFAR strategy, including Partnership Frameworks.

- Activity(ies) description: Please include the following points in the description of each activity being proposed. If capacity building or other external technical assistance needs are necessary for design, implementation and/or completion of activities, a description of these should be included in the proposal and budgeted for appropriately.
  a. Target groups and goals and objectives the activity/ies are trying to achieve.
  b. Description of the activities
     i. Which of the key population groups does this activity plan to address (you may target more than one, as appropriate)?
     ii. How does the activity fill a gap or build on current evidence based practices?
     iii. Provide a brief description of the proposed activity(ies). What are the objectives and intended short-term outcomes of the activity(ies)?
  c. Activity timeframe—What is the duration and timeline for the activity?

d. Integration and leveraging—Indicate whether the activity will be integrated with other PEPFAR or USG ongoing activities in the country or region, and/or with programs and activities funded by the host government and/or other donors (e.g., Global Fund).
e. Funding levels—What is the total funding required from HQ, the field and, potentially other sources over the time frame of the activity? Please be sure to include activities focused on building capacity among PEPFAR's implementation partners to implement key populations programming, and indicate the level of matched contribution from COP/ROP/OP budgets, staff time, or other funds.
f. Proposed agency and mechanisms—What mechanism(s) would be used to implement the program activities in country?
g. Implications for management and staffing—How will the activity be overseen on the ground? Does it require additional staffing and/or training? Who will serve as the technical and budgetary leads?

- Monitoring and Evaluation Plan: Describe how you intend to monitor and evaluate the activities described in your proposal. If you propose a new program/new activity describe if you need or plan to use funds to conduct a rapid or formative assessment prior to starting implementation.
- Letters of supports from key collaborators should be included with the submission of detailed proposals

- Timeline/schedule

i. **November 1, 2012**: Countries/regional programs submit 2 page concept papers describing the proposed activity/ies..
ii. **December 1, 2012**: Key Populations TWG will complete their review of concept papers and select a limited number for development of more detailed proposals. Where needed, these countries will be provided with technical assistance to write a full proposal.
iii. **January 21, 2013**: Countries/regional programs submit full 10-page proposals.
iv. **February 22, 2013:** The Key Populations TWG will complete their review of full proposals and make recommendations to the Deputy Principles to request approval for funding from Ambassador Goosby.
v. **March 1, 2013**: Countries/regions submit programming requests as part of their FY13 COP/ROP/OP submission**.**

Please submit concept papers by November 1, 2012 to Tonia Poteat (PoteatTC@state.gov).

Please contact Tonia Poteat if you have any questions.

Appendix 15: Change Table

Version	Date	Location of Change	Description of Change
2	Oct 12, 2012	Appendix 13, Annex A Pg. 102	Country Ownership categories updated