

The President's Emergency Plan for AIDS Relief

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**FY 2009**

# **COUNTRY OPERATIONAL PLAN GUIDANCE**

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*Final Draft for USG Distribution Only*

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## Introduction

Just five years ago, many questioned whether prevention, treatment and care could ever successfully be provided in resource-limited settings. Only 50,000 people living with HIV in all of Sub-Saharan Africa were receiving antiretroviral treatment.

President Bush and a bipartisan Congress reflected the compassion and generosity of the American people in restoring hope by combating this devastating pandemic. They recognized that HIV/AIDS was and is a global health emergency requiring emergency action. But to respond in an effective way, it has been necessary to build systems and sustainable programs as prevention, care and treatment are rapidly provided, creating the foundation for further expansion of services and programs to those in need. The success of PEPFAR is firmly rooted in these partnerships, in the American people supporting the people of the countries in which we are privileged to serve -- including governments, non-governmental organizations including faith- and community-based organizations and the private sector -- to build their systems and to empower individuals, communities and nations to tackle HIV/AIDS. And as the first phase of PEPFAR has shown, it is working.

In rolling out the largest international public health initiative in history, we have acted quickly. We have obligated 94 percent of the funds appropriated to PEPFAR so far, and outlaid or expended 59 percent of them. But success is not measured in dollars spent: it is measured in services provided and lives extended and saved.

PEPFAR is well on the way to achieving its ambitious targets of supporting treatment for two million people, prevention of seven million new infections, and care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children. PEPFAR-supported programs have reached tens of millions of people with prevention services and messages. Since 2004 the U.S. Government has supplied 1.8 billion condoms worldwide – more than all other developed countries combined. PEPFAR has supported antiretroviral prophylaxis during approximately 800,000 pregnancies, preventing an estimated 157,000 infant HIV infections. PEPFAR has supported HIV testing and counseling for 30 million people, and supported care for more than 6.6 million, including more than 2.7 million orphans and vulnerable children infected and affected by HIV. As of September 2007, PEPFAR supported antiretroviral treatment for approximately 1.45 million men, women, and children worldwide. Of these, more than 1.33 million are in Sub-Saharan Africa.

## Country Operational Plans

*The President's Emergency Plan for AIDS Relief (PEPFAR)* is a landmark initiative that brings together all U.S. Government (USG) global HIV/AIDS assistance into a coordinated interagency approach to prevent new HIV infections and to treat and care for individuals living with the disease. The U.S. Global AIDS Coordinator, who is the President's representative on international HIV/AIDS issues, has "primary responsibility for the oversight and coordination of



all resources and international activities of the United States Government to combat the HIV/AIDS pandemic.”<sup>1</sup>

PEPFAR incorporates U.S. Government support to HIV/AIDS efforts through U.S. bilateral programs and U.S. contributions to multilateral initiatives. Support for multilateral initiatives includes the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund/GFATM) and UNAIDS; bilateral programs include those in the 31 countries that report directly to OGAC, as well as smaller programs in dozens of other countries. In total, PEPFAR supports activities in approximately 100 countries around the world.

At the country level, it is essential that all USG agencies working to fight AIDS come together as one team under the leadership of the U.S. Ambassador, in partnership with host country governments and other key stakeholders, to plan, implement and monitor progress. The one USG PEPFAR team should be staffed to meet country-specific programmatic goals and targets. Coordination with other stakeholders, including national governments and other implementing partners, is vital to the sustainability of programs and efficient use of resources. PEPFAR is committed to supporting the principles of the “Three Ones” in all countries receiving support from the USG; PEPFAR activities should be aligned with the host country’s national framework, national coordinating authority and national monitoring and evaluation system. Development of the Country Operational Plan (COP) is an important step in this coordinated planning and reporting process as well as the vehicle for funding approval.

The **Country Operational Plan and Reporting System (COPRS)** combines all U.S. Government agencies planning and reporting on PEPFAR activities into one central data system, to facilitate country-level interagency planning, monitoring and data management. COPRS is also the tool that provides information for funding review and approval and serves as the basis for Congressional notification, allocation and tracking of budget. In addition, this central USG data system provides the means to collect and analyze data related to PEPFAR planning and reporting requirements, including the COPs and Annual Program Results (APR). Data from COPRS is also provided to the Department of State’s Director of Foreign Assistance (F) as appropriate. COPRS serves as the single means of documentation for PEPFAR funding, activities and results, and has greatly strengthened our transparency and accountability to key stakeholders.

## Why prepare a COP?

PEPFAR seeks to combat the epidemic through support to focused prevention, care and treatment programs and foster bold leadership and support to strengthen national and community responses. Building sustainability, in particular through strengthening the capacity of local organizations, is also a key theme. Development of an annual COP provides an important opportunity to bring the USG country team and key host country and international partners together in a planning process that highlights areas for USG investments and support within the context of the Three Ones.

The COP itself is, essentially, a comprehensive and rigorous information system. It inventories detailed information about planned activities in a given country that are based on strategies and

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<sup>1</sup> U.S. Leadership Against AIDS, Tuberculosis and Malaria Act of 2003, Section 102.

approaches developed in-country, as well as additional PEPFAR programmatic guidance and technical considerations. Such a system is essential in order to link resource allocation to results and demonstrate program impact and fiscal accountability. The ability to make this linkage has helped ensure continued support for PEPFAR at the highest levels of leadership. The COP also serves as an important tool to communicate program advances from a technical and policy standpoint. The Global AIDS Coordinator's final approval of country plans and annual budgetary decisions are based on the thorough review of information submitted through the COPRS system.

### **Which Countries Prepare an FY 2009 COP?**

The countries asked to prepare a full COP and/or mini-COP remain the same as FY 2008. Phase I focus countries, as well as Cambodia, India, and Malawi, will prepare a full COP. Angola, China, Dominican Republic, Democratic Republic of the Congo, Ghana, Indonesia, Lesotho, Russia, Thailand, Ukraine, Sudan, Swaziland and Zimbabwe will prepare Mini-COPs. In FY 2010, there will not be the distinction of a COP and Mini-COP; all countries will use the same format for planning and reporting.

## **COP Formulation**

### **Burden Reduction in the FY 2009 COP**

Recognizing how hard country teams work to plan, implement, and report on PEPFAR programs, steps have been taken to reduce the burden of COP development and submission on country teams in FY 2009. These steps include:

- The FY 2008 COPRS database will be maintained, allowing for importation of continuing activities.
- Activity-level targets will not be collected for the FY 2009 COP. Please note that while country teams will not be required to upload activity-level targets in COPRS, these targets must be collected by country teams in order to track partner performance and to calculate the program summary targets.
- As in FY 2008, countries meeting performance benchmarks in PMTCT, Counseling and Testing, and Adult Treatment will receive performance passes in FY 2009. Further information about which countries will receive performance passes will be forthcoming.
- The Emphasis Areas section of the COP has been streamlined, with fewer required tickboxes. Only two Target Populations will be captured this year - Refugees/Internally Displaced Persons and Military Populations - and these will be listed in the same table as the Emphasis Areas. In addition, the Geographic Coverage area requirement has been eliminated.
- Activities approved in FY 2008 and that are ongoing do not need extensive revision in FY 2009. An additional 5,000 characters have been added so country teams can add an update, rather than re-write the narrative.

## Deadline

All FY 2009 COPs and Mini-COPs must be submitted to OGAC by Friday, November 14, 2008. This year, Annual Progress Reports will also be submitted on the same date, so please plan appropriately.

## Interagency Coordination

A key focus of PEPFAR is the USG interagency response, in which all USG agencies working in a host country plan, implement and monitor a unified country program as one USG team. This is critical as you formulate your country's COP. Thus, **it is essential that ALL USG agencies working on HIV/AIDS programs in-country be included in discussions regarding the COP.** Countries may have several sources of HIV/AIDS funding; however, ALL HIV/AIDS programming decisions are to be made as an inter-agency USG Team. Funds directed through a particular USG agency should not be programmed independently by that agency, but should support the entire country strategy.

Not all USG agencies may have a country presence, but that should not obviate their ability to work in-country if the area of expertise of that agency would benefit the program. The COP process presents an opportunity to seek that technical expertise and support. If one or more of the five USG Agencies that must be listed in the Contact Section are not present in your country, you should be in contact with someone from the Agency Headquarters to involve them in the COP process.

All USG planning should occur within the context of the "Three Ones." As you develop your Fiscal Year (FY) 2009 COP and prepare for submission of the document to OGAC, you should include time in the schedule for active participation and review by the Host Country Government. Sharing of information with host government authorities, e.g., Ministry of Health, National AIDS Council, a local multi-sectoral PEPFAR Council, or multilateral partners (e.g., Global Fund, UN agencies) is an essential aspect of effective planning, leveraging resources, and fostering sustainability of programs. Approval of the COP by the host government is also a requirement for submission to OGAC. At the same time, procurement-sensitive information contained in the COP needs to be protected. Please note the following guidelines:

FY 2009 COPs should be shared on a "need to know" basis, as determined by the Ambassador or his/her designee. The USG team may share the entire FY 2009 COP, including partner narratives, and funding levels, with host government officials that have responsibility for COP approval, subject to the following instructions:

- Electronic copies of the COP should not be distributed to the host government to prevent distribution beyond those with a legitimate "need to know" for planning and coordination purposes.
- Hard copies of the full COP may be shared with the host government reviewers, but all copies should be retrieved following the review session.
- Any award which is "to be determined" (whether at the prime or sub-partner level) should be redacted (deleted) from the hard copy of the COP to be reviewed by the

host government. However, aggregate dollar amounts for TBD award(s) within one program area (as opposed to by mechanism) may be summarized for the host government, e.g., “In the PMTCT program area, we plan to add \$2 million through new awards”. The activity-specific narrative for any “TBD” award should also be deleted.

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

The finalized COPs from previous years may also be shared with government officials and partners on a “need to know” basis as determined by the Ambassador or his/her designee. However, if the prior year COP continues to contain TBD awards, they should be deleted as described in bullet 3 above.

## Partner Performance Considerations

Country teams should regularly review partner programmatic and financial performance, especially in preparation for COP planning, to ensure the best use of resources and that partner spending is commensurate with workplans and results achievements. As part of a partner performance and portfolio review, an interagency team should review each partner’s overall performance based on clear technical targets and program indicators, as well as the partner’s technical approach, program and financial management, data quality, and management and staffing. Whenever possible, information from interagency on-site reviews of USG-supported partners should augment the program data. While the use of a standard template is not required this year, **each PEPFAR country team is expected to conduct joint interagency partner performance reviews of prime partners in FY 2008** for FY 2009 COP planning. There is no specific guidance as to how these are carried out, but many of the countries have found the use of technical working groups helpful. Headquarters (HQ) will NOT collect the review assessments; however, Core Teams and Deputy Principals will remain in touch with country teams to answer any questions and support completion of the reviews.

Country teams are responsible for ensuring that funding is spent at a pace commensurate with the requirements of PEPFAR. Therefore, country teams should confirm that partners do not have large pipelines before requesting additional funding. To help facilitate this in-country review in FY 2008, pre-populated templates were provided by Core Team Leads to country teams in March for entry of data for the pipeline analysis report. All countries that prepared a COP for FY 2008 are expected to prepare a pipeline analysis report that captures partner-level pipeline financial information, captures the pipeline data for all funding approved in the COPs, and is shared among agencies across the entire PEPFAR country team.

See the March 28, 2008, News to the Field for more information on the partner performance reviews and pipeline analysis report.

## Support for COP Development and Submission

Your Core Team Leader and Core Team members, including the Strategic Information (SI) Advisor, and technical working groups (TWGs) are important participants and can help in supporting the COP process. Your Core Team Leader is your main point of contact at OGAC and should be substantially involved. A key first step in the COP process should be a review of current priorities, activities, results, gaps and issues to ensure that programming is driven by the local country epidemic with consideration of overall budget allocation realities. The Core Team, and in particular the Core Team Leader and SI Advisor, play a critical role in this effort. In addition, the Core Team Leader can support the PEPFAR Coordinator in developing and overseeing the overall process of COP development, including facilitating essential assistance from the Core Team and technical working groups. Engaging the SI Advisor early in the process, to assist with target-setting and with planning of Strategic Information activities, is also essential. Your Core Team members can help with strategic planning of activities, drafting early versions of COP narratives, and reviewing and finalizing the COP. If you would like assistance from one of the technical working groups, please contact your Core Team Leader. The Technical Considerations Compendium, assembled by the TWGs, is a companion document to be used in conjunction with the COP Guidance.

## Changes from FY 2008

Due to the fact that the format of the COP will change in FY 2010, changes to the FY 2009 COP were limited to the extent possible. That said, there are a few changes that will need to be instituted this year:

### Policy Changes

1. Due to the fact that reauthorization of PEPFAR is still pending with the U.S. Congress, some areas of policy are still under discussion, including any possible funding directives. OGAC will provide an Addendum to the FY 2009 COP Guidance as information becomes available.
2. In the second phase of PEPFAR, Partnership Compacts will be the only way in which additional funding, above FY 2009 base levels, are allocated to PEPFAR countries. Further information about Partnership Compacts is available on page 17. In order to ensure responsible and ongoing support to those assisted through the first phase of PEPFAR, no programmatic scale-up should be planned to occur outside of the Partnership Compacts. Modest scale-up during FY 2009 should occur only to the extent the team feels that there is sufficient funding to maintain the increased levels of support on an ongoing basis under a baseline budget.
3. The submission and review process for Public Health Evaluations has been revised and will occur prior to the COP submission. In addition, PHEs will be funded centrally. Due to this change, renewal funding for country-priority PHE activities, including those originally funded in FY 2008 or earlier, will potentially limit the ability of programs with significant out-year commitments from undertaking new country-priority PHEs. Country program funds cannot be utilized to fund new or ongoing PHEs in FY 2009.
4. To further emphasize the importance of pediatric care and treatment programs, a pediatric care and treatment program area narrative and pediatric care and pediatric treatment budget codes have been added. See page 71 for more information. Similarly for Gender and Human Capacity Development, program area narratives have been added for both to highlight how countries are addressing these key issues. HCD will also have a secondary cross-cutting budget attribution field this year. See appendix 19 for more information.

5. Male circumcision continues to be an area of growth for PEPFAR, and in FY 2009 there is no funding limit per country for safe male circumcision services or other related activities. See page 24 for more information.
6. Based on a recent expert technical consultation on cervical cancer screening in HIV-positive women, and review by the Scientific Steering Committee, PEPFAR will support, as part of a comprehensive approach to opportunistic infections, screening and treatment to prevent cervical cancer in HIV-positive women. Country teams should document a detailed assessment of capacity to provide services related to cervical cancer screening and treatment. PEPFAR will support limited/pilot programs which provide screening for HIV-positive women only. Recommendations for screening programs are further defined in the technical considerations document and in Appendix 18.

### COP Structure Changes

1. The most significant change is the introduction of revised program areas, program area budget codes and secondary cross-cutting budget attributions. These changes were required in FY 2009 to meet Congressional requests. In addition, there is a need to track and report on the same fields over the five years of PEPFAR II. There is additional guidance on splitting comprehensive activities across program areas / program area budget codes. It is important to note that two of the new program areas, HCD and Gender, do not have associated program area budget codes and will be captured in the Required Supporting Documents section. HCD does have a secondary cross-cutting budget attribution. Gender will be tracked through tickboxes at the activity level. Information about program area budget codes and secondary cross-cutting budget codes can be found below.

PROGRAM AREAS	PROGRAM AREA BUDGET CODES
PMTCT	01-MTCT Prevention: PMTCT
Sexual Prevention	02-HVAB Sexual Prevention: AB 03-HVOP Sexual Prevention: Other sexual prevention
Biomedical Prevention	04-HMBL Biomedical Prevention: Blood Safety 05-HMIN Biomedical Prevention: Injection Safety 06-IDUP Biomedical Prevention: Injecting and non-Injecting Drug Use 07-CIRC Biomedical Prevention: Male Circumcision
Adult Care and Treatment	08-HBHC Care: Adult Care and Support 09-HTXS Treatment: Adult Treatment
Pediatric Care and Treatment	10-PDCS Care: Pediatric Care and Support 11-PDTX Treatment: Pediatric Treatment
TB/HIV	12-HVTB Care: TB/HIV
OVC	13-HKID Care: OVC
Counseling and Testing	14-HVCT Care: Counseling and Testing
ARV Drugs	15-HTXD ARV Drugs

Laboratory Infrastructure	16-HLAB Laboratory Infrastructure
Strategic Information	17-HVSI Strategic Information
Health Systems Strengthening	18-OHSS Health Systems Strengthening
Human Capacity Development	
Gender	
Management and Staffing	19-HVMS Management and Staffing

<b>Secondary Cross-cutting Budget Attributions</b>
<b>1.</b> Human Capacity Development
<b>2.</b> Public Health Evaluation
<b>3.A</b> Food and Nutrition: Policy, Tools and Service Delivery
<b>3.B.</b> Food and Nutrition: Commodities
<b>4.</b> Economic Strengthening
<b>5.</b> Education
<b>6.</b> Water

2. Due to the changes in Program Areas, Table 2 targets and Table 3 targets for FY 2009 will be collected through an Excel template that will be uploaded into the Required Supporting Documents Section. Activity level targets will not be collected for the FY 2009 COP. Please note that while country teams will not be required to upload activity level targets in COPRS, these targets must be collected by country teams in order to track partner performance and to calculate the program summary targets.
3. Table 2 includes an additional indicator measuring human resources for health. Further guidance about this indicator will be given shortly.
4. The Emphasis Areas listed below have been streamlined from FY 2008 and will be required. Only two Target Populations will be captured this year: Refugees/Internally Displaced Persons and Military Populations. These will be listed in the same table as the Emphasis Areas. Geographic Coverage is not required to be updated.

- |  |   |
|--|---|
| <input type="checkbox"/> Construction / Renovation<br><input type="checkbox"/> Gender <ul style="list-style-type: none"> <li><input type="checkbox"/> Addressing male norms and behaviors</li> <li><input type="checkbox"/> Increasing gender equity in HIV/AIDS programs</li> <li><input type="checkbox"/> Increasing women's access to income and productive resources</li> <li><input type="checkbox"/> Increasing women's legal rights</li> <li><input type="checkbox"/> Reducing violence and coercion</li> </ul> <input type="checkbox"/> Workplace Programs | <input type="checkbox"/> Wraparound Programs (Health-related) <ul style="list-style-type: none"> <li><input type="checkbox"/> Child Survival Activities</li> <li><input type="checkbox"/> Family Planning</li> <li><input type="checkbox"/> Malaria (PMI)</li> <li><input type="checkbox"/> Safe Motherhood</li> <li><input type="checkbox"/> TB</li> </ul> <input type="checkbox"/> Refugees/Internally Displaced Persons<br><input type="checkbox"/> Military Populations |
|--|---|

5. Country teams should not spend significant time writing narratives for activities that were approved last year and will largely stay the same in FY 2009. For ongoing activities, countries should just provide a brief update to the current activity narrative and use the key phrases provided in Section 3 to distinguish the additional text. If an activity is new or significantly changed, country teams do need to provide a narrative.



6. The PHE process has changed and requires a submission of proposals to the PHE committee prior to COP submission. More information can be found in Appendix 23.
7. The definition of sub-partner has been updated. New guidance can be found on page 64.
8. The submission date for the COP is November 14<sup>th</sup>, but Early Funding will need to be submitted on September 12<sup>th</sup>. Early Funding requests will be submitted through a brief form on the PEPFAR Extranet.
9. For the FY 2009 Executive Summary, please start with the updated the Executive Summary used for FY 2008 Congressional Notifications. The FY 2008 Executive Summary is posted on the PEPFAR website: <http://www.pepfar.gov/about/opplan08/102048.htm>.
10. There is an additional table required for Management and Staffing, which itemizes each USG agency's M&S expenses by program area and fund account.
11. A Peace Corps Volunteer Matrix is not required this year. For each country and in aggregate, Peace Corps Washington will submit to OGAC for the number of PEPFAR-funded Peace Corps Volunteers.
12. Public-Private Partnerships (PPPs) will not be captured at the activity level as they were in FY 2008, but at the summary level. There will be one table that needs to be filled out for the entire portfolio and uploaded as a Supporting Document. Further information can be found in Appendix 26.
13. There is updated guidance on how to enter NPI Round 1 activities. Further information can be found on page 53.
14. The Health Care Worker Salary Report is a required supporting document this year.

**Please Note:**

- As in previous years, the appendices contain critical information which should benefit program planning. In addition, additional COP resources (such as the list of COPRS administrators) are available on the FY 2009 COP Planning section of the Extranet.
- Other channels of communication to strengthen COP planning, including work with Core Team Leaders and bimonthly “phone home” calls, are important. Based on these, headquarters will develop Questions and Answers to clarify issues in the COP, to be disseminated through News to the Field and by posting on the PEPFAR Extranet, and will disseminate any COP updates in the same fashion.
- The COPRS character counts is slightly different than the Microsoft Word count. When working in Microsoft Word, you need to add the count for “characters (with spaces)” to the count for both “lines” and “paragraphs” to get the same total that COPRS calculates.

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## Key Issues and Policies for FY 2009

### Planning and Reporting Redesign Process

A redesign of the PEPFAR planning and reporting policy has emerged from an ongoing and highly consultative process that integrates input from stakeholders. The process began last November and has been led by an inter-agency group made up of field and HQ staff, and includes the Office of the Director of Foreign Assistance (F) and the President's Malaria Initiative (PMI). A framework was developed with the dual objectives of reducing burden of planning and reporting, as well as improving the quality of the data collected. These concepts were vetted through a series of focus group discussions with USG field teams, Technical Working Groups, PEPFAR Coordinators, and the Deputy Principals to come up with a solution that best accommodate the varying needs.

Based on this input as well as the need to launch a new database platform, in coordination with F, PEPFAR will continue to work with the PEPFAR I COP platform. The FY 2009 COP will maintain the current activity-based model supported by the COPRS database. Some modifications will be made to the system to respond to areas of Congressional interest. The major changes are the introduction of new Program Areas, Program Budget Codes and Secondary Cross-cutting Budget Attributions. Specific titles and definitions appear on page 69 of the Guidance. Unlike previous years, where each budget code mapped one-to-one with a program area, in FY 2009, program areas provide summary level information about country programs. Activities will be captured under each program budget code, since in some cases program areas link to multiple program budget codes ("one-to-many"). In addition, we have added seven secondary cross-cutting budget attributions this year. These new codes allow us to capture more specific information on funding at the activity level, in order to better respond to legislative requirements and Congressional inquiries.

The development of FY 2010 COP Guidance and Next Generation Indicators will continue through the remainder of FY 2008 and into FY 2009, and will continue to be a consultative process. The goal is to provide training on the new IT system and COP guidance prior to the Implementer's Meeting in FY 2009. Please see the timeline below for further detail.

### Timeline for FY 2009 and FY 2010 COP Process

This calendar represents the timeline for the next 12 months of PEPFAR. News to the Field and PEPFAR.net will provide updates.

Date	Task	HQ/Field
May 1	COPRS II Specs	HQ
May 28	COP Guidance and Budget Levels to Field	HQ
June 1-3	USG Meeting in Uganda	HQ/Field
June 4-8	Implementer's Meeting	HQ/Field
June 30	Mini-COP Guidance, M&S Database, Technical Considerations to be distributed to the field	HQ
July 15	Final Required Indicators	HQ
July 15	Early Funding Database Open for entry	Field
July 30	COP Guidance Updates	HQ
August 7	Progress reports on continuing PHE activities due	
August 15	Concepts for new PHE activities due	Field
August 15	COPRS II developer contract awarded	HQ
September 1	Review of new PHE concepts and progress reports	HQ
September 12	Early Funding	Field
September 12	New Organization Submissions	
September 15	Response to country teams on PHE proposals. Note: final approval as part of the overall country program activities during COP review will still be required	HQ
September 15	COPRS Training Begins via conference call (schedule to be distributed shortly)	
September 30	APR Guidance	HQ
September 30	End of Fiscal Year	
October 1	COPRS Open for Data Entry	HQ/Field
October 1	First CN for Early Funding Request	
October 15	Final review status on PHE reported back to country for decision on inclusion in FY 2009 COP	HQ
October 15	COPRS Open for APR Data Entry	
November 14	COP and APR Submission Date	Field
November 15 – November 30	Data Cleaning	HQ/Field
November 15 – December 15	Reviews	HQ
January 10	Headquarters Principals Reviews	HQ
January 15 – January 30	Testing of new COPRS II	HQ/Field
January 30	Send feedback from Ps Review to the Field	
January 30	Second CN, which includes the majority of approved COP activities	HQ
January 30	Final Set of Next Generation Indicators (required and recommended) distributed to the field	
February	COPRS II screenshot layout review and user input	HQ/Field
February 28	Launch of COPRS II	
April	COPRS II demonstration and testing	
April - May	Portfolio Reviews	
May 1	Final FY 2010 COP Guidance	
May 15 – May 30	Regional COP and COPRS Trainings	Field
May 15	SAPR Due	
May 30	Third CN	

July	COPRS II full deployment and training for COP 2010	HQ/Field
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## FY 2009 Partnership Compacts

In FY 2009, all countries will be operating under a baseline budget equal to or very near the FY 2008 country level. The baseline levels will be communicated to each country by June 1, 2008.

In order to ensure responsible ongoing support to those supported through PEPFAR, no programmatic scale-up should be planned to occur after the end of FY 2009. Scale-up during FY 2009 should occur only to the extent the team feels that there is sufficient funding to maintain the increased levels of support on an ongoing basis under a constant FY2009 budget level.

The FY 2010 targets in the FY 2009 COP will be based on almost the same level of funding as the FY 2008 COP. Therefore, it is assumed that the trajectory should level off instead of continuing to increase as in previous years. There may be some increase due to the lag in expenditure, but the FY 2009 funding should be programmed, at a minimum, to maintain the results achieved by the end of FY 2008.

Additional funding, above the FY 2009 base level, will be allocated to a subset of PEPFAR countries selected to work on developing a National Scale-up Partnership Compact<sup>2</sup> or to drive a Technical Support Partnership Compact<sup>3</sup>. For these two categories, the objective criteria for Partnership Compact selection will include the state of the HIV epidemic, with a priority given to countries with a severe burden. Preference will also be given to countries where the USG has a well-established presence on HIV/AIDS that would allow the USG to play a significant role and have a comparative advantage in the fight against HIV/AIDS. The USG will also look at the performance of Global Fund grants as a country management indicator.

Additional subjective criteria include the following: the political will of the host Government; commitment to an improved policy environment; the level of strength and trust in the USG-host Government relationship; the ability to leverage resources; the management infrastructure of the host Government; the interest and capacity of the USG field team (including effective interagency efforts on HIV/AIDS); and the potential for high-impact change and contribution to PEPFAR goals.

<sup>2</sup> National Scale-Up Compacts will be considered for those countries that have shown potential for significant progress, ongoing or new, in the fight against HIV/AIDS, but which have very limited financial resources and capacity, and will continue to need USG program and technical support to scale up. These Partnership Compacts will likely require an increase in funding. PEPFAR will need to phase in these Partnership Compacts through a competitive selection process since USG funds will not be sufficient to cover every possible demand for support.

<sup>3</sup> Technical Support Partnership Compacts will focus on shifting the USG's role to that of provider of technical assistance and mentor. These Partnership Compacts will be for countries that receive relatively limited financial support from PEPFAR, particularly those with adequate resources to finance their own scale-up of programs, but which need technical support. While some level of USG financial support could continue to be a part of the Partnership Compact in these countries, the framework will particularly focus on transitioning from program implementation to a technical assistance model so as to lead to long-term sustainability of the programs without financial assistance from the USG.

For Partnership Compact countries, FY 2009 will largely be a transition year as the Compacts are conceptualized, negotiated, reviewed and approved. FY 2009 notional compact countries will receive communication that they are in a pool of potential Compact countries for FY 2009, pending country level interest and submission and approval of a concept paper. While the entire USG program/funding will be included in the negotiation of a final Partnership Compact commitment, funding at the FY 2008 baseline will be incorporated in the normal COP process and will likely reflect ongoing commitments and programs with, ideally, some evidence of transition towards a Compact.

#### Projected Calendar for FY 2009 Compact Countries

- May/June 2008: Compact guidance disseminated prior to the 2008 Implementer's meeting followed by a presentation during the USG Days
- July 1, 2008 – Communication from PEPFAR HQ to a subset of PEPFAR countries asking for development of a compact concept paper. The concept paper should include notional funding levels over the life of the compact.
- September 1, 2008 - Concept papers from FY 2009 notional compact countries are submitted to PEPFAR HQ for review and final approval to develop a full compact arrangement
- October 15, 2008 - PEPFAR HQ notification of selected FY 2009 compact concepts and notional funding levels for FY 2009
- May 1, 2009 – Completed partnership compacts submitted to PEPFAR HQ for review and clearance
- May 30, 2009 – Clearance of partnership compacts for FY 2009
- June, 2009 – Congressional notification of funds for partnership compact countries

Funding above the FY 2009 base level will only be available for implementation upon concluding a Partnership Compact arrangement. However, the Compact covers the entire PEPFAR program including benchmarks for performance. It is anticipated that full implementation of the Partnership Compact will be in FY 2010.

The additive USG portion of the notional compact funding should be left unallocated in the FY 2009 COP. Once a partnership compact is fully negotiated, the unallocated funding and subsequent increases to targets will be captured through reprogramming. Implementation by country partners will follow to meet the compacts' defined objectives including scaling up to meet the PEPFAR Phase II goals.

For additional information on Partnership Compacts please reference the Field Guidance for the Development of Partnership Compacts in PEPFAR.

## Sustainability

Building sustainable programs is essential to PEPFAR's success and continues to be a strong priority under PEPFAR II. A guiding principle of PEPFAR is to build local and host-nation capacity so that national programs can achieve results, monitor and evaluate their activities, and sustain them for the long term. Our goal is to utilize and provide more funding to local partner organizations to expand and enhance host country capacity.

Sustainability should be a key consideration during COP planning. PEPFAR incorporates key elements that support: sustainable human resources for health, and institutional capacity building that supports organizational and financial sustainability of our implementing partners. Increased levels of sustainability are achievable through a three-pronged approach that promotes (1) greater assumption of responsibility over implementation and management by host country nationals, (2) support for developing the capacity of an increasing number of local partner organizations, which will help expand and diversify a country's base of partners, and (3) support for developing and retaining health care workers in both public and NGO healthcare settings. The recent declaration of a joint US/UK partnership for human capacity development in four PEPFAR countries is indicative of the important emphasis that human capacity building will continue to receive. As you plan for and develop your FY 2009 COP, approaches for building sustainability should be considered. Appendix 13 outlines multiple ways PEPFAR funding can be used to achieve increased sustainability over the next five years.

Some key activities to support governmental and NGO capacity-building include: enhancing the capacity of health systems and health care workers; strengthening quality assurance; improving financial management and accounting systems; building health infrastructure; and improving commodity distribution and control. Where feasible, national information systems, including human resource information systems and supply chain management systems that serve an array of government and non-governmental partners, should be supported in preference to separate costly systems for each partner.

USG staff, contractors and grantees should work with a goal to transition support to host country nationals and institutions in the provision of technical assistance and program management. 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. The Procurement and Assistance Working Group (PAWG) is developing forthcoming language for inclusion in grants and awards that will require prime partners providing sub-awards to have transition plans supporting graduation of sub-grantees to prime grantee status. [These transition work-plans will require concurrence from the USG in country team.](#)

If you have special initiatives or projects that support long-term sustainability, please make sure to highlight these in the Executive Summary, program area narratives, or activity narratives, as appropriate. For additional details on measures to support sustainable programs, including capacity building of local organizations, please see Appendix 13.

## Management and Staffing

Management and Staffing, including Staffing for Results (SFR), continues to be a key priority for PEPFAR. Given the very large resource levels in many countries, it is imperative that USG country teams seek innovative approaches to ensure appropriate fiscal oversight and technical leadership relative to PEPFAR funds, building on the strengths of the inter-agency team. Every country program is expected to analyze its staffing and management structures prior to finalizing the FY 2009 COP and demonstrate progress toward achieving SFR, which includes identifying priority actions needed to more fully incorporate efficiencies in the inter-agency approach. Countries that have already made significant progress toward achieving SFR should use the COP planning timeframe to reassess the structural organization of the country team and consider other ways to foster interagency team-building.

Given that we are in year three of SFR, it is expected that all countries would have established functional organizational charts and fully operational interagency teams. Some standards include:

- Interagency site visits
- Interagency portfolio and partner performance reviews
- Interagency partner meetings
- Shared problem/issue analysis
- Joint priority setting
- Joint allocation of resources, including staffing
- 360 degree feedback process

In addition, our locally employed staff (LE Staff) are critical members of our PEPFAR team. They bring immense talent, experience, relationships, and dedication to our efforts to save and transform lives. They are also critical to the long-term sustainability of programs to fight HIV/AIDS in each country. Therefore, it is important that we are able to recruit and retain these staff. A number of efforts are under way from headquarters, with field support, to address recruitment and retention issues and to develop new ways to empower LE Staff. However, country teams can provide leadership in this area. Country teams are encouraged to look for innovative ways to empower LE Staff, including opportunities to utilize or develop technical leadership, such as chairing a TWG; training opportunities internal or external to PEPFAR; and appropriate participation in conferences. Teams that are using innovative approaches should report on them in the Management and Staffing program area.

## Mandatory Budgetary Requirements

Because reauthorization of PEPFAR is pending with the U.S. Congress, it is not yet clear what mandatory budgetary requirements may be in force in FY 2009. Updated guidance will be provided as soon as possible.

If mandatory requirements come into effect, as in past years, teams should keep the following in mind as they develop their programs:

- Track 1.0 central budgets (from headquarters) will be attributed to these mandatory requirements (see further explanation below).
- If meeting any of the mandatory requirements is not reasonable from a programmatic perspective, please submit a justification with the COP (see the COP Planning section on the Extranet for the format of the justifications). Engage your Core Team Leader in discussions of any necessary justifications.
- Integrated programs should be distributed, as appropriate, across program areas. For more information, please see the guide to allocating activities across program areas on page 69.

Regardless of legislative budgetary requirements, program areas historically addressed by directives remain priorities for developing strategies and programs to effectively respond to HIV in the context of each country's epidemic and response.

### ORPHANS AND VULNERABLE CHILDREN (OVC)

As a matter of PEPFAR policy, country programs should allocate at least 10% of total prevention, care, and treatment resources towards OVC programs. Given the maturity of the PEPFAR program and the magnitude of the problem, there is an expectation that all countries are bringing OVC programs to scale. As in FY 2008, pediatric treatment will not be counted towards the 10%. Pediatric treatment is also a priority and should have its own dedicated funds be attributed only to the pediatric treatment program budget code, not to the OVC program budget code.

There is an expectation that all countries with a generalized epidemic will meet the 10% OVC budget allocation.

### SINGLE-PARTNER FUNDING LIMIT

The single-partner funding limit aims to promote the most efficient use of funding, diversify the organizations with which PEPFAR partners, and increase partnerships with local partner organizations, all with the goal of promoting long-term sustainability of HIV/AIDS programs in our partner countries.

There is no change in this requirement for FY 2009. For focus countries, in FY 2009 the percentage limit on funding to a single partner remains 8%. For Other Bilateral programs, the limit is \$2 million or 8%, whichever is greater.

In computing the percentage, the denominator consists of the country COP budget (central and field dollars), excluding U.S. Government country team management and staffing costs.

$$\frac{\text{Total Partner Funding (Includes funding received as a prime or sub)}}{\text{Country Budget (Central and Field Dollars) - USG Management and Staffing Costs}} = \% \text{ Partner Funding}$$

The single-partner funding limit only applies to funding provided through grants and cooperative agreements. **The limit does NOT apply to funding provided or to be provided under competitively awarded contracts**, due to legal requirements for "full and open competition" under the Competition in Contracting Act (1984) and the Federal Acquisition Regulations. This does not apply to funding allocated to USG agencies.

There are three additional exceptions to the cap on single partner funding levels:

- Umbrella awards;
- Commodity/drug costs; and
- Government ministries and parastatals.

Please see Appendix 14 for definitions of the exceptions and additional guidance on implementing the single-partner funding limit.

## Justifications

Please submit a justification for any partner that exceeds the 8% limit, after excluding organizations (host country government organizations, parastatals) and funding (umbrella grants, 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, in the activity narrative please provide the dollar amount of funding the partner will use for commodity procurement.

## Priority Program Areas

Certain program areas were identified in FY 2008 as having broad gaps generally across all countries and thus require special attention in the FY 2009 COP. In addition, given that new information is now available concerning the introduction of male circumcision, this is also a new area to be addressed. Staffing for Results is also a critical area that requires careful team planning and discussion in the COP.

### PREVENTION

### BEHAVIOR CHANGE

Preventing new infections represents the only long-term, sustainable way to turn the tide against HIV/AIDS. Successful strategies for fostering effective behavior change require comprehensive, multi-sectoral, complex prevention interventions that address prevailing norms associated with the spread of HIV, while still meeting the needs of people who face elevated risk exposure. Prevention programs must move beyond raising awareness about HIV, to encouraging people to make positive and lasting behavior changes by creating an enabling environment that supports individuals to make safer choices and sustain healthy behaviors. Prevention programs should be closely aligned with the country-specific profile of the epidemic. Country teams should ensure that, at the portfolio-level, the combination of prevention activities supported provides comprehensive coverage of the most affected populations and localities, and that program content explicitly addresses the key drivers of the epidemic.



Approaches and mix of prevention strategies must be responsive to the stage of the epidemic. However, no one intervention is likely to be fully protective and thus multiple prevention approaches are needed. Comprehensive prevention programs should take into consideration the coverage, dose (intensity) and quality of combined intervention strategies. In concentrated epidemics that are driven by sexual and injection practices, especially among HIV-vulnerable groups including people in prostitution, men who have sex with men and injection drug users, targeted programs should continue to expand coverage of interventions targeted at high-risk groups. In generalized epidemics, driven primarily by sexual behavior in the general population, program efforts should focus on large-scale, fundamental changes in community norms, social values and sexual practices to create social and community change. In these settings, priority target audiences often include young adult women and men and migrant populations. Behavioral outcomes, such as abstaining or delaying the age of first sex, reducing number and concurrency of sexual partners, being faithful to a single, HIV-negative partner, and using condoms correctly and consistently, can reduce the risk and rates of HIV infection. These ABC behavior change approaches should also link to HIV counseling and testing and include prevention strategies for people living with HIV, including discordant couples. These approaches should also then be coupled with other biomedical and social interventions that address environmental factors, such as addressing the particular vulnerabilities of women and girls and other marginalized populations.

For more information about programming by stage of the epidemic, please refer to the PEPFAR ABC Guidance.

## **PMTCT**

The original goals of the President's MTCT Initiative were to reach 80% of HIV+ pregnant women with prophylaxis and reduce new infant infections by 40% by the end of 5 years in the 15 focus countries. UNGASS has also set goals of reaching 50% of women globally with PMTCT services by 2005 and 80% by 2010. Although much progress has been made, FY 2007 year-end data indicate that only slightly more than 20% of HIV-positive women attending antenatal care in the 15 Phase I "focus countries" received PMTCT services. There is a clear need for programs to accelerate efforts in this area. Many countries should strategically plan and program resources to meet the unmet need. Please see the PMTCT technical considerations for more guidance on approaches for accelerating scale-up and maximizing impact of PMTCT programs.

PMTCT programs should be an important "gateway" to HIV/AIDS prevention, care and treatment services. In the FY 2009 COP, countries should increase focus on supporting ART provision for treatment-eligible HIV-positive pregnant women. Almost one-third of USG-supported HIV testing in the focus countries is conducted in PMTCT settings, yet a disproportionately small number of HIV-positive pregnant women are receiving ART. There are also key unmet needs for collecting and reporting data on the numbers of HIV-positive pregnant women initiating ART while pregnant, which is a required PEPFAR indicator. Ensuring this sub-group of HIV-infected women are appropriately screened and treated will dramatically reduce the risk of HIV transmission to their infants and improve overall maternal health and child survival.

## **MALE CIRCUMCISION**

PEPFAR guidance is consistent with the March 2007 WHO/UNAIDS recommendations on male circumcision for HIV prevention. Under the leadership of host country governments, and consistent with local policies and norms, PEPFAR funds can now be utilized to support the implementation of safe male circumcision services. In FY 2009, there is no funding limit per country for safe male circumcision services or other safe male circumcision activities.

It is critical to ensure appropriate follow-up and treatment of any complications of male circumcision procedures, while continuing to emphasize the importance of comprehensive prevention messages focusing on an ABC approach. Recognizing that male circumcision is not 100 percent protective, it is essential for countries that are incorporating male circumcision service delivery to place it within a comprehensive HIV prevention package. The Male Circumcision task force is available to provide additional support and information as you consider the introduction of this important but challenging prevention intervention.

## **CARE**

## **ORPHANS AND VULNERABLE CHILDREN (OVCS)**

Caring for orphans and vulnerable children is a crucial part of our efforts to mitigate the impact of HIV/AIDS. In FY 2007, PEPFAR supported over 2.7 million children directly or indirectly. While this is a substantial increase over the half-million children served with PEPFAR funds in 2004, it still represents just a small portion of the millions more in need. When the President announced his intention to work with Congress to reauthorize PEPFAR, he specifically proposed a goal of reaching 5 million OVCS. Therefore, countries should continue to work on a comprehensive approach, collaborating with key government ministries and at the community level to bring OVC programs to scale nationally. In scaling up services, it will be important to address linkages with wraparound services, quality and programming gaps, and to identify best practices. Adequate PEPFAR country team staffing for strategizing and supervising OVC programs is essential for this scale-up. Hiring specialists in child development or related field to guide quality and appropriate OVC program scale-up can be very helpful.

Please see the OVC Program Area narrative instructions and OVC technical considerations for more guidance on approaches for accelerating scale-up and maximizing impact of OVC programs.

## **TUBERCULOSIS (TB) / HIV**

Tuberculosis (TB) is the leading cause of death among people living with HIV/AIDS in sub-Saharan Africa, and addressing TB/HIV is a priority program area for PEPFAR. The prevalence of HIV infection among patients in TB clinical settings is high, and thus patients in TB clinical settings are “high yield” for identification and referral for HIV prevention, care and treatment. TB threatens to undermine progress we are making in AIDS care and treatment as TB increases

mortality in PLWHA and complicates management of treatment for HIV. With the additional specter of extensively-drug resistant TB emerging among PLWHA both in communities and care settings, commitment of COP resources must be robust and commensurate with this emerging threat.

Recent data published in the 2008 Global TB Report paint a mixed picture. There has been considerable progress in HIV testing among TB patients, provision of co-trimoxazole preventive therapy, and antiretroviral treatment for HIV-positive TB patients. It is particularly encouraging to see the high rates of HIV testing in highly-impacted countries: Kenya, Malawi and Rwanda reported testing rates of 60%, 64% and 76%, respectively. Progress is being made, but we still have a long way to go.

From the HIV program entry point, the data indicate levels of achievement that are far below the global targets. The Global TB Control Plan established a target to screen 11 million PLWHA for TB in 2006 and the actual figure reported was just 314,000. Isoniazid preventive therapy was reported for only 27,000 persons or 0.1% of the 33 million people estimated to be infected with HIV. TB infection control measures, especially in HIV care settings, are lacking in the vast majority of resource-constrained settings and a huge unmet demand for laboratory scale-up exists. These are massive opportunities.

In the FY 2009 COP, please describe TB/HIV activities so that the reviewers can understand how the program addresses the TB/HIV technical priorities (see program narrative guidelines and technical considerations for priorities). While maintaining momentum in scale-up of HIV testing, care and treatment for TB patients (as well as suspects and other TB clinic attendees), emphasis should also be on the so-called “Three I’s” at HIV entry points as priority activities in TB/HIV (isoniazid preventive therapy, intensified TB casefinding, and TB infection control).

To maximize USG resources and avoid duplication, we encourage USG teams to develop a USG-wide strategic plan in the area of HIV/TB and TB funding. There are a number of approaches to accomplishing this joint planning objective (e.g., joint visits by USAID bilateral TB TA and PEPFAR TB/HIV TA, interagency technical working groups, annual one-day planning retreats, interagency portfolio reviews, etc.) and TA is available to facilitate the process. We hope that these efforts to link all USG support to TB in a cohesive country strategy will also be reflected in the F/OP. While in future years we would like to better integrate these processes, please note that for this year, we will be working with F to participate in the F/OP review for TB to ensure that during the review, both PEPFAR and USAID resources and assistance will be considered.

## **PEDIATRIC CARE AND TREATMENT**

PEPFAR has supported the rapid scale-up of pediatric HIV care and treatment programs. In FY 2008, roughly 85,900 children under the age of 15 were enrolled in treatment programs directly supported by PEPFAR in the Phase I focus countries (9% of all persons receiving ART with USG downstream support), making pediatric treatment and care services a significant component of PEPFAR programs. However, rates of coverage with pediatric ARV treatment relative to the need for treatment are exceedingly low in many of the PEPFAR countries, reflecting the complexities of identifying children (particularly infants) with HIV, overcoming social and

logistical barriers to enrolling them in care and treatment, and developing a workforce that is adequately trained to provide pediatric care.

Therefore, in order to provide maximum attention to HIV-infected children in USG-funded programs, the FY 2009 COP guidance includes a separate pediatric care and treatment program area narrative, as well as two additional program area budget codes. This was done to pull together guidance from multiple COP program areas including palliative care and ARV services to look at pediatrics more holistically. Countries should continue to prioritize pediatric care and treatment in FY 2009 and be sure to address linkages with PMTCT, efforts to rapidly scale up early infant diagnosis through dry-blood spot/DNA PCR laboratory networks, training of healthcare workers in the provision of pediatric care and treatment, and other key aspects of pediatric care and treatment.

## **GENDER**

PEPFAR places a high priority on confronting the changing demographics of the HIV/AIDS epidemic; working to reduce gender inequalities and gender-based abuse and violence; expanding priority gender activities; and integrating gender considerations throughout all programs. The societal issues around gender and HIV/AIDS are complex, and can vary from one country to another; however, addressing these challenges successfully is critical to the achievement of PEPFAR's prevention, treatment, and care goals. Local partners are particularly important in this area.

In support of these goals, PEPFAR employs a two-pronged approach: 1) gender mainstreaming into all prevention, care, and treatment programs, and 2) programming to address 5 cross-cutting gender strategic areas:

1. Increasing gender equity in HIV/AIDS activities and services
2. Reducing violence and coercion
3. Addressing male norms and behaviors
4. Increasing women's legal protection, and
5. Increasing women's access to income and productive resources.

Gender should be at the forefront of strategic program planning, and a program area on gender has been added. Countries should write a program area narrative highlighting the priority gender issues affecting HIV prevention, care and treatment in the country and describe the overall approach to addressing them. The latter should include highlights of how gender is being mainstreamed into the other PEPFAR program areas and the types of activities that are being implemented to support the five strategic areas. Specific implementation approaches for gender-related activities also should continue to be described within the other relevant program and activity narratives.

## **STRATEGIC INFORMATION**

### **Know Your Epidemic/Know Your Results**

The foundation of Strategic Information can be characterized as supporting the PEPFAR global initiative, USG country teams, and most importantly resource-constrained host country nations and their members of civil society ***to strategically collect and use information in support of the global and local HIV response***, or in other words, to “know their epidemics/know their results” and to respond appropriately with sustainable, evidence-based, cost-effective program interventions.

Country teams should be planning activities that promote and build the capacity to appropriately manage, analyze, display, and interpret data for program decision-making. Now that countries have basic systems in place, emphasis should be on increasing the use of the data for decision-making. Evidence-based decision-making is one of the most important uses of HIV/AIDS data and information. When stakeholders use data to make decisions, they help to improve overall health care by increasing the health system’s ability to respond to the needs of those affected. This should be happening at all levels, including at specific program sites, at regional and national levels in host country governments, and within PEPFAR management in both field teams and at HQ.

The theme of sustainability articulated earlier in the guidance equally applies to strategic information. Strategic information interventions that reflect the principle of sustainability support organizational development and financial management as well as individual and institutional capacity building at national and sub-national levels, hand in hand with M&E, HMIS, and surveillance technical assistance. In country financial, human and institutional technical and managerial capacity in the areas of M&E, HMIS and surveillance need to be primary focus areas.

## Linkages With Development/Wraparounds

Supporting linkages with development remains an important focus. Key areas for linking with development include; maternal and child health, TB, malaria, food and nutrition, education and livelihoods. Further guidance on how to link PEPFAR programming to other development efforts is included in Appendix 12.

Linking PEPFAR programs to other development initiatives provides a platform to support a comprehensive approach to HIV/AIDS-affected communities and to ultimately improve quality of life. This can be done through wraparound activities that leverage resources, both human and financial, from entities with non-PEPFAR funding sources in order to complement PEPFAR goals and maximize the effectiveness of programs. Development activities linked to PEPFAR 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, these activities are supported with a mix of funds, primarily from sources other than PEPFAR. However, wraparound activities that directly serve PEPFAR priority HIV-infected and -affected 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 other development activities, such as delivery of bednets through PMI, immunizations, or medications for neglected tropical diseases.

EXAMPLE: You are working on a PMTCT program that has a strong community follow-up component and is working to decentralize services to community health centers. USAID has a small Safe Motherhood program, and your country is a PMI focus country. There is a desire to strengthen care for pregnant women. The PEPFAR PMTCT team reaches out to other maternal child health managers and together the teams learn that there are existing training materials on PMTCT, emergency obstetric care and prevention and treatment of malaria in pregnancy. PEPFAR agrees to integrate these modules into the PMTCT training. In addition, the PMI team agrees to fund malaria nets and treatment for all clients of PMTCT programs and their infants. They work closely with the PMI team to ensure that commodity needs for PMTCT clients are incorporated into procurement and logistic planning for malaria.

EXAMPLE: In a country, USAID is working with the education sector to strengthen primary education, both at the national level and with provincial authorities. Addressing HIV in education is a key objective of the MOE, including addressing issues of orphans in education. The ministry requests support for technical assistance to improve support for orphans in the schools, incorporating community outreach, funding for books and other needs, training of teachers in social support and HIV prevention using a life-skills approach. They are also concerned about their workforce and would like to adopt an HIV counseling and testing program with linkages to treatment for teachers. PEPFAR and the USAID education program agree to partner on this initiative. PEPFAR agrees to fund a technical advisor to work with the MOE to address HIV and to provide assistance in developing a comprehensive HIV/AIDS and Education strategy. PEPFAR and USAID education programs share funding for scholarship programs for orphans to ensure needs of both those orphaned as a result of AIDS and those orphaned by other causes are met. PEPFAR funds the counseling and testing, care and treatment programs for the teachers. Finally, the World Food Program has a school feeding program in-country. The education and health team work with WFP to target community and primary schools where USG is providing support. The PEPFAR team issues a small grant to WFP to provide funding, based on an estimate of the percentage of children that are HIV-related OVCs to provide some additional support to this feeding program.

EXAMPLE: In a country, PEPFAR has a strong community-based care program. USAID is also supporting a micro-credit program through its economic growth portfolio. PEPFAR works with the economic growth team and provides funding to its grant to support micro-credit activities to OVCs and/or their caregivers.

Additional information about specific linked development programming, in particular concerning education, food and nutrition, and livelihoods is in Appendix 12.

For the FY 2009 COP, we have incorporated secondary cross-cutting budget attributions for the development linkages with food and nutrition, safe water, education, and livelihood support. Further information can be found on page 69.

## Partnerships

### COLLABORATION WITH THE GLOBAL FUND TO FIGHT AIDS, TB, AND MALARIA (GLOBAL FUND)

Both in-country bilateral program support and USG central investments in the Global Fund are essential to PEPFAR's success. Implementation of PEPFAR has demonstrated the interdependence of these two approaches on the ground. USG teams are strongly encouraged to have a representative on the Global Fund Country Coordinating Mechanism (CCM). Country teams should seek to identify areas where Global Fund and bilateral assistance can complement each other, possibly assigning a division of labor between the two resources. For example, where Global Fund grant Principal Recipients focus on purchasing first-line drugs, PEPFAR might dedicate its resources to procuring of second-line regimens.

Given the commitment of the USG to the principles of the Three Ones, PEPFAR resources and/or activities should be invested and programmed as needed to directly support HIV/AIDS Global Fund grants. Examples of these activities include the strengthening of CCM (including Secretariat) capacity, or placing time-limited technical advisors in Ministries of Health to build capacity in areas such as logistics systems and unified procurement approaches, strategic planning, and monitoring and evaluation. Such investments should be time-limited, not focused on long-term recurring costs, and oriented to specific outcomes that will allow Global Fund money to flow more quickly and efficiently. Technical assistance to Global Fund grants can be funded either by country teams - using the field budget - or with headquarters central funds. *(Note: In PEPFAR Phase I focus countries, the Global Fund TA mechanism is available to provide support for PRs of Malaria and/or TB grants, as well as for the CCM. It is not available for PRs of HIV/AIDS grants. Country teams should plan TA for PRs on HIV grants into their COPS).*

In FY 2009, reviewers will assess how country programs are coordinating with Global Fund-financed programs. Please note that there are three questions on Global Fund Collaboration in Table 1, and that the Global Fund Supplemental has been expanded and updated (see the Extranet for a sample). Please also describe USG Team interagency and external coordination with Global Fund grants, including TA, in program area narratives and activity narratives, where appropriate.

#### **PRESIDENT'S MALARIA INITIATIVE (PMI)**

The President's Malaria Initiative (PMI) is a five-year USG inter-agency initiative that aims to achieve a 50% reduction in malaria-related mortality in supported countries. PMI targets groups that suffer the major burden of malaria in sub-Saharan Africa, primarily children under five and pregnant women, and to a lesser extent adults living with HIV/AIDS. Though each program has somewhat different priority target constituencies and is accountable for different results, there is considerable overlap between PMI and PEPFAR in both target groups and potential activities, creating a need for both technical and fiscal coordination.

Where both PEPFAR and PMI are active, country PMI and PEPFAR teams should coordinate to optimize program interventions, use of available resources (including Global Fund and World Bank resources), and monitoring and evaluation. Please describe the process of coordination and coordinated activities in the relevant program area narratives (e.g., PMTCT, palliative care, OVC, laboratory, supply chain management, blood safety, SI). Please include additional detail in activity narratives where applicable.



Seven Phase I PEPFAR focus countries are also PMI focus countries: Ethiopia, Kenya, Mozambique, Rwanda, Tanzania, Uganda, and Zambia. Other PMI focus countries that receive PEPFAR resources include Ghana and Malawi.

### **MILLENNIUM CHALLENGE CORPORATION (MCC)**

The Millennium Challenge Corporation (MCC) is a USG corporation whose mission is to reduce global poverty through the promotion of sustainable economic growth. Established in January 2004, MCC operates on the principle that aid is most effective when it reinforces good governance, economic freedom and investments in people. MCC provides monetary assistance to eligible countries through two types of programs: compact agreements and threshold agreements. An MCC Compact is a multi-year agreement between the MCC and an eligible country to fund specific programs aimed at reducing poverty and stimulating economic growth. The Threshold program assists countries that have not yet qualified for MCC Compact funding but have demonstrated a significant commitment to improve their performance on the eligibility criteria. MCC staff oversee Compact development and implementation, whereas USAID runs the Threshold program.

Country teams are encouraged to coordinate with USAID on Threshold programs and with MCC staff on Compact programs. Plans and opportunities for leveraging MCC activities should be described in the FY 2009 COPS.

Among the Phase I PEPFAR focus countries, Mozambique and Namibia are Compact eligible; Guyana, Kenya, Rwanda, Uganda and Zambia are Threshold eligible; and Tanzania is both Compact and Threshold eligible. Other eligible countries include Lesotho (Compact) and Malawi (Compact and Threshold). MCC Compacts vary in their scope and may or may not have a direct health component.

### **PARTNERSHIP FOR SUPPLY CHAIN MANAGEMENT (SCMS)**

The USG's contract with the Supply Chain Management System (SCMS) project is unique, because SCMS services and expertise are available to USG agencies, foreign governments, USG-financed contractors and grantees, and other organizations doing HIV/AIDS work such as the Global Fund. Country teams are encouraged to use SCMS because of the efficiency of consolidated procurement and its expertise in supply chain management system strengthening. Please note that country teams are required to have partners report to OGAC for the congressionally mandated annual report on ARV drugs. See Appendix 17 for further detail. While SCMS prices on ARV drugs are generally very good; other partners have been able to achieve similar prices. Countries are encouraged to actively guide partners in procuring ARV drugs at the lowest possible cost.

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



laboratory supplies and equipment, and other commodities that lend themselves to centralized purchasing.

SCMS provides a full range of supply chain management services and related technical assistance, including forecasting, warehouse and inventory control, procurement, freight and freight forwarding, quality assurance, and logistics and information systems management. Capacity-building of national and local supply chains represents a core SCMS priority, and technical assistance is available regardless of who is purchasing the commodities. SCMS can also be involved in national coordinated procurement planning with governments and other international donors to avoid duplications and create supply chain efficiencies in-country.

The SCMS initially received core funding for many field activities in FY 2007 and FY 2008. In FY 2009, field activities will transition to being fully field-funded. As with other central projects, the fully loaded costs to the USG will be made available and transparent for COP planning purposes.

Allocating funds to SCMS in the COP: COP funds for SCMS will come “off the top,” meaning they will go directly from OGAC to USAID and then SCMS, without being allotted to post. Identify USAID as the USG agency and Partnership for Supply Chain Management as the Prime Partner when entering the activity into the COP. If you determine at some point after your COP has been approved that you would like to reprogram funds from another activity to SCMS, you should use the reprogramming process to accomplish this. If your commodity-related needs are urgent and cannot wait for the next reprogramming, you should contact your Core Team Leader, who will work with OGAC/Budget and USAID/OHA/SCMS to determine the most expeditious means of addressing your situation. **Money programmed to SCMS cannot be reprogrammed.**

In addition, Track 1.0 recipients and other USAID and HHS partners can subcontract non-competitively with SCMS, thereby relying on SCMS to satisfy the contract and agreement clauses that require subcontracts be competed to the maximum extent practicable, (often referred to as “the rule of three”). (When doing so, it is recommended that the grantee seek documentation from SCMS regarding its compliance with this competitive standard.) Foreign governments and other organizations can also contract directly with SCMS or they can buy into the SCMS contract through a direct funding transfer to the HIV/AIDS Working Capital Fund.

The SCMS contract is managed by USAID. If you have questions about the SCMS project or the Working Capital Fund, please contact the Supply Chain Management team - Carl Hawkins ([chawkins@usaid.gov](mailto:chawkins@usaid.gov)), Sherif Mowafy ([smowafy@usaid.gov](mailto:smowafy@usaid.gov)), Kelly Badiane ([kbadiane@usaid.gov](mailto:kbadiane@usaid.gov)), Michael Hope ([mhope@usaid.gov](mailto:mhope@usaid.gov)), Heidi Mihm ([hmihm@usaid.gov](mailto:hmihm@usaid.gov)), Chana Rabiner ([crabiner@usaid.gov](mailto:crabiner@usaid.gov)) or Jan Miller ([jmiller@usaid.gov](mailto:jmiller@usaid.gov)). More information about SCMS is available at [www.scms.pfscm.org](http://www.scms.pfscm.org).

## PUBLIC PRIVATE PARTNERSHIPS

PEPFAR defines public-private partnerships (PPPs) as collaborative endeavors that combine resources from the public sector with resources from the private sector to accomplish HIV/AIDS prevention, care, and treatment goals. PPPs enable the U.S. Government and private-sector entities to maximize their efforts through jointly defined objectives, program design, and implementation, and through the sharing of resources, risks, and results. Three hallmarks of

PPPs are that they help ensure sustainability of programs, facilitate scale-up of interventions, and leverage significant private-sector resources.

Country teams are encouraged to build and support local PPPs that draw on the private enterprises' extensive infrastructure and supply/value chains to target at-risk populations, as well as to utilize the management, marketing and core business expertise private enterprises bring to bear. Through the long-term commitments that companies have made by virtue of their investment in PEPFAR-supported countries, there exists greater potential to enhance the sustainability of country programs, positioning PPP funding as capital to catalyze sustainable action.

Additionally, interested country teams are encouraged to contact the PPP TWG to explore opportunities to buy into existing multi-country partnerships, such as Phones for Health, Becton-Dickinson Laboratory Capacity, and Microsoft.

PPP models, technical assistance opportunities, and information on multi-country PPPs are available upon request. Please contact British Robinson ([robinsonba1@state.gov](mailto:robinsonba1@state.gov)), Mary Jordan ([majordan@usaid.gov](mailto:majordan@usaid.gov)), Dick Keenlyside ([dyk8@cdc.gov](mailto:dyk8@cdc.gov)) or Jessica Daly ([dalyjm@state.gov](mailto:dalyjm@state.gov)).

## COP Overview

### COP Sections

1. Table 1 – This table is essentially an overview of the COP, and contains the following information
  - Ambassador Letter.
  - Executive Summary / CN Summary – This should follow the Congressional Notification format. The latest country CN's are posted on the PEPFAR website: <http://www.pepfar.gov/about/opplan08/102048.htm> and can be used as the starting point. Core Team Leaders can assist countries in drafting the Executive Summary, in order to ensure correct formatting and reduce the need for extensive editing.
  - Five-Year Strategy Updates – This section provides space to update any of the information provided in the Five-Year Strategy.
  - Country Contacts – The contact information for each USG Agency participating in PEPFAR in your country.
  - Global Fund Questions.
2. Table 2 – There are eight indicators listed here for which downstream (direct) and upstream (indirect) country targets need to be set. Targets are required for both the end of FY 2009 and the end of FY 2010.
3. Table 3.1 – This funding mechanism list provides a summary of the unique funding mechanisms in the plan, defined by mechanism type, funding source, USG Agency and prime partner.
4. Table 3.2 – This table is where sub-partner information is entered.
5. Table 3.3 – Activities by funding mechanism are the core of the COP. Table 3.3 provides the details on the activities planned for the fiscal year.
6. Table 4 – The summary budget report is generated automatically by the data system.
7. Table 5 – This table asks for information on any broad data collection efforts that are planned for the fiscal year.

### Required Support Documents

**Any uploaded tables must be live Word documents or Excel tables.**

1. Budgetary Requirements Worksheet – Because reauthorization of PEPFAR is still pending with the U.S. Congress, it is not yet clear what mandatory budgetary requirements may be in force in FY 2009. Updated guidance will be provided as soon as possible. Once that guidance is provided, we will post a new Budgetary Requirements Worksheet to PEPFAR.net.
2. Table 3 Summary Targets and Explanation of Target Calculations – In FY 2009, country teams will fill out all summary targets on an Excel template, which will also contain narrative boxes to explain how targets were calculated and address any other data quality issues.

3. HCD Program Area Narrative – This year, all countries are required to submit an HCD program area narrative, detailing how human capacity issues are being addressed by your country program. Further information is available in Appendix 19.
4. Health Care Worker Salary Report – This document provides an estimate of the number of health care workers supported by the USG in the categories of clinical services staff, community services staff, and managerial and support staff.
5. Gender Program Area Narrative – This year, all countries are required to submit a Gender program area narrative, detailing how you are mainstreaming gender into all aspects of your country program. Further information is available in Appendix 21.
6. Global Fund Supplemental – This document summarizes the support your country provides to the Global Fund in-country. A template and specific instructions are found on the Extranet.
7. Management and Staffing Budget Table – This table itemizes each USG agency's M&S expenses by program area and fund account.
8. Staffing Analysis – This Excel file includes the staffing database data, the functional staffing chart, and a management chart for each agency. Additional guidance will be disseminated to country teams separately regarding the staffing database and upgrades for FY 2009.
9. PPP Supplemental – This table captures information about PPPs at the USG level and includes information on financial contributions by both the USG and the other partner(s).
10. Budgetary requirement justifications (if applicable)
11. Single Partner Funding Justification (if applicable)

## System Overview

The COPRS data system is intended for use after you have largely determined the content of your Country Operational Plan. To assist in COP development, we have posted several partner information forms developed by USG field teams on the PEPFAR Extranet under FY 2009 COP Planning.

**Help:** If you need help using the COPRS data system, there is contact information in the “Contact Us” section on the COPRS navigation bar. Please email SSS (the informational technology contractor responsible for the COPRS system) at [COPRSSupport@s-3.com](mailto:COPRSSupport@s-3.com) with a copy to: [sgac\\_cop@state.gov](mailto:sgac_cop@state.gov). Email will be checked on a regular basis throughout the data entry phase.

**Working in Word:** Text can be entered into the data system by copying the text, and then pasting it into the appropriate text box in the COPRS data system. Please be aware that special fonts (including underlined, bold, and italic text), bullets, boxes, images, and similar formatting cannot be used in the data system. If you try to copy different fonts (including underlined, bold, or italic text), the font information will be lost and text will be shown in a single font. Bullets may be converted to periods or lost. Images and boxes will usually be ignored.

The COPRS data system **will not** spell-check your text. However, narratives drafted in Word can be readily edited (including spell-checked & length checked) before text is pasted into the COPRS data system.

Please note that COPRS character counts is slightly different than the Microsoft Word count. When working in Microsoft Word, you need to add the count for “characters (with spaces)” to the count for both “lines” and “paragraphs” to get the same total that COPRS calculates.

**Saving:** Data you type or paste into your web browser will be saved into a database, on a server in the United States, whenever you click on the **Save** button. You can also save your page by using a navigation link such as **Next**, **Previous**, or **Table of Contents**. For those tables which have automatic formulas, such as Table 2, there is also an **Update Total** button that will save your information. If you receive the three minute timeout warning (discussed below in Authorization and Security), clicking the **Continue** button will NOT save your work. However, clicking the **Continue** button will refresh the page, with all of your work still showing. You will then want to immediately click the **Save** button in order to save your work.

If you are working in an environment where the Internet connection or power to your computer is frequently interrupted, you will want to use the **Save** button on a regular basis so that you do not lose information.

Please be aware that if you navigate using the roll-over menus, your information will NOT be saved. Your information will also NOT be saved if you use the browser buttons (the Back and Forward buttons at the top of the screen immediately under File). You will need to click on the **Save** button or the **Update Total** button prior to navigating with the roll-over menus in order to save your work.

**Multiple Users:** Multiple users can enter data for a single COP at the same time. However, they should coordinate so that they are NOT working on the same sections of the COP at the same time. Saving information for the same section at about the same time may result in data loss. When this happens, the last user to press the **Save** button determines the content of the data system.

## User Roles

There are numerous user roles for accessing and using the COPRS data system, each with varying degrees of system access. One user may have more than one user role, as necessary. Depending on the administrative rights that you have, you will see only a subset of all the available roles.

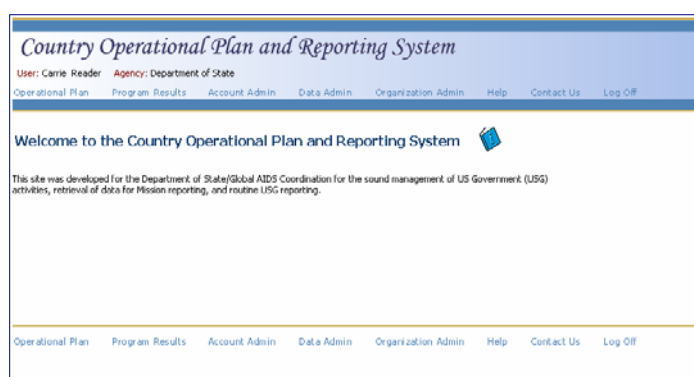
The roles for users in-country are set up to allow more controlled input of data and to ensure the accuracy of the data. The access levels of in-country users will vary throughout the year depending on whether the COP, APR or SAPR are open for data entry. The access levels for users at OGAC and Headquarters Agencies are different from that of in-country users. Core Team Leaders at OGAC have the ability to approve activities outlined in the COP. They are also able to assist countries in terms of data entry and/or reviewing information.

## Getting Started

**Technology Requirements:** The system's only technology requirement is a web browser that supports session variables (non-persistent cookies), which are necessary to allow the system to identify users as they navigate the different data screens in order to ensure data integrity. The latest browser versions are recommended, with Netscape 6.2 and Internet Explorer 5.0 being the minimum requirements. Pop-ups must be allowed.

**Login:** The Country Operational Plan and Reporting System login screen is located at: <https://www.epcopr.net>

**Welcome:** The login screen leads you to the Welcome screen, through which you can access system functions from the toolbar in the top part of the screen (from left to right):



The different *sections* of the data system that you can access consist of the following:

**Operational Plan**—Allows users, depending on their access level, to view and/or enter data, print reports, and submit and approve the COP. At any point in time, individuals with any level of access to the COP section will be able to view data in this section.

For all countries, the data entry window for the FY 2009 COPs will begin on October 1, 2008 and will end on November 14, 2008.

**Program Results**—Allows users to enter data, print reports and submit the Program Results. This section is only available for data entry one month prior to SAPR or APR submission. Users will still be able to review data, search for information and print reports. However, data entry will not be available.

For all countries, the data entry window for the FY 2008 APR will begin on October 15, 2008 and end on November 14, 2008.

**Account Admin**—Allows users to change their passwords and see the list of permissions. This section also allows in-country and HQ administrators to reset passwords; add, update, or delete users; and generate reports on user activities.

**Data Admin**—Allows HQ/ Country USG COPRS administrators to add and update data (agency, country, funding source type, program type, etc.) in the data system.

**Organization Admin**—Allows HQ USG administrators to add and update partner and sub-partner information.

**Help**—Provides access to a printable PDF version of support and reference documents.


**Contact Us**—Provides contact information for questions regarding technology, bugs, connection problems.

**Log Off**—Allows users/administrators to log off from the system.


**Authorization and Security:** You will receive notification of authorization to use the COPRS data system through an automated e-mail from COPRS. The e-mail notification will include your assigned user name, temporary password, type of access/user roles, and the link to the COPRS data system. Upon first login, users will be prompted and must change the temporary password to a new password. The temporary password is valid for only ONE log-on session.

After receiving authorization and login information, you can freely access the COPRS data system as many times as you like and a record of your edits will be stored in the system. As long as you save data at each page, you are free to navigate to different screens, work on different tables, exit the data system and resume entering or editing data at any time.

**As a security feature, the COPRS data system automatically logs off users after 30 minutes of inactivity. After 30 minutes of inactivity, users will be prompted to re-enter their user name and password on the login page. You will be notified when you have only three minutes remaining before being logged off. If you receive the three minute timeout warning, clicking the **Continue** button will NOT save your work. However, clicking the **Continue** button will refresh the page, with all of your work still showing. You will then want to click the **Save** button in order to save your work.**

**Information Icons:** COP Guidance as directly related to specific required fields/concepts is distributed throughout the system and alongside specific fields. This additional guidance is available whenever there is a  button. Click on the button next to the specific required field or concept to review relevant COP Guidance.

Instructions and references with regard to data entry are also available through the system.

This guidance is signified by the  button. Click on the button to obtain instructions on how to enter information into the data system.

## Confidentiality Agreement

Much of the data that is included in the COPRS data system is considered sensitive and is classified as “sensitive but unclassified.” Because of the sensitive nature of the information contained in the COPRS data system, all users are required to sign a confidentiality agreement. The system administrator who initiated your user account will have copies of the confidentiality agreement. This confidentiality agreement must be signed and faxed or emailed to OGAC ([sgac\\_cop@state.gov](mailto:sgac_cop@state.gov)) within one week of receiving your user account. If the confidentiality

agreement is not returned within one week of receiving your user account, your account will be disabled.

USG Implementing Partners should not have direct access to COPRS given the sensitive nature of the data.

[Return to Table of Contents](#)



## COP Sections

### Table 1 Overview

#### MODIFICATIONS IN THIS SECTION:

Table 1 now contains the Executive Summary/CN Summary, Ambassador Letter, Five-Year Strategy updates, and three questions on Global Fund collaboration.

#### AMBASSADOR LETTER

##### CONTENT:

In FY 2009, this letter will be uploaded as part of Table 1. While the document is uploaded in Table 1, it will also appear in the Supporting Documents section. Although it shows up in both Table 1 and in the Supporting Documents section, it is only one file. If you delete the document out of one section, it will automatically delete the file in the other location.

#### EXECUTIVE SUMMARY

For the FY 2009 Executive Summary, please start with the updated the Executive Summary used for FY 2008 Congressional Notifications. The FY 2008 Executive Summary is posted on the PEPFAR website: <http://www.pepfar.gov/about/opplan08/102048.htm>.

Please upload the updated Executive Summary to COPRS as a Word document.

Instructions for Executive Summary/Congressional Notification:

1. Please update only the narrative sections and partner lists. Please leave blank the Budget Summary, HIV/AIDS Epidemic information, Targets Table and the funding levels under Prevention, Care, Treatment and Other. OGAC will complete these centrally.
2. Please do not refer to partner organizations by name (except for host government ministries) in the narrative of the Executive Summary. List all partner organizations together at the end of each program area section.

In addition, please follow these style guidelines:

1. Please insert two spaces after each period.
2. Please spell out each acronym the first time it appears in the document, followed by the acronym in parentheses if it is used later in the document.
3. Please write in the active voice, using direct and concise language.
4. Spell out all numbers less than 10.

Use the following formulation when referring to fiscal years: FY 20XX (not FYXX or FY20XX).

Note: Special instructions for Other Bilateral Countries at the end of this section.

##### CONTENT:

The format of the Executive Summary should follow the Congressional Notification format and be no longer than five pages in length. A sample of the CN format and specific formatting instructions can be found on the Extranet. Please write the Executive Summary in Word and then upload the file into the data system.

Please note that Core Team Leaders can assist with preparing this document. Please engage them in this process at least a month before your COP is due.

Please do not include additional support documents here. There is a separate section for additional support documents (see page 130 for instructions).

#### **SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:**

As in FY 2008, Other Bilateral Countries will submit a CN Summary instead of an Executive Summary. The CN Summary should follow the format and instructions described on the Extranet. It should be no more than one paragraph for each USG agency receiving GHAI funding.

#### **DATA ENTRY:**

1. Enter Filename—Click on the **Browse** button to select appropriate Executive Summary file to upload from your local system to the HQ Data system (Document must be a text file, RTF, Word, or PDF).
2. Additional Description—Click on the **Additional Description** box and begin entering any additional information you would like included. You may enter up to 500 characters (approximately one paragraph) in this section. You may want to enter the specific date or the author in this box.
3. Click on the **Upload File** button to upload the country Executive Summary.
4. If you would like to look at a file that has already been uploaded, select **View**
5. Please do NOT use this section for additional support documents. A section has been added to the data system that allows you to upload additional support documents, such as acronyms lists, maps, explanation of upstream (indirect) target calculation, etc.

#### **FIVE-YEAR STRATEGY UPDATES**

#### **CONTENT:**

We expect that the new legislation may require that both a global strategy and corresponding country level strategies be developed for the next five years of PEPFAR. Once the legislation for reauthorization is final, further guidance will be given to country teams. In the meantime, please provide any information on significant changes to the USG strategic direction or country context in the box provided in Table 1. If the country context remains largely unchanged, or you have no modifications to the USG Five Year Strategy at the current time, simply answer no to the first question and move on.

#### **DATA ENTRY:**

1. Select either Yes or No from the drop down menu for the question “Will you be submitting changes to your country’s Five-Year Strategy this year?”
2. If the answer is No, continue on.
3. If the answer is Yes, please provide a brief narrative describing the planned changes. The character limit for the text box is 4,000 characters (approximately 1 page).

#### **COUNTRY CONTACTS:**

## CONTENT:

Please list the contact information for each of the USG agencies working in your country. Typically, this includes individuals for the following USG agencies and the PEPFAR

Coordinator:

1. PEPFAR Coordinator
2. U.S. Embassy
3. HHS/CDC
4. USAID
5. DoD
6. Peace Corps

Optional contacts from USG Agencies include: HHS/HRSA, HHS/OGHA, HHS/NIH, HHS/SAMHSA, Department of Labor, and USDA. You may also include additional contact information for any host country ministries or other key organizations/individuals that you feel should be listed. Please do not list any implementing partners here, other than those who might be associated with a Host Country Government Agency.

## DATA ENTRY:

A “contact type” is an Agency or Organization for which you are required, or want, to list a contact. By default, a row will appear for each contact type in the data system; however, you can change the types for each row. Additionally, you may enter multiple contacts for a single type.

**First Name**—The first name can be up to 255 characters in length.

**Last Name**—The last name can be up to 255 characters in length.

**Title**—The title can be up to 255 characters in length.

**E-mail**—The e-mail address can be up to 255 characters in length.

You may add additional contacts by clicking the **Add More Rows** button, and you may delete your entries by clicking the **Delete** link. You will NOT be asked to verify your deletion. Click on the **Save** button to save your entries without leaving the page or click on the **Cancel** button to exit the screen without saving.

If you would like to add a new contact type - that is, add a contact organization that is not already in the data system - your country system administrator will need to add the contact type.

## GLOBAL FUND QUESTIONS

Please answer the following questions concerning your in-country assistance to the Global Fund. You will provide a more detailed explanation in the Global Fund Supplemental.

1. What is the planned funding for Global Fund Technical Assistance in FY 2009?
2. Does the USG assist with Global Fund proposal writing? (Yes/No)
3. Does the USG participate on the CCM? (Yes/No)

## TABLE 2 Prevention, Care and Treatment Targets

**For the FY 2009 COP, you will be asked to complete Table 2.1 and 2.2.**

- Table 2.1 is an opportunity to provide an update on the targets submitted in your FY 2008 COP for the period that ends September 30, 2009 (FY 2009).
- Table 2.2 covers the period that ends September 30, 2010 (FY 2010).

**The instructions below apply to both tables.**

### **MODIFICATIONS IN THIS SECTION:**

- 
- There is one additional indicator on Table 2 to meet an expected congressional requirement.
- 

### **CONTENT:**

#### **PREVENTION, CARE AND TREATMENT GOALS:**

The prevention, treatment, and care goals set for your country at the initiation of PEPFAR were five-year goals to be achieved through support by the USG in collaboration with all other international partners working in the country and the host country government. The date for achieving your country-level care and treatment goals remains September 30, 2009. In last year's COP, countries' teams entered the targets they actually thought they would achieve by the end of FY 2009. These will be carried over into Table 2.1 in this year's COP. Country teams have the opportunity to revise these targets if appropriate.

Country teams will not be assigned targets for the second five years of PEPFAR at this time. New additional targets will be negotiated through Compacts once the objectives and deliverables are defined. For FY 2010, countries should assume that funding will be maintained at current levels, with the assumption that targets will also remain fairly constant.

#### **Infections Averted:**

The date for achieving your country-level prevention (infections averted) goal remains unchanged; this goal is to be achieved by September 30, 2010.

Due to the difficulty of estimating infections averted, countries are not required to provide a fiscal year target for infections averted. Rather, headquarters will estimate infections averted through modeling, using data from periodic prevalence studies, with the U.S. Census Bureau taking the lead. Trends in HIV prevalence can be used to estimate trends in HIV incidence and the number of infections averted. The first step of this approach is to establish baseline prevalence trends for each country using data through 2004 to estimate the baseline HIV incidence. Trends will be established again at the end of the PEPFAR's first phase using the most up-to-date information available and the difference between these two HIV incidence trends will represent the net impact of program activities since the start of PEPFAR. At present, the Census Bureau has completed the development of all 15 PEPFAR Phase I focus country baseline estimates for HIV incidence. During the five years of PEPFAR, each focus country will have a number of assessments at strategic intervals; infections averted will be estimated following those assessments.

For further information on the method for estimating prevention targets, contact Tim Fowler at the Census Bureau ([timothy.b.fowler@census.gov](mailto:timothy.b.fowler@census.gov)).

**The following indicators are included Table 2:**

<b>Prevention</b>
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results (#1.2)
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting (#1.3)
<b>Care</b>
Number of individuals provided with HIV-related palliative care (including TB/HIV) (#6.2)
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (this is a subset of all individuals provided with palliative care ) (#7.2)
Number of orphans and vulnerable children (OVC) served by an OVC program (#8.1)
Number of individuals who received counseling and testing for HIV and received their test results (#9.2)
<b>Treatment</b>
Number of individuals receiving antiretroviral therapy at the end of the reporting period (referred to as CURRENT clients) (#11.4)
<b>Human Resources for Health</b>
<i>Further guidance about this indicator will be disseminated based on reauthorizing legislation.</i>
<b>Notes</b>
<p><b>Care:</b></p> <ul style="list-style-type: none"> <li>The Total Care sum used to report against the legislative goal of 10 million in care is automatically generated by the system by adding the Care indicator #6.2 and OVC indicator #8.1.</li> <li>The indicator for counseling and testing is not included in the Total Care calculation.</li> <li>Children may be counted in either OVC #8.1 or Care #6.2 depending on the services that they receive. However, they <u>cannot</u> be counted in both OVC and Care, since these indicators will be added together.</li> <li>The Care indicator shown above, inclusive of TB/HIV, is NOT the same indicator that will appear in Table 3. This is because care and TB/HIV are two separate program areas and therefore need to have separate indicators to show targets. Please see Appendix 6 for the complete list of the indicators that appear in Table 3.</li> </ul> <p><b>Treatment:</b></p> <ul style="list-style-type: none"> <li>All individuals receiving ART should also be receiving care and so should also be counted under the care indicator.</li> </ul>

## TARGET SETTING

### GENERAL GUIDANCE

- Downstream, Upstream, and Total Targets (see definition below) are required in Table 2
  - Downstream Targets in Table 2.2 are equal to the Program Summary target in Table 3 for the same indicator.
  - Upstream Targets are calculated by first estimating the Total Target and then subtracting the Downstream Target (See below for additional guidance).
- Upstream and Downstream targets are equally valued by PEPFAR.
- These targets will be used to report to the U.S. Congress what we plan to accomplish over the coming year.

- Annual Program Results (APR) will be evaluated against these targets.
- Timeframe:
  - The timeframe for Table 2.1 is USG FY 2009, which covers October 1, 2008 – September 30, 2009.
  - The timeframe for Table 2.2 is USG FY 2010, which covers October 1, 2009 – September 30, 2010.
- Funding Source:
  - The targets set in Table 2 should reflect the expected accomplishments within the given fiscal year, regardless of the funding source year (budget cycle).
  - For example, the accomplishments you expect to achieve in 2009, may be funded through monies coming from past budget years. Your target should reflect all of these accomplishments.
- A target must be expressed as a whole number value (e.g. 400,000), not as a range (e.g. 250,000 – 500,000).
- Track 1.0: The number of individuals receiving care and treatment as a result of central funding to Track 1.0 activities must be included in your USG end of fiscal year country targets.
- Assistance with Targets:

It is critical that you begin working with your Core Team SI Advisor and Core Team Members on this section as early as possible. Your Core Team SI Advisor can assist with setting your targets. OGAC will provide general guidelines, but not specific guidance on how to set these targets for each country, as this is a very country-specific process (See Appendix 6 for information on target setting).

Additional Guidance (These documents can be found in the help section of the COPRS database or on the PEPFAR Extranet):

- *The President's Emergency Plan for AIDS Relief Indicators, Reporting Requirements, and Guidelines: Revised for FY 2007 Reporting, January, 2007*
- *Data Quality Assurance Tool for Program-Level Indicators; January 2007*
- *Target-setting examples*

## **PROCESS FOR SETTING COUNTRY LEVEL (TOTAL) TARGETS**

The FY 2009 and FY 2010 targets listed here in Table 2 will be evaluated by HQ based on results reported in the relevant APR.

## **COLLABORATION WITH HOST COUNTRY GOVERNMENTS AND OTHER KEY STAKEHOLDERS:**

In support of the "Third One", one national reporting system, the process of estimating Total Targets for the indicators in Table 2 would be most effective taking place through a process established in-country with the host country and other key stakeholders (see Appendix 7).

## **SUPPORT DOCUMENTATION:**

The procedures and methodologies used for estimating all targets must be clearly documented and submitted with your COP in the Support Documents section (see examples on the Extranet). Your SI Advisor and Core Team Leader can provide you with target setting support and should be included in discussions around target setting.

### DOWNSTREAM (DIRECT) TARGET:

An intervention or activity is considered to be a type of “downstream (direct) support” if it can be associated with counts of uniquely identified individuals receiving prevention, care, and/or treatment services at a unique program or service delivery point that receives USG support. Sites may receive support from additional partners but should be counted as USG-supported sites if they receive USG direct support.

Please estimate the number of individuals receiving prevention, care, and treatment services through service delivery sites/providers directly supported by USG interventions/activities (commodities, drugs, supplies, supervision, continuing on-site training, quality assurance, etc.) at the point of service delivery. If you do not provide downstream support, please use a zero (“0”) for the downstream result.

### UPSTREAM (INDIRECT) TARGET:

Upstream (indirect) support refers to contributions made by the USG to overall system strengthening and capacity building that occur apart from, and at higher levels than, the actual points of service delivery. The level of funding available for USG upstream programs will vary by country, and while USG upstream funded activities may contribute to projected national or regional results, they may not contribute significantly, which is a requirement for setting upstream targets. (See the *Data Quality Assurance Tool for Program-Level indicators* for additional guidance). Upstream and downstream services are valued equally and the distribution of programs and hence results between upstream and downstream is a function of national program development.

For upstream (indirect) targets, project the number of individuals receiving prevention, care and treatment services, beyond those counted above under downstream (direct) USG support, as a result of the USG’s contribution to system-strengthening or capacity-building of the national HIV/AIDS program as a whole.

For those program areas where only upstream funding is provided, use the national or regional target for that indicator and provide appropriate justification. If national targets do not exist, the USG team needs to estimate a target based on the number of individuals served during the previous fiscal year in the country or region and any other available contextual information.

Examples of upstream (indirect) support include:

- Development of national HIV/AIDS policies
- Development and implementation of national HIV/AIDS clinical standards and guidelines, as well as associated training protocols and programs
- Technical assistance for the development and maintenance of national commodity and drug procurement and logistics systems
- National laboratory support
- Technical assistance for strategic information activities such as surveillance and facility-based health management information systems.

### TOTAL TARGET:

The Total target, except in specific and well-documented cases, should not be greater than the national total for any indicator. This target represents all of the individuals that are expected to receive services through either upstream or downstream USG support. This target will be needed to calculate your upstream target.

It is assumed that some of the individuals who receive services at sites directly supported by PEPFAR are the same individuals who receive services as the result of upstream (indirect) support through national systems strengthening. By using the suggested calculation (i.e. subtracting downstream target from total target) you will avoid double counting individuals who might fall into both categories. All countries should move towards this method of target setting. However, in this transition year, if you choose to estimate your upstream target by other means you will need to ensure that individuals being reached directly through a USG-supported site and also indirectly through USG support to national systems strengthening are not being counted twice, once in each category.

All results reported against these targets should be coordinated with country governments and reviewed by them before submission.

	National 2-7-10 ⓘ	USG Direct Target End FY06 ⓘ	USG Indirect Target End FY06 ⓘ	Total USG Target End FY06 ⓘ
<b>Prevention ⓘ</b>	<b>Target 2010: 810,202</b>			
Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<b>Care ⓘ</b>	<b>Target 2008: 1,050,000</b>			
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)		<input type="text"/>	<input type="text"/>	<input type="text"/>
Number of OVC served by an OVC program during the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Number of individuals who received counseling and testing for HIV and received their test results during the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<b>Treatment ⓘ</b>	<b>Target 2008: 210,000</b>			
Number of individuals receiving antiretroviral therapy at the end of the reporting period		<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<input type="button" value="Update Total"/>				

#### DATA ENTRY:

Enter target numbers into the cells for the two prevention indicators, the three care indicators, the one counseling and testing indicator, the one treatment indicator, and the one human resources indicator. While you will need to determine your Total target in order to calculate your upstream target, the COPRS system is set up such that you will need to enter both downstream (direct) and upstream (indirect) targets for each indicator. The data system will then automatically sum downstream (direct) and upstream (indirect) targets to calculate total targets, which you can check against your calculations. Additionally, the data system will automatically sum the components of care to arrive at a total for this section. By hitting the



**Update Total** button at the bottom of the table, the summary information will appear and the data will be saved.

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## TABLE 3 USG Country Plan

Table 3 is the heart of the Country Operational Plan. Though all sections of this report are important, Table 3 is where the bulk of your time spent in the planning process will be reflected. It is critical that you work as one USG team, engaging all of the USG agencies with HIV/AIDS activities in-country when coordinating your activities in Table 3.

### PLANNING OBJECTIVES AND TIMEFRAME:

Table 3 provides a valuable opportunity to describe your program, and serves primarily as a planning and accounting tool. Program areas have been defined to track budgetary requirements and directives required by the legislation and are, therefore, necessary for reporting to Congress, OMB, and other constituents. Collection of this information through the COPRS data system will minimize the need for follow-up requests and maximize our ability to manage and report on various program elements.

## Table 3.1 Funding Mechanisms and Source Table

### FUNDING MECHANISM DEFINITION

#### CONTENT:

The COP is designed to be a document that follows funding, and as such, funding information is organized by what we have termed “funding mechanisms.” A funding mechanism is a discrete dollar amount passed through a prime partner entity and for which the prime partner is held fiscally accountable. Examples of funding mechanisms are bilateral contracts, bilateral grants, field support (USAID) to a HQ-managed project/entity, PASA, etc.

In Table 3.1, you will list all funding mechanisms needed to provide funds to your partners.

One unique funding mechanism has six key characteristics that together make up a unique entry:

1. funding mechanism type
2. funding mechanism name
3. procurement / assistance instrument (new in FY 2008)
4. USG agency
5. funding source
6. prime partner

One or more of these key characteristics should be different for each funding mechanism entry.

Example: In the case of a prime partner, such as Family Health International, or a specific project, such as the UTAP Project, which could receive multiple sources of funding in a given country (from more than one USG Agency, more than one funding source within a USG Agency, or more than one funding mechanism type), it will have to

be entered more than once in Table 3.1. Each entry corresponds to a unique combination of the other six key characteristics, with its own unique identifier.

You should not have multiple entries for a funding mechanism where the six key characteristics listed above are the same. For example, do NOT enter separate funding mechanisms for each program area but select the same mechanism in each Activity Table that is relevant.

There is one exception. You might have a prime partner working in your country under two different HQ mechanisms. For example, Academy for Educational Development is the prime partner on both the FANTA Project and the Linkages Project. In this case, it is two separate contracts (and therefore two different funding mechanisms) and would be distinguished by the funding mechanism name cell. However, there is only a limited set of partners for which this may happen.

**\*Note:** It is possible for a given USG agency to also be considered a prime partner. Please see page 56 for further details about this.

To create a funding mechanism and its row in the master list, you will complete the screen in Table 3.1, which asks for the six characteristics of a unique mechanism. Entering these mechanisms may be the most time-consuming part of working in the COPRS database. FY 2008 funding mechanisms can be imported into your FY 2009 COP, which will save time.

### IMPORTING ITEMS FROM YOUR FY 2008 COP:

#### MODIFICATIONS IN THIS SECTION:

- In FY 2009, there will be a new set of program areas and program area budget codes. Therefore, when importing an activity, country teams should select ALL appropriate FY 2009 budget categories that the existing FY 2008 activity falls within.
- In FY 2009, we have eliminated Related Activities, Target Populations, Geographic Coverage and Activity level indicators. Therefore, when you import an activity, this information will not appear.
- You will not be able to select “Import All Activities” this year. Due to the new budget codes, you must make a selection for each activity.

#### OVERVIEW:

The COP is designed to be a document that follows funding and as such, many funding mechanisms and activities are the same from one year to the next. You can select mechanisms from your FY 2008 COP to be imported into your FY 2009 COP. There is a “button” in Table 3.1 that is labeled import mechanisms. However, due to the change in budget codes, you will now need to select the **ALL** new FY 2009 program area budget code(s) that are related to the activity. The activity can be imported into multiple new program area budget codes, so there is a one-to-many relationship, **however please note that the program area budget codes remain mutually exclusive.**

For example, OVC remains the same across years, so if you are importing an OVC activity, you can select OVC program area budget code in FY 2009. However, there is a new budget code for Male Circumcision. If you had an activity in FY 2008 in Other Prevention, but the activity included a male circumcision component, you would select both Other Prevention and Male

Circumcision from the program area budget code drop down list. Once imported, you will need to split the FY 2009 planned funds accordingly so there is no overlap.

## CONTENT:

---

You are able to import items from your FY 2008 COP. This import feature will bring in:

- the funding mechanisms listed on Table 3.1
- the sub-partners listed in Table 3.2
- the selected activities linked to that funding mechanism from the different program areas in Table 3.3.

When you select to import funding mechanisms from Table 3.1, you will then have the option of selecting specific activities linked to that funding mechanism. When you select an activity, you will be importing the information associated with that activity, including the existing narrative. Emphasis areas will not import since the list has been modified. At a minimum, you will need to update the Planned Funding and Emphasis Areas for all imported activities. You will receive an error message in the Quality Assurance Report for any imported items that are not updated. In Table 3.1, you will see a red asterisk (\*) next to any mechanism with activities that indicates the activity was not updated.

Once you have imported items, you will be able to edit both the funding mechanism information and the activity by funding mechanism information. **Please note – while you are able to re-import funding mechanisms, the newly imported mechanism will not overwrite the old mechanism, but will create a new record.**

For activities that fall into a new program area budget code you will need to enter a new narrative. Text can be taken from other relevant FY 2008 narratives, but must accurately reflect the activity. In the male circumcision example above, text could be taken from the FY 2009 Other Prevention activity narrative, but there may also be a counseling and testing or AB component that needs to be added to the narrative.

Emphasis areas will also need to be updated. Since they have changed from FY 2008, the tickboxes will not be imported, but will appear under the activity entry as blank. The imported item will not show the sections that have been eliminated for FY 2009, such as target populations, geographic coverage, etc.

Each activity in COPRS is assigned an Activity Number. Last year when you imported an activity, the base number stayed the same and only the extension changed, i.e.: 1763 became 1763.08. In FY 2009, you may import an activity twice, therefore, the numbering convention will need to be modified with an additional qualifier. The Activity Number for FY 2009 activities that are newly created in FY 2009 will continue to use the same format from FY 2008 explained above: 00000.yy (e.g., 34257.09) where 00000 represents the part of the ID that stays the same over time, and yy represents the year of the COP. In this example, 34257 is the same ID number that this activity had in the FY 2008 COP. However, if this activity is copied from FY 2008 to FY 2009, then the ID for the resulting activity (or activities if it is copied to multiple Budget Codes) will have the form 00000.xxxxx.yy (e.g. 34257.98765.09) where 00000 is the same as the ID in FY 2008 and yy is the year, but xxxxx represents an arbitrary, system-generated value. In this example, 34257 is still the ID number that this activity had in the FY 2008 COP, and 98765 is

automatically generated and assigned by COPRS. This method will allow countries to track activities over time.

### ACTIVITY NARRATIVES FOR ONGOING ACTIVITIES

Activities approved in FY 2008 and are ongoing do not need extensive revision in FY 2009, but please make sure that all narratives have been updated to reflect accurate information. If an activity is imported, but will not change scope, clearly mark that this narrative is from FY 2008 and has not been updated. Please use the following conventions in ALL CAPS:

- ACTIVITY UNCHANGED FROM FY2008
- ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

Countries will again receive “passes” in FY 2009 based on performance and will be notified by their Core Team Leader if they qualify. If the country team does not have to complete narratives in a specific program area, please delete the activity narrative text before submitting the COP. However, you should still import the activity from the FY 2008 COP to indicate that it is continuing from already approved entry. If a country received a pass last year, but did not qualify in FY 2009, activity narratives are required.

Unless explicitly stated in the activity narrative text, we will assume all narratives have been updated.

### DATA ENTRY:

Mech ID	Mech System ID	Funding Mechanism Name	Mech Type	Agency	Planned Funding	Prime Partner
1022.08	4942	Health Services and Systems Program	Local - Locally procured, country funded	USAID		ABT Associates

Activity ID	Activity System ID	Old Program Area	Activity Funding	Activity Narrative	New Budget Categories
					To select multiple Budget Categories, hold down the CTRL key and then click on your selections
<input type="checkbox"/> 3531.08	8794	HTXS - ARV Services		Zambia continues to face an acute shortage of health care personnel which severely constrains...	Prevention: PMTCT Sexual Prevention: AB Sexual Prevention: Other sexual prevention Biomedical Prevention: Blood Safety Biomedical Prevention: Injection Safety
<input type="checkbox"/> 3532.08	8795	HVSI - Strategic Information		In the area of strategic information, Health Services and Systems Program (HSSP) will develop...	Prevention: PMTCT Sexual Prevention: AB Sexual Prevention: Other sexual prevention Biomedical Prevention: Blood Safety Biomedical Prevention: Injection Safety
<input type="checkbox"/> 3529.08	8793	OHPS - Other/Policy Analysis and Sys Strengthening		The Health Systems and Services Program (HSSP) will build on FY 2005 and FY 2006 activities...	Prevention: PMTCT Sexual Prevention: AB Sexual Prevention: Other sexual prevention Biomedical Prevention: Blood Safety Biomedical Prevention: Injection Safety

Mech ID	Mech System ID	Funding Mechanism Name	Mech Type	Agency	Planned Funding	Prime Partner
600.08	4956	EQUIP II	HQ - Headquarters procured, country funded	USAID		Academy for Educational Development

In Table 3.1, click on the button labeled **Import from Previous COP**.

1. Put checks into the boxes next to each of the entries that you would like to import. If an item does not have a check box, then this item has already been imported into your FY 2009 COP. For each activity, select one or more choices from the “New Budget Code” list. A copy of the FY 2008 activity will be made for each New Program Area you select. Click the **Carry Over Selected Activities** button at the bottom of the table.
2. You will be asked to verify what you are importing, including the list of all the activities in the program areas that will also be imported. If this is all correct, click Yes. If it is not correct, click Cancel.
3. You will receive a confirmation message that reads “Selected Mechanisms and all related sub-records from previous fiscal year have been carried over to current fiscal year.”
4. Click on the **Return to Mechanisms** button to return to Table 3.1.

Click on **Carry Over More Mechanisms** button if you would like to import additional mechanisms and activities.

NOTE: This screenshot is for illustrative purposes, as the actual data entry screen and data entry instructions may be slightly different.

## ACTIVITIES LIST

### CONTENT:

You can view all activities linked to a particular Funding Mechanism at once, and you will be able to navigate from this list to the specific Activity by Funding Mechanism entry for editing or review. Simply click on the **Activity List** link at the far right of each Funding Mechanism row. Users will also be able to add activities from the List Activities screen.

3.1 Funding Mechanisms and Source Print/Export  
View/Add Comments

**Activity List**

**Mechanism Name:** TBD Cooperative Agreement  
**Prime Partner:** To Be Determined  
**Agency:** HHS/CDC  
**Mechanism Type:** Headquarters procured, country funded (HQ)

	Activity ID	Program Area	Activity Narrative	Planned Amount	
<a href="#">Edit</a>	8757	PMTCT	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>
<a href="#">Edit</a>	8778	HVAB	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>
<a href="#">Edit</a>	9898	HVOP	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>
<a href="#">Edit</a>	9898	HVOP	07-P0211 TBD-Civil Society Capacity Building. This activity has USG Team Botswana Internal Refere	\$500,000	<a href="#">Delete</a>

Add activities to:  Add

Return to Funded Mechanisms and Source

## FUNDING MECHANISM ID

### CONTENT:

When users import activities from the FY 2008 COP, COPRS will establish the link between activities and mechanisms. The Mechanism Numbering convention for FY 2009 will continue to use the same format from FY 2008 COP: ooooo.yy (e.g., 34257.09) where ooooo represents the

part of the ID that stays the same over time, and yy represents the year of the COP. Since the mechanisms will continue to have a one-to-one relationship, or in other words, can only be imported once, the numbering convention will remain the same.

### FUNDING MECHANISM TYPE:

#### CONTENT:

Funding Mechanism Type is an extremely important designation. It is critical that headquarters knows what funding is planned for HQ funding mechanisms to ensure the ceiling capacity. To assist you in completing this section accurately, please use the list of HQ mechanisms found in Appendix 8. **Review of this Appendix before entering data in Table 3.1 is crucial!**

There are four options for the funding mechanism type:


1. **CENTRAL:** Headquarters-procured and centrally-funded - Central activities include Track 1.0 grants and the New Partners Initiative.
2. **HQ:** Headquarters-procured and country-funded - HQ mechanisms include field support (USAID), MAARDS (USAID), buy-ins to headquarters managed activities, task orders to headquarters managed activities, PASA activities and country buy-in to Track 1.0 awards. Please see Appendix 8 for a list of HQ mechanisms by Agency.  
*For DoD, this would include:*
  - a. Military International HIV/AIDS Training Program
  - b. Technical assistance including TAD
  - c. Similar activities where the funds do not flow through the country.
3. **LOCAL:** Locally-procured and country-funded - Local mechanisms include bilateral agreements (either contracts, cooperative agreements or grants), MOUs with the host country government, Associate Awards (USAID) and in-country RFA/RFP/RFC that is not yet awarded.  
*For CDC, all funds allotted to post via cable are considered local.*  
*For DoD, this would include:*
  - a. NGOs such as PSI, PCI, Kansani
  - b. Universities such as Drew, UMD
  - c. MIPRS to embassies for locally procured items, regional training, etc
4. **UNALLOCATED:** Only the GHAI account may be tagged for unallocated funding. Please see page 59 for more information.

**Strategic Objective Agreements:** Money obligated into a SOAG cannot be considered a funding mechanism until it is sub-obligated to another level with identified partners, activities and planned results.

**New Partners Initiative:** NPI mechanisms should be entered as separate mechanisms in Table 3.1, and the mechanism type should be Central. Please name the mechanism NPI.

#### DATA ENTRY:

“Mechanism Type” is a drop down menu that will have the above four options. You can only select one option.

Table 3.1: Funding Mechanisms and Source ⓘ 

Add Mechanism/Source

Save Cancel

Mechanism Type: -- Select -- ⓘ

Funding Mechanism Name: ⓘ

Planned Funding (\$): ⓘ

Agency: -- Select -- ⓘ

Funding Source: ⓘ

Prime Partner: ⓘ Select Partner ⓘ

New Partner: ☐ Yes ☐ No ⓘ

Early Funding Request: ☐ ⓘ

### FUNDING MECHANISM NAME:

#### CONTENT:

While this is not a required field, many countries find it much easier to reference and reprogram funds when the mechanism has a unique name.

We have seen the following mechanism naming conventions:

- Partner Acronym: AIHA; CHAZ
- Contract / Cooperative Agreement Number
- Project Name: Support to RDF; Sun Hotel PPP; GHAIN; Track 1.0 buy-in; Track 1.0 OVC
- Funding Source: GHAI, Base (this helps identify different funding streams when users add activities in Table 3.3)

If this is a HQ funding mechanism, you must put the name of the HQ project in the funding mechanism name cell. For example, if you are using the CTRU Project or UTAP, you should use these names in the funding mechanism name field. Please see Appendix 8 for a list of HQ mechanisms by Agency, with both the project name and the prime partner name.

Please do not confuse funding mechanism name with prime partner name (see definition below). Below are several examples of the difference between funding mechanism type, funding mechanism name and prime partner name.

Examples of Prime Partners and Funding Mechanism Names:

Mechanism Type	Funding Mechanism Name	Prime Partner Name
Central	Together We Can	American Red Cross
HQ	Twinning	American International Health Alliance
HQ	MEASURE/DHS	Macro International
HQ	Lab Supplies	Crown Agents
HQ	UTAP	Columbia University



Local	PSC	U.S. Agency for International Development
Local	Network RFP	To Be Determined

**DATA ENTRY:**

Please type directly into the Funding Mechanism Name cell. The character limit for this field is 1,000 characters.

**PROCUREMENT/ASSISTANCE INSTRUMENT:****MODIFICATIONS IN THIS SECTION:**

This is a new field in FY 2009

**CONTENT:**

In FY 2008, we added a new field for procurement/assistance instrument. The types of procurement/assistance instruments are:

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

Note: IQCs should be listed as contracts

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

Note: PASAs should be listed as cooperative agreements

- **Grant:** A legal instrument where the principal purpose is the transfer of money, property, services or anything of value to the recipient in order to accomplish a public purpose of support or stimulation authorized by Federal statute and where substantial involvement by USG is **not** anticipated.
- **Inter-agency Agreement (IAA):** The IAA is an Inter-Agency Agreement. This is a mechanism to transfer funding between agencies. If the USG team decides that one agency has a comparative advantage and is best placed to implement an activity, the USG team has the option of transferring money from one agency to another through an IAA.
- **USG Core:** We have also added a "USG" option to the procurement/assistance instrument field to capture USG agency funds that do not qualify as contracts, cooperative agreements, or grants.

**DATA ENTRY:**

Select the procurement / assistance instrument from the drop-down menu.

### FY 2009 PLANNED FUNDING (\$):

#### CONTENT:

This field is automatically generated by the data system. As you enter planned funding for activities in Table 3.3, the data system will calculate the total amount for that funding mechanism and display it here.

#### DATA ENTRY:

N/A

### USG AGENCY:

#### CONTENT:

From the drop-down list, select the USG Agency responsible for managing the funding mechanism.

It is critical that you identify the correct agency, because the USG Agency / Operating Division will be the one that receives the funding from OGAC.

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

**NIH** - The only NIH activities that you should include in your COP are non-research activities. For example, if you are providing country funding to add a service component, such as care or treatment, to an NIH study, only the country funding for the additional service component would be put into the COP. The NIH study would NOT be included.

**HRSA** - Please note that although CDC locally manages HRSA partners such as ITECH, the Twinning Center (American International Health Alliance (AIHA)), NY AIDS Institute (HIVQUAL) and Georgetown University (Nursing Capacity Building), HRSA should be listed as the associated agency.

**Peace Corps** – Funding going to the Peace Corps should be identified with Peace Corps as the USG Agency receiving the funding. Peace Corps should never appear as another USG Agency's prime partner.

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

**State** – To expedite the distribution of funds, please identify the State Department Bureau for all mechanisms where the Department of State is the USG Agency. For any project using State's Regional Procurement Support Offices for construction or renovation, list the relevant State regional bureau as the USG Agency (see Appendix 15 for more information).

#### DATA ENTRY:

Please select the USG Agency from the drop down menu.

**Table 3.1: Funding Mechanisms and Source** ⓘ

**Add Mechanism/Source**

Save Cancel

Mechanism Type: Locally procured, country funded (Local) ⓘ

Funding Mechanism Name: ⓘ

Planned Funding (\$): ⓘ

Agency: DoD ⓘ

Funding Source: DoD ⓘ  
DoL ⓘ

Prime Partner: HHS/CDC ⓘ  
HHS/HRSA ⓘ  
HHS/NIH ⓘ  
HHS/OS ⓘ  
HHS/SAMHSA ⓘ

New Partner: ⓘ

Early Funding Request: Peace Corps ⓘ  
State ⓘ  
State / A ⓘ  
State / AF ⓘ

Select Partner ⓘ

Save Cancel

#### FUNDING SOURCE:

##### MODIFICATIONS IN THIS SECTION:

Due to an account change in the FY 2008 Foreign Operations appropriation, the GHAI (field and central) and CSH funding sources were updated in COPRS (i.e.: GHAI is now GHCS). Country teams will use the updated funding source categories shown in the table below under the column "FY 2009 COP Submission Funding Source Categories" for the FY 2009 COP. Any further updates to funding sources will be managed centrally.

**CONTENT:**

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

USG Agency	FY 2009 COP Submission Funding Source Categories	FY 2008 COP Submission Funding Source Categories
USAID	GHCS (State) Central GHCS (State) GHCS (USAID) *	GHAI Central (GHAI) AEEB *# CSH * FSA * ESF *
HHS/CDC	GAP GHCS (State) Central GHCS (State)	GAP GHAI Central (GHAI)
HHS/HRSA	GHCS (State) Central GHCS (State)	GHAI Central (GHAI)
HHS/OS	GHCS (State) Central GHCS (State)	GHAI Central (GHAI)
DoD	GHCS (State)	GHAI
DoL	GHAI	GHAI
State	GHCS (State) Central GHCS (State)^	GHAI Central (GHAI) FSA*
Peace Corps	GHCS (State)	GHAI
ALL OTHERS	GHCS (State)	GHAI

\* Other Bilateral Countries Only

^ If the USG Agency is State Department, RPSO should be the only partner with Central GHCS (State) funding source

# There should not be AEEB, FSA or ESF funds allocated to countries in FY 2009. However, these accounts will continue to appear in the drop-down menu in COPRS.

**GAP** – This category used to be called “Base (GAP Account),” and is still applicable. The list, by country, of “Base” levels will be provided to you in early June 2007. USAID will NOT have “Base” funding for the Phase I PEPFAR focus countries.

**Reminder** – Please ensure that you are coordinating as a USG Team in determining funding decisions and that all USG HIV/AIDS funding is being programmed as an interagency USG Team.

**Central/Track 1.0 Mechanisms Funded by HQ Budgets:** When the funding mechanism is Central (Headquarters procured, centrally funded), the funding source category is “Central”. Central is only to be used for Track 1.0 or NPI partners. Country funding that is going into a Track 1.0 mechanism should be entered as a unique Funding Mechanism and labeled with the HQ (Headquarters procured, country funded) funding mechanism type.

**DATA ENTRY:**

This is a drop down menu. The funding source is linked to the USG Agency, so you must select a USG Agency in order for your funding source selections to appear. Select one choice from the drop down menu.

**UNALLOCATED:**

**Note:** In FY 2009, other bilateral countries cannot have unallocated funds

**CONTENT:**

OGAC recognizes that early COP planning reduces program flexibility. Therefore, a flexible funding option will again be available in this year's COP. You may designate up to five percent of your GHCS (State) budget as unallocated. The Quality Assurance Report will verify that no more than 5% of GHCS (State) is set aside as unallocated.

Allocation of unallocated requests must be submitted to OGAC as part of the April 2009 reprogramming process so that all FY 2009 can be approved and notified by the 3<sup>rd</sup> Congressional Notification of FY 2009.

Country: Ethiopia FY: 2006

**Table 3.1: Country Plan - Funding Mechanisms and Source** ⓘ

Mechanism Type:	Unallocated ⓘ
Planned Funding (\$):	ⓘ

**DATA ENTRY:**

Click the **Add Mechanism/Source** button.

1. In the Mechanism Type drop down box, select Unallocated.
2. Type in the planned Unallocated funding into the cell.
3. You do not need to include the \$ sign, commas, decimal places or cents. Enter a number rounded to the nearest dollar.
4. Click on the **Save** button.

**PRIME PARTNER:****CONTENT:**

A prime partner is an entity which receives funding directly from, and has a direct legal relationship (contract, cooperative agreement, grant, etc.) with, the USG agency. This is where the name of the implementing partner should be entered. The data system includes all partner or organizations that were entered in the FY 2004 - FY 2008 COPs, which currently includes over 3,000 organizations. Please note that there is a distinction between an organization and a

partner. An organization can be any organization listed in the COPRS system. An organization becomes a partner by being selected by a country as either a prime or a sub-partner.

Adding an Organization or Partner to the COPRS Database
<p>There are two ways for you to determine if the organizations you are looking for are in the COPRS system.</p> <ol style="list-style-type: none"> <li>1. You could use the <a href="#">Organization Admin</a> to search for organization names.</li> <li>2. Second, there is a full list of the organizations in the data system in the <a href="#">Operational Plan - Reports</a> section entitled “Master Organization List”.</li> </ol> <p>Please use one of these two options early on to determine if all of the organizations that you need for your COP data entry are in the data system.</p> <p>A new organization can only be added to COPRS <b>after you have thoroughly searched</b> the organization list under the “Organization Admin” tab on the COPRS navigation bar and can not find an organization which resembles the partner you would like to add. At this point, you can send an email to <a href="mailto:sgac_cop@state.gov">sgac_cop@state.gov</a> requesting that this information be entered into the system. A template is available on the Extranet, which contains all of the required information. You must provide:</p> <ol style="list-style-type: none"> <li>1. Full name of the organization (spelled out, without acronyms or abbreviations)</li> <li>2. Type of organization (see below for Prime Partner Type list)</li> <li>3. Local status of the organization (see below for definition of local organization)</li> <li>4. Associated country (only include this information if a partner works in just one country)</li> </ol> <p>We strongly encourage you to submit this as early as possible to make sure organizations are entered when you begin data entry. If you provide all of the required information to us in the spreadsheet on the Extranet, we will be able to get it entered into the system fairly quickly.</p> <p>For all organizations that need to be added to the COPRS, we MUST receive your request and list of organizations by September 12<sup>th</sup> if not before. This will allow time for verification and entry before data entry begins on October 1st.</p>

There can be only one prime partner per funding mechanism. When funding mechanisms are awarded to a consortium, the lead partner is the prime, and any other partners in the consortium should be identified as sub-partners (see Table 3.2 below). With the exception of the prime partner, you will only need to enter those members of the consortium that are active in your country.

Do not list partners until they have been formally selected through normal Acquisition & Assistance processes, such as Annual Program Statements, Requests for Application, or Requests for Proposals. If a partner has not been formally selected, list the partner as To Be Determined (TBD). Please see Appendix 14 for guidance on notifying OGAC once you have identified a prime partner.

There will be times when you will include one of the USG agencies as the prime partner for a funding mechanism. This is expected for such items as management and staffing costs, or technical staffing costs which would fall into one of the program areas. However, for those occasions where a USG Agency is the prime partner, you should **NOT** have sub-partners under that funding mechanism. If there is a sub-partner under a USG agency, this is the same as having a prime partner and therefore should be entered as a separate funding mechanism. For HHS/CDC, there is additional guidance on when CDC would be the prime partner.

<b>CDC as Prime Partner for a Funding Mechanism:</b>
<p>CDC should only be the prime partner for a funding mechanism in two instances:</p> <ol style="list-style-type: none"> <li>1. management and staffing costs</li> <li>2. technical assistance that CDC in-country provides directly</li> </ol> <p>If funding will eventually be obligated to another organization, then CDC should NOT be the prime partner. Additionally, there should NEVER be sub-partners under an activity where CDC is the prime partner.</p> <p>For more assistance with this issue, please contact Heather Pumphrey (hbp7@cdc.gov)</p>

**NOTE: In FY 2009, please do not list the Working Capital Fund as a prime partner. Please see page 30 for more information on SCMS.**

#### **DATA ENTRY:**

1. Click **Select Partner**.
2. Enter the partner name (or any part of the name). We have found that keeping the search very broad works best, such as only entering "Family" if searching for "Family Health International." This year, you will be able to search using the acronym. Remember that not all partners were submitted with associated acronyms.
3. You will receive a selection of possible partner names depending upon what you typed into the search box. If the partner is not on the list or if you think that any of the information is incorrect, please send an email to: sgac\_cop@state.gov.
4. Click the button next to the partner name and click **Select**.

#### **PARTNER TYPE:**

##### **CONTENT:**

This information will be provided by the data system if the organization already exists in COPRS. If the organization needs to be added to the data system, please send an email to sgac\_cop@state.gov with all of the necessary information (see above under Prime Partner Name). Each organization can only be ONE type. If it is an FBO and is also any other type of organization, please select FBO.

1. FBO (Faith Based Organization). Please ensure that the organization is actually an FBO rather than basing the determination on a name sounding like an FBO (i.e., St. Catherine's Hospital might not be an FBO).
2. NGO (Non-governmental organization other than FBO). This includes organizations created as a private sector company's foundation, e.g. Coca Cola Foundation.

3. Host Country Government Agency. This includes ministries, such as a Ministry of Health.
4. Private Contractor. This includes private sector companies such as Deloitte-Touche, John Snow, Inc., and any company involved in a Public-Private Partnership.
5. University. (Note: a university affiliate, such as Johns Hopkins JHPIEGO, would be listed under NGO, but Columbia University School of Public Health would be listed under University.)
6. Multi-lateral Agency. This is for organizations such as the World Health Organization or UNAIDS.
7. Other USG Agency. This is any USG entity other than one of the six USG Agencies that are part of PEPFAR (DoD, DoL, HHS, Peace Corps, State Dept, USAID)
8. Own Agency. This is for any one of the six USG Agencies that are part of PEPFAR (DoD, DoL, HHS, Peace Corps, State Dept, and USAID).
9. Parastatal. This is a state-owned enterprise that operates using a combination of public and private funds. It may be headed by a government appointee.

Determine partner type based on the nature of the entity, not by the funding that it might receive. Please make sure that you identify the type of organization and NOT the source of funding the organization receives.

Example: An entity that receives funding from the host country government is not necessarily a host country government agency. It could be an FBO that receives funding from multiple sources.

#### **DATA ENTRY:**

No data entry necessary. This is done when the partner is added to COPRS.

#### **LOCAL PARTNER ORGANIZATION:**

##### **CONTENT:**

Definition: The definition of local partner organization is currently under review internally. We disseminated to the field as soon as it is final.

#### **DATA ENTRY:**

No data entry necessary. This is done when the partner is added to COPRS.

#### **NEW PARTNER:**

##### **CONTENT:**

As part of our efforts to increase sustainability, country teams should build local capacity by funding new partners.

A new partner is one working for the USG for the first time in health projects in the country or one that has not worked with the USG as a prime partner or sub-partner on a health project in that country in the past five years.<sup>4</sup>

<sup>4</sup> Please note that this definition of a new partner is different from the definition used by the New Partners Initiative.



Please be aware that new partners are for the USG in your country as a whole, not for each individual USG agency. If USAID is already working in health with a partner who will be working with CDC for the first time in FY 2009, that partner is NOT new. It is important for the USG Team to ensure that they are appropriately applying the “new” status.

**Examples:**

- A new department within a university that is a current or former partner is only a new partner if the funding is going directly to that department and is not going through the university. If you are working with additional departments in a university that you have worked with in previous years and the funding goes directly to the university that is NOT a new partner.
- If a contractor has been working on training in child survival activities but not HIV, it is NOT new.
- If a contractor has been working in food monetization with a health component, it is NOT new.
- If a contractor has been working on micro-finance and is now working in HIV, it is NEW.
- If a contractor had an agreement in the recent past in the health sector (i.e. within the last five years), did not have an agreement in FY 2007, but does have an agreement in FY 2009, it is NOT a new partner.
- If a contractor has been working with USAID in health programs but is now being funded to work with HHS/CDC as well, it is NOT new.

**DATA ENTRY:**

This is a Yes/No radio button. If the partner is new, based on the criteria specified above, select “Yes”. If the partner is not new, based on the criteria specified above, select “No”.

The Quality Assurance Report will check that a partner is consistently marked “new” or “not new” throughout the FY 2009 COP. Users can also run a comparison of partners between the FY 2008 and FY 2009 COPs. Please see Appendix 10 for more information.

**EARLY FUNDING REQUESTS:**

**MODIFICATIONS IN THIS SECTION:**

The timeframe for FY 2009 COPRS data entry does not allow for early funding requests to be submitted through COPRS. **Therefore, FY 2009 early funding requests will be submitted by September 12<sup>th</sup> through a brief form on the PEPFAR Extranet.** In order to simplify the process, early funding requests will be submitted at the mechanism (or partner) level, with funding amounts being broken out for each early-funded activity (program budget code). All COP countries will submit an identical form.

**Please note:** Country teams are asked to submit early funding requests for the GHAI (or GHCS-State) funded-activities only, as OGAC can only notify for this one account. Early funding for all other accounts should be done through the associated agency process.

Please see page 108 for more information.

## Table 3.2 Sub-Partner

### MODIFICATIONS IN THIS SECTION:

In FY 2009 there will be no technical modifications to this section. However, in FY 2010, sub-partner reporting will be moved to a hierarchical model that will relate subs to primes and then sub-sub-partners (or “subs of subs”) to their respective sub-partners. Please note the revised definition of sub-partner below.

### CONTENT:

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

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

The COPRS data system already includes all partner/organizations that were entered in the FY 2004-2008 COPs. The total currently includes over 3,000 organizations. Please search thoroughly before you decide that the entity that you are looking for is not included in the list. If the organization needs to be added to the data system, please send an email to: [sgac\\_cop@state.gov](mailto:sgac_cop@state.gov) with all necessary information (see above under Partner Name).

**OGAC must receive the organizations to be added to the COPRS organization list by September 12th to ensure their availability in the system.**

You are asked to enter information for sub-partners only if **EITHER** the name of the sub-partner organization or the amount of funding is known. If **NEITHER** the name of the sub-partner NOR the amount that the sub-partner will receive has been determined (even though there are plans to have subs under the mechanism), there is nothing to be entered into COPRS at this time; however, sub-partner lists should be updated throughout the year during the Reprogramming process. Please follow the below guidance in determining if a sub-partner needs to be entered into the data system:

		Sub-Partner Name	
		<u>Known</u>	<u>Unknown</u>
Planned Funding	<u>Known</u>	Include	Include

	<u>Unknown</u>	Include	<i>Do Not Include</i>
--	----------------	---------	-----------------------

**Sub-Partner or Sub-Sub-Partner:** Please enter all sub-partners here, regardless of whether the sub-partner has a direct relationship with the prime partner or with another sub-partner. The FY 2009 COP does not distinguish between sub-partners and sub-sub-partners at this time. All sub-partners are linked with the prime partner.

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

**Examples:**

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

**Sub-Partners where USG Agency is the Prime Partner:** For those occasions where a USG Agency is the prime partner, you should NOT have sub-partners under that funding mechanism. If there is a sub-partner under a USG Agency, that is really the same as having a prime partner, and this should be entered as a separate funding mechanism.

**Implementing Organizations Only:** Please do not include consultants in your sub-partner list. Individual consultants should not be entered into the COPRS data system. In addition, only organizations that have a formal agreement, as outlined in the definition, should be entered into COPRS. Vendors that provide office supplies or other goods/services on an ad hoc basis should also not be included.

**SUB-PARTNER NAME:**

**FEATURES:**

When you open Table 3.2, you will see a list of all sub-partners that have been added to the current year's COP through importing a funding mechanism (and its attached sub-partners) or by entering new sub-partners. This list can be sorted by clicking any of the hyperlinked column headings. This table can also be filtered in the following ways:

- Detail View – Click on **Show/Hide Details** to see the associated program areas and new partner status. In detail view, the sub-partner entries can be edited directly on screen.

- Mechanism View – Clicking on any mechanism ID number will display all sub-partners in a specific mechanism. Entries can be edited in this view.
- Custom – You can select a custom list of sub-partners by checking the tickbox in the left-hand column and then clicking **Edit Selected**.

#### DATA ENTRY:

1. Click on the button that says **Add Sub-partners**
2. Select the mechanism you would like to add sub-partners to
3. Enter the partner name (or any part of the name). We have found that keeping the search very broad works best, such as only entering “Family” if searching for “Family Health International.” If you would like to enter multiple sub-partners, do not enter any information in the box and click Search. This year, you will be able to search using the acronym. Remember that not all partners were submitted with associated acronyms.
4. You will receive a selection of possible partner names depending upon what you typed into the search box. If the partner is not on the list or if you think that any of the information is incorrect, please send an email to: sgac\_cop@state.gov.
5. Click the button next to the partner name and click **Select**. You may add more than one sub-partner at a time.

#### NEW PARTNER:

##### CONTENT:

See the information from Table 3.1 regarding new partners on page 60.

##### DATA ENTRY:

This is a Yes/No check box. If the partner is new, based on the criteria specified in Table 3.1, select “Yes”. If the partner is not new, based on the same criteria, select “No”.

The Quality Assurance Report will check that a partner is consistently marked “new” or “not new” throughout the FY 2009 COP. Users can also run a comparison of partners between the FY 2008 and FY 2009 COPs. See the “helpful reports” appendix for more information.

#### FY 2009 PLANNED FUNDING (\$):

##### CONTENT:

Enter the amount of total FY 2009 planned funding requested for the sub-partner.

The Quality Assurance Report will double-check that the funding for a given sub-partner does not meet or exceed the funding for the prime partner/mechanism.

Please remember that if the partner funding is TBD, you will need to update the funding amount before completing the APR. This can be submitted through reprogramming or at other times of the year when COPRS is open for data entry.

**DATA ENTRY:**

Enter the planned FY 2009 funding directly into the field. If the amount of FY 2009 planned funding has not yet been determined for an identified sub-partner, check the box that says "Funding is To Be Determined".

**SUB-PARTNER BUDGET CODES:****CONTENT:**

Please check the box next to each budget code where that particular sub-partner will be working (see Section on Table 3.3, p. 68 for a list of budget codes). While you do not need to link sub-partners to specific activities in table 3.3, a sub-partner cannot be assigned a budget code if there is not an activity in Table 3.3 for the prime partner. For instance, if a prime partner is only working in PMTCT, the sub-partner cannot have a check mark in the OVC budget code. The Quality Assurance report will double-check this.

When you are in detail view, you can change the associated program area without opening a new screen.

**DATA ENTRY:**

Please check the box next to each budget code that the sub-partner will be assigned.

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## Table 3.3 Program Planning Table

### MODIFICATIONS IN THIS SECTION:

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Table 3.3 has been updated this year, with modified budget codes and program areas. Unlike previous years where each program area mapped one-to-one with a budget code, in FY 2009, program areas capture the summary of a program, and in some cases include multiple program area budget codes. These changes will carry through to PEPFAR II and are designed to ensure that we have essential information about your program for approval and reporting while, as much as possible, collecting that information in a manner that is closest to the way programs are already implemented in the field. Program area narratives and budget coding serve different but linked objectives. Program area narratives provide us with an overview of your integrated programs in various areas of prevention, care, and treatment, while budget codes provide details necessary for tracking program funds in response to legislative requirements and Congressional inquiries. This year we have both program area budget codes, which are designed to capture exclusive funding information about specific types of activities (e.g., male circumcision or laboratory infrastructure), and secondary cross-cutting budget attributions, which are designed to capture all funding associated with a cross-cutting program, regardless of program area. As a result, each secondary cross-cutting budget attribution field will capture dollars that are already reported under a program area budget codes. Secondary cross-cutting budget attributions may, for example, capture funding for HCD that is captured under ART Treatment, PMTCT, and TB/HIV.

There are six new program areas in FY 2009: Sexual Prevention, Biomedical Prevention, Adult Care and Treatment, Pediatric Care and Treatment, Gender, and HCD. Pediatric Care and Treatment will be captured in Table 3.3, and is associated with two new program area budget codes: pediatric care and support and pediatric treatment. Please see the table below.

The Gender and HCD program area narratives do not have any program area budget codes associated with them. While countries will need to write a program area narrative about how they address gender in across programs, activity level information about gender will still be captured through emphasis area tickboxes. Funding information for HCD will be captured through secondary cross-cutting budget attributions, described below. It is important to note that both the Gender and the HCD program area narratives will be captured as supporting documents, and the Required Supporting Documents section on page 130 contains more information.

PROGRAM AREAS	PROGRAM AREA BUDGET CODES
PMTCT	01-MTCT Prevention: PMTCT
Sexual Prevention	02-HVAB Sexual Prevention: AB 03-HVOP Sexual Prevention: Other sexual prevention
Biomedical Prevention	04-HMBL Biomedical Prevention: Blood Safety 05-HMIN Biomedical Prevention: Injection Safety 06-IDUP Biomedical Prevention: Injecting and non-Injecting Drug Use 07-CIRC Biomedical Prevention: Male Circumcision
Adult Care and Treatment	08-HBHC Care: Adult Care and Support 09-HTXS Treatment: Adult Treatment
Pediatric Care and Treatment	10-PDCS Care: Pediatric Care and Support 11-PDTX Treatment: Pediatric Treatment
TB/HIV	12-HVTB Care: TB/HIV
OVC	13-HKID Care: OVC
Counseling and Testing	14-HVCT Care: Counseling and Testing
ARV Drugs	15-HTXD ARV Drugs
Laboratory Infrastructure	16-HLAB Laboratory Infrastructure
Strategic Information	17-HVSI Strategic Information
Health Systems Strengthening	18-OHSS Health Systems Strengthening
Human Capacity Development	
Gender	
Management and Staffing	19- HVMS Management and Staffing

Secondary Cross-cutting Budget Attributions
1. Human Capacity Development
2. Public Health Evaluation
3.A Food and Nutrition: Policy, Tools and Service Delivery
3.B. Food and Nutrition: Commodities
4. Economic Strengthening
5. Education
6. Water

#### PROGRAM AREA BUDGET CODE DEFINITIONS

Program area budget codes are used for activities that fall under specific prevention, care, and treatment programs. It is important to remember that program area budget codes are mutually exclusive. This means funding that is captured under Pediatric Treatment cannot be captured under Pediatric Care or OVC. Likewise targets for one program area budget code may not be duplicated in another program area budget code.

## PREVENTION

1. **PMTCT** – activities (including training) aimed at preventing mother-to-child HIV transmission, including ARV prophylaxis for HIV-infected pregnant women and newborns and counseling and support for maternal nutrition. PMTCT-plus ART activities should be described under ARV Drugs and Adult Treatment. Funding for HIV counseling and testing in the context of preventing mother-to-child transmission can be coded under PMTCT or Counseling and Testing; targets should be included in PMTCT. Early infant diagnosis should be included under Pediatric Care.
2. **Sexual Prevention** – activities (including training) intended to prevent sexual transmission of HIV.
  - 2.A. Abstinence/be faithful** – activities (including training) to promote abstinence, including delay of sexual activity or secondary abstinence, fidelity (including partner reduction), and related social and community norms.
  - 2.B. Other sexual prevention** - other activities (including training) aimed at preventing HIV transmission including purchase and promotion of condoms, STI management (if not in palliative care settings/context), messages/programs to reduce other risks of persons engaged in high-risk behaviors. Prevention services should be focused on target populations such as alcohol users; at risk youth; men having sex with men (MSM); mobile populations, including migrant workers, truck drivers, and members of military and other uniformed services (e.g. police); and persons who exchange sex for money and/or other goods with multiple or concurrent sex partners, including persons engaged in prostitution and/or transactional sexual partnerships.
3. **Biomedical prevention** – activities (including training) intended to prevent HIV transmission through biomedical interventions. This program area includes four program area budget codes: blood safety; injection safety; male circumcision; and injecting and non-injecting drug use.
  - 3.A. Blood safety** – activities supporting a nationally-coordinated blood program to ensure a safe and adequate blood supply including: infrastructure and policies; donor-recruitment activities; blood collection, testing for transfusion-transmissible infections, 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.
  - 3.B Injection safety** – policies, training, waste-management systems, advocacy and other activities to promote medical injection safety, including distribution/supply chain, cost and appropriate disposal of injection equipment and other related equipment and supplies.
  - 3.C Male circumcision** – policy, training, outreach, message development, service delivery and follow-up, and equipment and supply purchase related to male circumcision. ABC messaging, condom provision, prevention counseling and STI treatment should all be part of a comprehensive male circumcision package. HIV



counseling and testing associated with male circumcision can be included in either counseling and testing or male circumcision.

**3.D Prevention among injecting and non-injecting drug users (e.g.: methamphetamines users)** – activities including policy reform, training, message development, community mobilization and comprehensive approaches including medication assistance therapy to reduce injecting drug use. Procurement of methadone and other medical-assisted therapy drugs should be included under this program area budget code. Programs for prevention of sexual transmission within IDUs should be included in this category

## CARE

4. **Adult Care and Support** – all facility-based and home/community-based activities for HIV-infected adults and their families aimed at extending and optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness through provision of clinical, psychological, spiritual, social, and prevention services. Clinical care should include prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria and diarrhea (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. Psychological and spiritual support may include group and individual counseling and culturally-appropriate end-of-life care and bereavement services. Social support may include vocational training, income-generating activities, social and legal protection, and training and support of caregivers. Prevention services may include “prevention for positives” behavioral counseling and counseling and testing of family members. The purchase of OI drugs (excluding TB drugs) should be included under Adult Care and Treatment. ARV treatment should be coded under Adult Treatment and ARV Drugs.
5. **Pediatric Care and Support** – all health facility-based care for HIV-exposed children aimed at extending and optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness through provision of clinical, psychological, spiritual, social, and prevention services. Clinical care should include early infant diagnosis, prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide treated nets, safe water interventions and related laboratory services), pain and symptom relief, and nutritional assessment and support including food. Other services – psychological, social, spiritual and prevention services – should be provided as appropriate. Pediatric care and support services should be counted if they are provided at a facility; community 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.
6. **Orphans and Vulnerable Children** – activities are aimed at improving the lives of orphans and other vulnerable children (OVC) affected by HIV/AIDS, and doing so in a measurable way. Services to children (0-17 years) should be based on the actual needs of the child and could include ensuring access to basic education (from early childhood development through secondary level), broader health care services, targeted food and nutrition support, including support for safe infant feeding and weaning practices, protection and legal aid, economic strengthening, training of caregivers in HIV

prevention and home-based care, etc. Household-centered approaches that link OVC services with HIV-affected families (linkages with PMTCT, palliative care, treatment, etc.) and strengthen the capacity of the family unit (caregiver) are included along with strengthening community structures which protect and promote healthy child development (schools, churches, clinics, child protection committees, etc.) and investments in local and national government capacity to identify, monitor and track children's well-being. Programs may be included which strengthen the transition from residential OVC care to more family-centered models. (See the OVC Technical Considerations and OVC Guidance for further details.) It is important that funding for OVC is not double-counted in pediatric care activities.

7. **TB/HIV**– includes exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis (including medications), as well as screening and referral of TB clinic clients for HIV testing, and clinical care. The location of HIV/TB activities can include general medical settings, HIV/AIDS clinics, home-based care and traditional TB clinics and hospitals. Pediatric TB/HIV services should be included in this budget code.
8. **Counseling and testing** – includes activities in which both HIV counseling and testing are provided for those who seek to know their HIV status (as in traditional VCT) or provider initiated counseling and testing. Funding for counseling and testing in the context of preventing mother-to-child transmission can be included under PMTCT or Counseling and Testing; targets should be included in PMTCT.

## TREATMENT

9. **ARV Drugs** – including procurement, delivery, in-freight of ARV drugs. All antiretroviral Post-Exposure Prophylaxis procurement for rape victims should be included within this program area. Distribution/supply chain/logistics, pharmaceutical management and related systems strengthening inputs are to be included in the Health Systems Strengthening section.
10. **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.
11. **Pediatric 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 Pediatric Care and Support.
12. **Laboratory infrastructure** – development and strengthening of laboratory systems 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 Counseling and Testing 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.

## OTHER

13. **Strategic information** –HIV/AIDS behavioral and biological surveillance, facility surveys, monitoring partner results, reporting results, supporting health information systems, assisting countries to establish and/or strengthen such systems, and related analyses and data dissemination activities fall under strategic information. Program area-specific monitoring and routine evaluation should be incorporated under the specific program area.
14. **Health Systems Strengthening** –including broad policy reform efforts and system-wide approaches, for example national procurement and logistics systems or strengthening of Global Fund programs and donor coordination. Other policy support such as stigma reduction or widows/orphan protection should be included in this area. Broad support to construction and renovation can also be incorporated, however, it may also be included in specific program areas.
15. **Management and staffing** – costs of supporting USG mission staff to manage, support and administer HIV/AIDS programs including related training, salaries, travel, housing and other personnel-related expenses. Implementing agency/grantee staffing costs are coded under the appropriate functional category rather than under Management and Staffing.

#### SECONDARY CROSS-CUTTING BUDGET ATTRIBUTIONS

Further information about how to add secondary cross-cutting budget attributions, including definitions and how to add them to an activity, please see page 110.

#### GUIDE TO DETERMINING IN WHAT PROGRAM AREA BUDGET CODE AN ACTIVITY FITS

PEPFAR encourages integrated programs, and as described in the policy overview, promotes cross-cutting activities in key areas. As the COP tracks funding by program areas, it is necessary to distribute components of your integrated program across the 19 program area budget codes and 7 secondary cross-cutting budget attributions. Many activities have components that should be described (with funding amounts) in several different budget codes. Below is a list of common cross-cutting issues/programs with considerations for how to distribute their constituent elements across the program area budget codes and secondary cross-cutting budget attributions. While the information below can guide you, please use common sense when distributing activities into different program areas. 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 consequences to results reporting.

##### PMTCT

Provision of ARV prophylaxis and other ANC services (not to include family planning, which cannot be supported with PEPFAR resources) for HIV-infected pregnant women should be funded under PMTCT. Procurement and provision of HAART for pregnant women should be attributed under ART drugs and ART services. Funding for counseling and testing in the context of preventing mother-to-child transmission can be included under PMTCT or Counseling and Testing; targets should be included in PMTCT. Early infant diagnosis should be funded under Pediatric Care.

##### ABC

While many sexual prevention activities will either be AB only or Other Sexual Prevention only, integrated ABC prevention programs should be attributed to Abstinence/Be Faithful and Other Sexual Prevention in proportions appropriate to the scope of the activity. Comprehensive ABC programs can be divided by activity, with certain activities (e.g. programs focusing on delaying sexual debut, reducing number of sexual partners, and behavior change around male norms and transgenerational sex) funded under AB. Activities related to condom promotion and distribution should be funded under Other Sexual Prevention. One should use common sense in this process. For example, activities targeted toward persons in prostitution should be covered entirely in Other Sexual Prevention; likewise, a school-based activity for youth ages 10-14 should be covered entirely in AB (consistent with PEPFAR's ABC guidance). Please contact your Core Team Leader should you have any questions.

#### Gender-based Violence, including Antiretroviral Post-Exposure Prophylaxis

Activities to address the intersections between gender-based violence and HIV/AIDS are multifaceted and may include clinical services, behavioral change interventions, and local and systems-level work with law enforcement, legislative, and judicial bodies. Relevant program areas include AB, ARV Drugs, Counseling and Testing, and Health Systems Strengthening. The proportion of GBV funding categorized under each program area will reflect the particular package of activities offered. Procurement of antiretroviral post-exposure prophylaxis (PEP) for rape victims should be funded under Drug Procurement: ARV Drugs. Depending on the target population and other program attributes, behavior change prevention such as promotion of social and community norms against rape, incest and other forced sexual activity might be funded under AB. Additional activities such as work with police and judicial systems could be funded under Health System Strengthening.

#### Prevention with Positives

Prevention with Positives interventions are generally a component of a care and/or treatment intervention, including both behavioral and biomedical interventions that are routine standard of care in HIV care and treatment settings. Consequently, they should be coded under Adult Care or Adult Treatment depending on where the program service is being delivered. For example, if the activities are being carried out in a clinic setting, then funding would be reflected in Adult Treatment. If carried out in home-based settings, the activities would be part of Adult Care. Promotion of consistent and correct condom use and provision of condom supplies should always be an essential component of programming for prevention with positives; however, the activity can remain in Adult Care or Treatment.

#### OI Drugs

All procurement, delivery, and in-freight of drugs for the prevention and treatment of Opportunistic Infections, excluding drugs to treat and prevent HIV-related tuberculosis, are included in Adult Care and Support or Pediatric Care and Support, depending on whether the drugs are used to treat adult or pediatric populations. Distribution/supply chain/logistics, pharmaceutical management and related systems strengthening inputs are to be included in the Health Systems Strengthening section.

#### TB/HIV

Activities directed at the nexus of TB and HIV often encompass several program areas, including TB/HIV, ARV Drugs, Adult Treatment, Adult Care, Pediatric Treatment, and Counseling and Testing. TB/HIV programs that provide basic health care and support services such as

clinical or psychosocial services should be categorized under TB/HIV, including activities focused on pediatrics; those expanding to provide clients with ART should code such services under ARV Drugs and Adult Treatment/Pediatric Treatment; resources for building lab capacity and infrastructure for TB/HIV should be included under TB/HIV

If TB programs provide HIV testing and counseling services on-site or refer patients to co-located and integrated USG-supported counseling and testing services, these services would be coded under Care: TB/HIV. Care: TB/HIV funding may be used to procure HIV rapid test kits and other commodities necessary for these services.

#### Pediatric Care and Support

Care for HIV-negative children is **not** included under the Pediatric Care and Support program area budget code and should be coded under OVC. ARV treatment of children is **not** included under the Pediatric Care and Support program area budget code, and should be coded under ARV Drugs or Pediatric Treatment. All health facility-based care for HIV exposed and HIV-positive children (excluding TB/HIV services) should be coded under the Pediatric Care and Support program area budget code, including early infant diagnosis. Children cannot be counted under both OVC and Pediatric Care and Support.

#### OVC

Health facility-based care for HIV-infected children should be coded under Pediatric Care and Support. ARV treatment of children should be coded under ARV Drugs or Pediatric Treatment. All other health care should be coded under the OVC program area budget code, when delivered within programs for orphans and other vulnerable children affected by HIV/AIDS. Children cannot be counted under both OVC and Pediatric Care and Support.

#### Pediatric Treatment

Procurement of pediatric ARVs should be funded under ARV Drugs. All other treatment services should be funded under Pediatric Treatment.

#### SI

Country teams need to determine if an SI activity best fits in the SI section or within another program area budget code. Large scale SI activities that support multiple program areas or national systems might best fit under the SI budget code. This would include the following types of activities:

- Activities that support the collection, analysis and dissemination of HIV/AIDS behavioral and biological surveillance and monitoring information;
- Facility surveys;
- Support for national, USG-wide, or program monitoring systems or HMIS activities which involve multiple implementing partners; and
- Assistance to countries in the establishment of standard data collection methods and capacity building.

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

- Activities that are relatively small in scope and cost;
- 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 could be included in the PMTCT budget code, when the funding mechanism is entered and described within the narrative. If an HMIS 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.

### Health Systems Strengthening

Activities supporting a specific program area budget code can be included under the appropriate technical program area budget code. However, all activities in OHSS must still have benchmarks, or other deliverables associated with the activity.

Below are a few examples that should be coded under OHSS. The following activities should be placed in the Health Systems Strengthening program area budget code.

- Strengthening the capacity of host country government institutions to plan, manage, and implement HIV programs, including national procurement and logistics systems.
- Strengthening local or local partner organizations, particularly in management, leadership and policy development.
- Strengthening leadership and the policy environment to reduce stigma and discrimination, including addressing key gender issues.
- Strengthening leadership and policy environment to expand access to HIV care and treatment.
- Strengthening the GFATM management structure and improving donor coordination.
- Support for construction and renovation.
- Policy advocacy
- Human Capacity Development (will also need to be coded with the HCD secondary cross-cutting budget attribution field)

Please note that for certain policies related to specific program areas, activities may be better placed in another program area. For example, interventions to establish policies to address alcohol consumption may be incorporated under AB or Other Sexual Prevention. Another example might be an activity that supports a national infant feeding policy, which might be in PMTCT, or an activity to improve host country logistics systems, which might be in ARV Drugs.

### Management and Staffing

The following categories should be included in the Management and Staffing budget code: leadership and/or management positions, program managers, contracting staff, financial/budget staff and administrative/support staff (see the Staffing Analysis guidance for additional information).

Technical advisors/non-management staff, who spend most of their time implementing programs in specific technical areas, as well as their administrative support staff, should be allocated as appropriate to the other 19 program area budget codes. However, if a position is supporting more than three program area budget codes, include that position in the Management and Staffing program area.

## Table 3.3 Program Area Summary

There are two main parts to the overview of each program area: program area narrative and FY 2009 planned funding for program area. For FY 2009, program area summary targets will be collected in a separate Excel spreadsheet. More information can be found on page 130.

As noted above, in FY 2009, there are 15 program areas and 19 program budget codes. There are three program areas that are a summary of two or more program budget codes: Sexual Prevention (AB and Other Sexual Prevention); Biomedical Prevention (Blood Safety, Injection Safety, Injecting and non-Injecting Drug Use, Male Circumcision); and Adult Care and Treatment (Adult Care and Support and Adult Treatment). For these three program areas, the program area narrative context for the combined program area should be written in the text box provided on the summary page of the first program area budget code. No text box will appear on the summary pages of the remaining budget codes in that program area. The aggregate planned funding information will be captured on separate pages for each budget code, and there will not be an overall summary of funding for the entire program area.

For example, for Sexual Prevention, you will write a program area narrative in the text box under Sexual Prevention. This narrative should be comprehensive and cover all activities to prevent sexual transmission, including AB and Other Sexual Prevention. Total planned funds for Sexual Prevention: AB will be captured on the same page as the narrative. On the next overview page, the total planned funds will be captured, but there will not be a text box. Reviewers will use the comprehensive narrative about sexual transmission as a starting point for reviewing both AB and Other Sexual Prevention activities.

Gender and HCD will also be required program area narratives, however, in the case of gender, there will be no associated budget code and for HCD, the budget code will be captured in the cross cutting section. Due to the fact that there is no associated budget information to be captured in COPRS, these two program area narratives should be done in Microsoft Word and uploaded in the Supporting Documents section. All program area narratives will have the same maximum character limit of 15,000. **It is not required that you use all the space provided.**

### PROGRAM AREA NARRATIVES:

Note: Special instructions for Other Bilateral Countries at the end of this section.

Program area narratives should provide a sufficient level of detail to evaluate whether the USG approach, as reflected in the activities, appropriately targets and addresses the needs of the country. The program area narratives should:

1. Provide the context for that program area in your country and focus on describing the broader strategic USG vision, instead of merely listing separate activities. Be sure to link the FY 2009 COP with the vision expressed in the five-year Strategy and with accomplishments and program directions established from FY 2004 through FY 2008.
2. Discuss progress made and barriers encountered since the FY 2008 COP.

3. Discuss the work of, as well as linkages with, other implementing partners, in particular the Global Fund, and the host country government in the specific program area.
4. Discuss how you will address sustainability for this program area (e.g., site graduation, government capacity building, etc.).
5. Describe how the USG team will support the monitoring and evaluation of routinely collected program indicators. If there are any PHEs proposed for this program area, please highlight how these specific activities and/or answers will contribute to and enhance programming in this area.

In addition, you will find program-area specific guidance below. We request this additional information to facilitate a better understanding of the context and overall approach and to reduce the need for excessive clarification from the field post-COP submission. **Please note: In some cases, the information requested may not be available. If this is the case, please do not respond.**

The program area narratives should not be more than 15,000 characters (approximately three pages). **You are not required to use the entire space.**

#### **SPECIAL INSTRUCTIONS FOR OTHER BILATERAL COUNTRIES:**

If the PEPFAR program is not supporting a particular program area, because of limited resources and/or government and/or other international partner efforts, please leave the Program Area Context blank. There is no expectation that the Other Bilateral Countries will work across all program areas or program budget codes.

Please note that in Other Bilateral Countries, the central approach of interventions is to leverage other host country and international partner resources, including the Global Fund. Thus, there is no expectation that these program area descriptions will demonstrate support to comprehensive programs; rather, they will describe strategic interventions that could be brought to scale nationally by others or that fill essential program area gaps.

#### **DATA ENTRY:**

These are narratives that are entered into a text box provided on the Program Area Summary page. There is a 15,000 character limit (approximately three pages) for each narrative. We recommend that you write the narrative in Word and then paste the text into the text box in COPRS. You may also type directly into the box on the screen, but COPRS does not have a spell-check or character count function.

#### **FY 2009 PLANNED FUNDING FOR PROGRAM AREA:**

##### **CONTENT:**

The data system will automatically generate the Total FY 2009 Planned Funding for each program budget code, which is the sum of all FY 2009 planned funding for the activities listed in each program budget code of Table 3.3. You cannot enter any information into this cell. As noted above, in cases where the program area is a summary of multiple budget codes, each program budget code funding total will be captured separately.



<b>PROGRAM AREA SUMMARY TARGETS</b>
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**MODIFICATIONS IN THIS SECTION:**

- The program summary targets do not fully align with the new budget codes; therefore, the targets will be captured in one summary sheet in Excel, rather than within COPRS.
- Program summary targets will be set based on expenditures within that reporting period rather than on planned funding for a given 12 month period (budget cycle).
- The disaggregation of targets by sex is recommended for FY2009 COP, with the intention of requiring disaggregation in FY 2010.

**Target Timeframe:**

The targets in this section represent FY 2010 (October 1<sup>st</sup> 2009 - September 30<sup>th</sup> 2010). These targets should reflect expected program results in FY 2010 regardless of the funding year (budget cycle) used to reach targets. For example, partners might still be spending FY 2007 and FY 2008 funds during the October 1, 2009 and September 30, 2010, but ALL results should be counted.

**By setting targets based on expected results within a given time period rather than based on a given budget year, we will be able to make comparisons between targets and the annual results reported in Annual Progress Report (APR).**

**CONTENT:**

The program summary targets are intended to show what will be accomplished by all USG funded activities collectively in that program area. The program summary targets should not simply be the sum of the targets for a given indicator across individual activities listed. Many individual activities may be supporting the same sites, training the same individuals or serving the same clients. Therefore, we are requesting that each USG team provide these summary targets for each program area, adjusting for double counting. It is expected that some double counting will occur at the partner level and in many cases can be programmatically beneficial. However, the USG in-country team should identify and resolve any double counting issues prior to submitting the COP to OGAC. The targets should be an accurate reflection of the partners' total expected reach during the period between October 1, 2009 and September 30, 2010.

Program summary targets represent downstream results (see Appendices 6 and 7 for the definition of downstream and additional guidance on program summary target setting). For the eight high-level indicators, the downstream results in Table 3 will be equal to the downstream results in Table 2.2.

Please review *The President's Emergency Plan for AIDS Relief Indicators Reference Guide: July 2007* document for additional indicator guidance and to ensure that all necessary data are being collected throughout the year.

**DATA ENTRY:**

The indicators in Table 3.3 at the program summary level have been deleted from COPRS since they do not match the new budget codes. Instead, an Excel template will be provided for country teams to capture these targets. This template will be pre-populated with the targets that were provided in Table 3.3 of the FY 2008 COP. Please review these targets and make any necessary changes. Country teams should then add their FY 2009 COP targets (representing FY 2010) in the fields provided. Please upload the Excel template into the Supporting Documents section once completed.

**DESCRIPTION OF OTHER ACCOMPLISHMENTS:****CONTENT:**

There is a narrative box included within the Excel template to provide country teams an opportunity to set qualitative targets that describe some of the key activities that are not sufficiently captured by the quantitative service delivery indicators. These targets should be very specific so that country teams will be able to measure whether or not the target has been achieved. **These are not required.**

Example:

If your program plans to support the development and roll out of a national early infant diagnosis protocol, in addition to describing the activity in general terms in your program or activity narrative and setting targets on training or organizational development indicators, country teams can set quantitative targets on key (high-level) deliverables, such as:

- National protocol developed by [add date]
- Protocol piloted in X number of districts by [add date]
- National protocol approved by ministry by [add date]
- Nationwide roll out completed by [add date]

**DATA ENTRY:**

The Excel template provided to capture your Table 3.3 targets will include a Qualitative Targets section for Prevention, Care, Treatment and Systems Strengthening. Please provide targets in the form of concise bullets as in the example above. Further description can be captured in the program area narratives.

**Assuring Quality Data:**

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

All country teams submitting COPs and mini-COPs must have a process in place for monitoring the quality of the program results collected by their partners. This process should also be an essential part of their portfolio review process. Additional information on data quality can be found in Appendix 27.

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## Program Area Specific Narratives

### PREVENTION OF MOTHER TO CHILD TRANSMISSION

#### PROGRAM AREA DESCRIPTION:

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

#### PROGRAM AREA SPECIFIC INSTRUCTIONS:

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

##### Statistics:

- The current national geographic coverage of PMTCT services
- The number and proportion of ANC and L&D sites providing PMTCT services and the number of sites providing services at different levels (i.e. primary health centers, district hospitals)
- The national antenatal prevalence and any relevant urban-rural or regional differences
- The current and planned (COP 2009) number of HIV+ pregnant women receiving antiretroviral prophylaxis nationally relative to the estimated total number of HIV+ women delivering annually (note key contributions of USG non-PEPFAR funds and other donors' contributions)
- The current and planned (COP 2009) USG-specific contribution to the national program including the number and proportion of women attending antenatal care each year who receive PMTCT services and the number of HIV+ women receiving antiretroviral prophylaxis. Targets should be consistent with the goal of reaching 80% of HIV+ women attending ANC with antiretroviral prophylaxis by the end of FY 2009.
- How USG resources are strategically focused to maximize PMTCT impact.
- The estimated number and proportion of pediatric infections USG support will help avert in the country with COP 2009 funding, taking into account the efficacy of antiretroviral prophylaxis provided. This estimate should be consistent with the goals of achieving a 40% reduction in new infections by the end of FY 2009.

##### Services:

- The type of counseling and testing for PMTCT (i.e. group pre-test counseling, opt-out, rapid tests with same day results)
- The current level of uptake of testing and antiretroviral prophylaxis (the "PMTCT cascade"), and explanations for low uptake if applicable. This would include information about the percentage of women who attend at least one antenatal care visit and the percentage that deliver in a facility.
- The current antiretroviral prophylaxis regimen(s) being used in the country and proportions of sites implementing the most effective regimens (i.e. AZT + single dose NVP and provision of ART for eligible women) in keeping with most recent WHO guidelines.
- Approaches to measuring and improving quality at PMTCT sites.
- Specific and measurable plans to strengthen the above elements of the program in FY 2009.

##### Referrals and Linkages:

- PMTCT is a "gateway" for other prevention, care and treatment services. Please describe how your program will facilitate linkages to care and treatment for eligible women and infants (e.g. number and proportion of women successfully referred for ART during and after pregnancy).

- The current and planned (COP 2009) number and proportion of HIV+ women identified in PMTCT programs initiated on ART during pregnancy. (Recommend this be 20% or more of women identified at PMTCT sites that are linked to ART)
- The current and planned (COP 2009) number and proportion of women identified in PMTCT settings enrolled in longitudinal care. (Recommend 80% or more of HIV+ women identified)
- Specific plans to strengthen linkages to routine maternal and child health services, and any wraparounds with family planning programs.

Policy:

- Plans to address national level policy barriers, supply chain management, training, monitoring and evaluation, management and supervision, and human resources, as well as other system strengthening. Please include specific plans for integration and coordination of PMTCT with ART, MCH and PMI.
- Activities to address gender-based violence, reduce stigma, and provide psychosocial support for HIV+ pregnant and lactating women.
- Partner testing, strategies to involve men in PMTCT, and primary prevention activities occurring in the context of PMTCT, including prevention with positives.

Please highlight any other outstanding challenges or gaps that the program is facing.

## SEXUAL PREVENTION

### PROGRAM AREA DESCRIPTION:

This section should contain activities previously contained in the Abstinence and Be Faithful section – (activities (including training) to promote abstinence, including delay of sexual activity or secondary abstinence, fidelity (including partner reduction), and related social and community norms) - and in the Condoms and Other Prevention section – (activities aimed at preventing HIV transmission including purchase and promotion of condoms, STI management (if not in palliative care settings/context), and messages/programs to reduce risks of persons engaged in high-risk behaviors). For prevention of sexual transmission in generalized epidemics, depending on the epidemic profile, populations at increased risk may include: young adults in the general population such as women 20-29 years and men 30-39, especially persons who exchange sex for money and/or other goods with multiple or concurrent sex partners; pregnant women; negative partners in long-term sero-discordant relationships, widows and divorcees; migrant populations; and, to varying degrees, young people, especially out-of-school youth. In concentrated epidemics, populations at increased risk often include persons engaged in prostitution and their clients; men who have sex with men (MSM); mobile populations, including migrant workers, truck drivers, and members of military and other uniformed services (e.g. police); and at-risk youth.

For more information, please see “ABC Guidance #1: *For United States Government In-Country Staff and Implementing Partners, Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections Within The President’s Emergency Plan for AIDS Relief.*”

### PROGRAM AREA SPECIFIC INSTRUCTIONS:

To the extent the information is available, please describe the following, highlighting plans for support in the upcoming year.

Epidemic Context:

- Please describe the profile of the epidemic within the general population, including overall national HIV prevalence (specifying whether the data come from a population-based survey or ANC surveillance), as well as a brief overview of major variations in prevalence by age, sex, geography or other factors.
- Please describe the demographic and epidemiological make-up of your population of persons engaged

in high-risk behaviors, with details about how emerging high-risk groups are identified. Please refer to data sources (e.g. BSS or other) if available.

- Drawing on data from recent surveys, please describe patterns of behavior that represent the major epidemic drivers in the country context. For example, in generalized epidemics, these may include frequency of: multiple and concurrent sexual partnerships; informal transactional sex; cross-generational sex; early initiation of sexual activity; low risk perception; etc.
- Please describe the availability of condoms in your country and the USG contribution to that supply. If known, please also discuss condoms procured by USAID population funds and other international partners. Additionally, please provide information on whether condom procurements will be targeted towards prevention with positives activities.
- Please mention how USG-funded sexual transmission programs support national prevention strategies and priorities, and complement activities supported by other donors.
- Please touch on key USG prevention of sexual transmission programs achievements to date, and highlight any major challenges these efforts are facing, e.g. weak political leadership, limited capacity of local implementing partners, etc.

#### Services:

- Please outline overall priorities for prevention of sexual transmission for the COP 09 period, including the relative emphasis on programming to prevent new infections among young adults and adults vs. among adolescent youth. Please briefly highlight key behaviors, populations and geographic locales that will be targeted by USG prevention partners, depending on the epidemic context.
- Describe the overall technical approaches to prevention that will be applied to different population segments and in different contexts. Please specifically address the balance and linkages between media and community outreach activities.
- Please summarize the AB components of the sexual prevention portfolio.
- Please comment on any activities that directly address prevention for men in the general population, including efforts to reduce multiple and concurrent sexual partnerships.
- Where relevant, please describe prevention activities that focus specifically on reducing cross-generational sex, informal transactional sex, and sexual coercion and violence.
- In concentrated epidemics, describe prevention activities that target “bridge” populations or subgroups within the general population engaging in risky behavior with risk avoidance messages (e.g., clients of persons in prostitution, young males in urban slum settings).
- Please comment on programs that provide access to prevention of alcohol abuse.
- Comment on how your program and other donors’/international partners’ programs provide outreach and HIV services to persons engaged in high-risk behaviors.
- Please mention any specific activities to harmonize and coordinate the overall USG prevention portfolio, and to improve the quality of prevention efforts.

#### Referrals and Linkages:

- Please describe the linkages and integration of AB activities with condoms and other prevention activities for all programs dealing with individuals who are sexually active and engage in high-risk behaviors.
- Please describe the opportunities and linkages for providing health services to persons engaging in high-risk behaviors, including HIV counseling and testing and STI and HIV/AIDS treatment and care.
- Please mention any linkages between prevention of sexual transmission and OVC, counseling and testing, and other care, support and treatment services. Please also mention any wrap-arounds to coordinate HIV prevention with voluntary family planning programs (both education and services.)

#### Policy:

- Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening relating to prevention of sexual transmission efforts.
- Please describe any plans to address changes in guidelines that are likely to facilitate greater access to

services for persons engaged in high risk behaviors and the removal of barriers to these services.

Please highlight any other outstanding challenges and gaps that the program is facing

## BIOMEDICAL PREVENTION

### PROGRAM AREA DESCRIPTION:

Biomedical prevention includes activities for blood safety, safe injection, injecting and non-injecting drug users and male circumcision. Alcohol programs are not captured here, but in Sexual Prevention. In 2009, the central funding (Track 1) for blood safety and injection safety will only support technical assistance. Therefore, funding for program implementation (through partners such as the National Transfusion Centers, etc.) will need to be funded from country budgets.

### PROGRAM AREA SPECIFIC INSTRUCTIONS:

#### **Blood Safety**

The general context should describe the national blood service, the network of national and regional blood banks, and key partners in blood safety. Describe the contribution that PEPFAR has made to the national program, as well as other sources of support. Note any problems in policy, infrastructure, or other barriers that limit the provision of an adequate supply of safe blood for the country.

#### **Statistics:**

- The number of units collected nationally per 1,000 population per year and the proportion collected by the national service
- The percent of voluntary, non-remunerated blood donations (as opposed to paid or family donation), and the proportion who are regular donors (donated in the previous 12 months)
- The prevalence rate of HIV among first-time and regular/repeat blood donors
- The proportion of blood donors who have their results returned to them and the process of confirming and delivering those results
- The production and use of red cell concentrates and other blood component preparations
- The number of health facilities that offer transfusion and the number that receive at least 80% of their supply from the national blood service
- The proportion of hospitals that transfuse blood that have functioning Blood Transfusion Committees
- The number of people trained in blood safety
- The cost of collecting, screening and processing a unit of blood

#### **Services:**

- Describe the approaches to increasing the pool of regular, voluntary non-remunerated blood donors.
- Describe the role of other organizations in recruiting and retaining blood donors.
- Describe the screening of blood donors and whether and how they receive results.
- Describe training needs and plans, including donor recruiting, blood collection and screening, and appropriate transfusion.
- Describe plans for management and supervision of blood banks and hemovigilance activities.
- Describe systems for data recording, program monitoring and quality assurance.

#### **Policy:**

- Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.
- Describe how the country intends to ensure rational use of blood including alternatives to transfusion when possible.

#### **Injection Safety**

The section should describe: policies, training, waste-management systems, advocacy and other activities to promote medical injection safety, including distribution/supply chain, cost and appropriate disposal of injection equipment and other related equipment and supplies.

**Please note that previously only renovation of incinerators could be supported with PEPFAR funds. Now, new construction of incinerators can now be considered but it is encouraged that every effort be made to leverage the cost with other donors.**

It is expected that for the most part funding to support the improvement of waste management would be described in this section; if though the improvement of waste management is tied to the scale-up of treatment sites, it may be appropriate to include funding for those activities in ARV Services.

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

Statistics:

- Average number of medical injections per person per year
- The number and proportion of USG supported facilities with medical/safe injection programs in place
- The percent of facilities in which syringes used for patient care (e.g., injections, preparation and administration of medications, phlebotomy) were single use and sterile (e.g., observed to come from a new, unopened package)

Services:

- Please describe the basic approaches being applied.
- Please describe how activities integrate with other HIV/AIDS services (like ARV Treatment, Counseling & Testing, TB/HIV clinics, PMTCT, etc.).
- Please comment on activities of Track 1.0 providers and the degree of collaboration with the country team.

Policy:

Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.

**Injecting and non-injecting drug users (IDU and NIDU)**

**Activities for injecting and non-injecting drug users (IDU and NIDU) (e.g.: methamphetamines users)** includes: messages/programs to reduce injecting and non-injecting drug use and programs that provide access to substance abuse and treatment (including medication assisted therapy). Programs for prevention of sexual transmission within IDUs should be included in this category. For more information on injecting drug use, please see *“The President’s Emergency Plan for AIDS Relief: HIV Prevalence Among Drug Users Guidance #1 - Injection Heroin Use.”*

Alcohol-related activities are to be included in the Sexual Transmission section. In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

Statistics:

- The demographic and epidemiological make-up of your population of persons engaged in drug abuse. Please refer to data sources (e.g. BSS, I-RARE, or other) if available.
- A size estimation, if available, of the IDU population in country and/or specific geographical areas
- Drawing on data from recent surveys, please describe other patterns of behavior in the IDU population that would put them at an additional risk of HIV infection such as transactional sex, multiple partners, lack of consistent condom use, etc.

Services:

- Please describe the basic approaches being applied and how they are building on previous years’ investments.



- Please comment on programs that provide access to substance abuse and treatment services. Please note whether Medication-Assisted Therapy is available.
- Please outline overall priorities for the IDU population for the COP 09 period, including the relative emphasis on reducing transmission through both injection and sexual prevention.” Please briefly highlight segments within the IDU population, key behaviors and geographic locales that will be targeted by USG prevention partners.
- Describe the overall IDU technical approaches to prevention that will be applied to different population segments within the IDU population and in different contexts.

Referrals and Linkages:

- Please describe the opportunities and linkages for providing health services to drug abusers, including HIV counseling and testing and STI and HIV/AIDS treatment and care.

Policy:

- Please describe any plans to address national level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.

**Male Circumcision**

Male circumcision (MC) activities include: feasibility studies and needs assessment activities; communication, training, service delivery and monitoring and evaluation. MC services must be delivered within a comprehensive package of prevention services focusing on an ABC approach, which include provider-initiated and -delivered HIV counseling and testing; active exclusion of symptomatic STIs and syndromic treatment where required; provisional promotion of correct and consistent use of condoms; and counseling on behavior change, including a gender component that addresses male norms and behaviors and sexual violence. **Currently MC is NOT recommended for men who are HIV-positive.** All male circumcision service delivery sites must include HIV counseling and testing for all patients (the USG follows the WHO MC for HIV prevention recommendations and therefore strongly encourages but does not mandate HIV testing). All MC sites should include links or referrals to HIV care and treatment for HIV-positive men. For countries that are planning MC service delivery, a letter from your Minister of Health requesting USG assistance for such work is required (please attach in supporting documents).

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

Statistics:

- The characteristics and size of the target population, including the number and percentage of men currently circumcised in the country and/or a given targeted region and the HIV prevalence in this population. Please refer to data sources (e.g. DHS or other) if available.
- The timeframe over which coverage levels will be achieved as an estimate of MC scale-up pace.

Services:

- Please indicate if your country has or will begin to offer MC services this fiscal year. If so, please describe the basic approaches being applied and how they are building on previous years' investments. Please list specific information related to providing the full package of MC for HIV prevention services, as well as post-operative follow-up (and treatment when indicated) as described above.
- Countries are required to offer HIV testing and counseling on site. Please describe this process and any information related to up-take
- Please comment on any preparatory or planning work that the country is engaging in, specifically needs assessments or policy- and advocacy-related activities.
- Please describe the communication approaches being planned/implemented nationally and locally to increase awareness of MC as HIV prevention, build demand for services, encourage healthy safe sexual behaviors and norms, and educate both men and women on the partially protective effect of the intervention and the need for life-long continued risk avoidance and reduction.
- Please describe any additional supportive services that are being included within the package, such

as programs to address male norms and behaviors.

- Please describe any actions related to addressing human resource needs, for example if there are plans for bringing in expatriate doctors or if task-shifting is being considered.
- Please describe if the country is utilizing or plans to utilize any WHO tools or resources for MC implementation (this is recommended approach so as to not duplicate effort)

Referrals and Linkages:

- Please describe the linkages with other types of services, specifically care and treatment services for men who test HIV-positive.
- Please describe how MC prevention fits within the context of the overall prevention strategy and approach for the country.
- Please describe if male circumcision activities are also being supported by other donors or funding sources (i.e. Global Fund, Gates Foundation, etc), If so, please describe coordination efforts.

Policy:

- **Has USG been formally requested by the host government to provide the proposed services or activities?**
- Please describe if your country has an active Male Circumcision Task Force and if the USG is a member.
- Please describe if your country has a National Male Circumcision Policy in place and if not, if there are plans to develop one.
- Please describe if and how the WHO/UNAIDS has assisted the country in any type of policy and or implementation activities.

Please highlight any outstanding challenges and gaps that the program is facing.

## ADULT CARE AND TREATMENT

### PROGRAM AREA DESCRIPTION:

For 2009, the program area narratives for Care and Support (formerly Palliative Care) and HIV/AIDS treatment/ARV services for adults will be integrated into a single section under the title Adult Care and Treatment. Adult Care and Treatment comprises all facility-based and home/community-based activities for HIV-infected adults and their families (HIV-affected individuals) aimed at extending and optimizing quality of life for HIV-infected individuals from the time of diagnosis throughout the continuum of illness, through provision of clinical, psychological, social, spiritual, and prevention services. Clinical services should include antiretroviral therapy, prevention and treatment of OIs (excluding TB), a preventative care package and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide treated nets, safe water interventions and related laboratory services), pain and symptom relief, and nutritional assessment and support. Psychological and spiritual support may include group and individual counseling and culturally-appropriate end-of-life care and bereavement services. Social support may include vocational training, income-generating activities, social and legal protection, and training and support of caregivers. Prevention services may include “prevention for positives,” behavioral counseling, and counseling and testing of family members. Adult Care and Treatment also includes the purchase, distribution, and management of OI drugs, excluding TB drugs. Purchase, distribution, and management of ARV drugs should be discussed in the ARV Drugs program area narrative.

For more information, please see *“HIV/AIDS Palliative Care Guidance #1 for United States Government In-Country Staff and Implementing Partners”*, and *“Guidance for United States Government In-Country*

*Staff and Implementing Partners for a Preventive Care Package for Adults.”*

**PROGRAM AREA SPECIFIC INSTRUCTIONS:**

Care and Support activities include services provided to HIV-positive individuals who are not on ART; for individuals on ART, Care and Support activities comprise services provided above and beyond those related to ART, with the exception of TB/HIV services. In this regard, please note that Prevention with Positives is included under Care and Support. We strongly encourage you to refer to the technical considerations for more information on Prevention with Positives and other critical components of Care and Support and Treatment.

Programs should describe any current or planned approaches to increase access to Care and Treatment. Such approaches might include decentralization (e.g. providing Care and Treatment in primary care clinics); providing home- or community-based services; improved referral mechanisms; training additional categories of providers, e.g. nurses, to provide basic care and treatment; providing case management services to link clients to care (e.g. for clients who face barriers to care, such as injecting drug users); or other approaches. Programs should describe how they plan to monitor and evaluate such approaches to ensure optimal quality of care.

For the narrative, in addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year. Briefly give a comprehensive picture of the context for this program area for adults in your country. Include a description of the activities and accomplishments of the host country government and other donors, linkages between USG-funded programs and the national program, and activities that leverage Global Fund support. Link proposed COP activities with the vision expressed in your country Five-Year Strategy and the accomplishments and program directions established in FY 2004-FY 2008 COPs. Address the following issues: (a) explain how the USG will reach PEPFAR treatment target for the country, (b) provide data demonstrating quality of HIV Care and Support and ARV treatment programs.

**Statistics:**

- Of adults enrolled in ART, what proportions are alive and on ART at 12 months of therapy? Explain how you have calculated these proportions.
- Of those who enrolled in ART but are not currently on ART, what proportions (a) died, (b) stopped therapy, (c) transferred, or (d) were lost to follow up at 6, 12, and 24 months? Explain how you have calculated these proportions.
- Where possible, please provide information on the number of adults accessing key services such as curative and preventive care (for example cotrimoxazole prophylaxis), palliative care (including symptom and pain assessment and management) or nutritional support.
- Estimated number of people requiring services during planning period.

**Services:**

- Please define what services are provided through Care and Support programs in your country program, including an explanation of who is counted as receiving Care and Support.
- Please describe key elements of the USG-funded Care and Support program and the basic approaches to scale-up, including:
  - the components of the program (clinical, psychological, social, spiritual, preventive),
  - the sites at which services are being provided (home-based, healthcare facility-based).
- Please describe the status of supply chain management for HIV care and treatment-related commodities.
- Please differentiate, where appropriate, services provided to specific groups (e.g. pregnant women).
- Please describe plans for establishing a minimum standard of care and program improvement through on-site supportive supervision and other efforts to improve quality.
- Please describe the strategy used to retain HIV-infected individuals who are enrolled in a care program and are not yet eligible for ART.

- Please include clearly defined prevention services targeted specifically to HIV-infected persons and their partners that are integrated into routine HIV care and treatment.
- Please outline any general efforts to involve PLWHA in providing palliative care services and any general efforts to provide support for caregivers.
- Please describe how the activities relate to the network model for provision of HIV care and support in your country and plans to strengthen these linkages. In particular, please note approaches to incorporate and/or refer to treatment, prevention, OVC and other needed social services.
- Where applicable, please use the program and activity narratives to describe plans for the coordination with other health programs (e.g.: PMI, TB, safe motherhood and child survival programs).

#### Policy

- Describe policy barriers that need to be overcome to ensure success of the care and treatment program in the future (e.g., national cotrimoxazole policy, drug regulatory processes - for new antiretroviral formulations, pain medications, etc.).
- Please highlight any other outstanding challenges and gaps that the program is facing.

All USG teams are strongly encouraged to use the Partnership for Supply Chain Management (SCMS) for commodity procurement, including ARVs, pain medications, OI drugs and rapid test kits. Please see the program area description in ARV Drug for details.

**Cervical Cancer Screening** – Please see Appendix 18 for more information on Cervical Cancer.

## PEDIATRIC CARE AND TREATMENT

### PROGRAM AREA DESCRIPTION:

For 2009, there will be a separate program area narrative for Pediatric Care and Treatment, incorporating Pediatric Care and Support (previously included within Palliative Care) and Pediatric Treatment (previously included within Treatment/ARV Services). Pediatric care and treatment comprises all health facility-based activities for HIV exposed and HIV-infected children (<2 years and 2-14 years) and their families (HIV-affected individuals) aimed at extending and optimizing quality of life for HIV-infected children from the time of diagnosis throughout the continuum of illness, through provision of clinical, psychological, social, spiritual and prevention services.

Clinical services should include early infant diagnosis, appropriate counseling and testing for at-risk children and adolescents, antiretroviral therapy, prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria and diarrhea (providing access to commodities such as pharmaceuticals, insecticide treated nets, safe water interventions and related laboratory services), pain and symptom relief, and nutritional assessment and support. A key component of clinical services is provision of the Preventive Care Package for children, described in separate guidance (see below). Other services – psychological, social, spiritual and prevention services – should be provided as appropriate. These services are provided within programs for orphans and vulnerable children (OVC) and clinic based partners should make linkages to OVC services and service providers to ensure the continuum of care for these children. Country teams should plan for M&E and program evaluation activities specific to the pediatric program (i.e.: HIVQUAL).

Pediatric Care and Treatment also includes the purchase, distribution, and management of OI drugs, excluding TB drugs. Purchase, distribution, and management of ARV drugs should be discussed in the ARV Drugs program area narrative

For more information, please see: *"Guidance for United States Government In-Country Staff and Implementing Partners, for a Preventive Care Package for Children Aged 0-14 Years Old Born to HIV-*

*positive Mothers.”*

**PROGRAM AREA SPECIFIC INSTRUCTIONS:**

In many PEPFAR countries, the proportion of HIV-exposed and HIV-positive children enrolled in care and treatment is extremely low, due to the challenges of identifying infants and children with HIV, significant barriers to enrolling infants and children in care and treatment, and the additional challenge of training a workforce to provide quality pediatric care. Of particular note, recent data show improved survival among HIV-positive infants offered early infant diagnosis and treatment. Thus countries are encouraged to increase programming in this area, ensuring appropriate linkages between PMTCT services and pediatric care and treatment, planning rapid scale-up of early infant diagnosis using dry-blood spot/DNA PCR testing, providing training to develop a workforce capable of providing quality pediatric care, and ensuring access to care and treatment for infected infants and children.

For the narrative, briefly describe the overall strategy for Pediatric HIV Care and Treatment and how PEPFAR is supporting activities to meet these goals and targets. In addition, describe activities and accomplishments of the host country government and other donors, linkages between USG-funded programs and the national program, and activities that leverage Global Fund support. In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

**Statistics:**

- If available: National estimates of the burden and prevalence of pediatric HIV infection, including any relevant urban-rural or regional differences.
- The number and proportion of clinical sites providing pediatric HIV 1) care services and 2) antiretroviral therapy at different levels (i.e. primary health centers, district hospitals) at the beginning of the reporting period and projected for the end of the reporting period. Please also comment on the geographic distribution of these sites – i.e. is care available in all areas with a significant burden of pediatric infection?
- Number of children (<2 years and 2-14 years) 1) tested for HIV, 2) receiving HIV care, and 3) receiving antiretroviral therapy, at the beginning of the reporting period and projected for the end of the reporting period.
- Proportion of HIV-infected children receiving antiretroviral treatment relative to the estimated total number of children needing ART (note other key international partners' contributions).
- Of those children who enrolled in ART but are not currently on ART, what proportions (a) died, (b) stopped therapy, (c) transferred, or (d) were lost to follow up at 6, 12, and 24 months? Explain how you have calculated these proportions.

**Services:**

- Describe the entry points that are used to identify HIV-exposed and infected children (e.g. PMTCT, maternal and child health clinics, other out-patient settings and in-patient settings). Describe approaches the USG will put into place to increase access to HIV testing for infants and children (including early infant diagnosis) and care and treatment services for this population.
- Describe availability of the basic preventive care package - the services which should be provided to all HIV-exposed infants in the first years of life, including infant feeding counseling, other nutritional support, cotrimoxazole prophylaxis, access to infant diagnosis, malaria interventions, safe water interventions, and strengthening of linkages to routine child health services. Describe plans to increase access to the preventive care package.
- Describe National and USG plans for expanding ARV treatment for infants based on evidence suggesting the need for early diagnosis and treatment of HIV-infected infants.
- The number and proportion of vulnerable HIV-exposed infants who will receive essential follow-up interventions, including nutritional support, infant diagnosis, cotrimoxazole prophylaxis, and other elements of the basic preventive care package for children.
- The approach to supporting infant feeding, including providing nutritional counseling, support for exclusive feeding modality, growth monitoring, nutritional supplementation, and support for

complementary feeding and safe early weaning where applicable.

- The number and proportion of HIV-exposed infants receiving a basic package of postnatal care interventions, as described under services above. (Recommend at least 80% of HIV-exposed children). Provision of care to these highly vulnerable children should be counted under pediatric care. Programs should however ensure the long-term care of these children and link them into OVC programs as appropriate. Please describe any established linkages to OVC programs.

Referrals and Linkages:

- Describe specific plans to strengthen linkages of pediatric care and treatment and integration with routine PMTCT services, routine child health services, including immunizations and other primary care activities, and malaria prevention and other relevant services.

Policy:

- Discuss plans to address national level policy barriers, supply chain management, training, monitoring and evaluation, management and supervision, and human resources, as well as other systems strengthening activities. Please include specific plans for integration and coordination of pediatric care and treatment with PMTCT and adult care and treatment systems in these areas.
- Please use the program narratives to describe plans for the coordination of PMI and PEPFAR resources in pediatric care and treatment programs.

Please highlight any other outstanding challenges or gaps that the program is facing.

## TB/HIV

### PROGRAM AREA DESCRIPTION:

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

If TB programs expand to provide clients with ART, such services would fall under ARV Drugs and Adult Treatment. Counseling and testing of TB facility clients including the purchase of HIV test kits should be included under TB/HIV program area. Lab support intended to strengthen TB diagnosis and management should also be included under TB/HIV.

PEPFAR TB/HIV program activities should address the following: HIV testing and counseling of TB clients and referral and/or management of HIV-positive patients; HIV prevention and clinical care (including ARV and cotrimoxazole prophylaxis); TB screening of people living with HIV/AIDS; Referral mechanisms for and/or provision of TB treatment (using DOTS management strategy) for HIV-infected persons diagnosed with TB; Relevant laboratory and diagnostic service capacity; Infection control activities to prevent TB transmission in HIV care facilities; Isoniazid preventive therapy (for HIV-positive persons in whom active TB has been ruled out) in HIV clinical care settings; Where appropriate, working with host governments and its partners, such as Global Fund, to conduct surveillance for and manage drug resistant TB.

### PROGRAM AREA SPECIFIC INSTRUCTIONS:

In addition to the general program area context information, please describe the following if available, highlighting plans for support in the upcoming year.

Statistics:

- Key TB control statistics (e.g., cases per 100,000 population, reported national cases per year, new

smear positive case detection and treatment success, DOTS coverage).

- The prevalence of HIV in TB patients.
- The number/percentage of TB patients tested for HIV.
- The number/percentage of TB patients on cotrimoxazole; number/percentage referred and on ART.
- Estimate of percentage of TB patients with multi-drug resistant TB (MDR-TB)

Services:

- Provide a general description of USG support to TB/HIV activities, building on previous years' successes, and explain how they contribute to achieving the goals stated above.
- Explain how program activities strengthen TB diagnostic capabilities for persons living with HIV/AIDS (e.g., smear microscopy services, external quality assurance, support for national reference laboratories, culture capability, drug resistance testing).
- Describe how program activities support HIV testing and counseling (both cases and suspects) in TB clinical settings.
- Describe how program activities address the recording/reporting of patients with TB disease and HIV-infection, including referral to HIV care and treatment.
- Describe TB/HIV related services provided to pediatric patients.
- Discuss how HIV patients in care are screened for TB and referred for diagnosis and treatment. How are services to increase TB casefinding linked to provision of isoniazid preventive therapy for PLWHA without active TB disease?
- Describe PEPFAR efforts to improve TB infection control in settings providing care to PLWHA.

Referrals and Linkages:

- Describe integration of TB and HIV programs in the country. Discuss how patients are referred between programs and the systems to ensure that patients receive adequate care and treatment.

Monitoring and Evaluation:

- Describe the systems for monitoring and evaluating TB/HIV activities including on-site supervision.

Policy:

- Describe the extent to which TB is a part of the national HIV strategic plan and note any national policies or legislation that address TB/HIV.
- Please describe any plans to address national level policy barriers, training, management and supervision as well as other system strengthening.
- Describe policies and plans to address TB infection control issues to prevent TB transmission in HIV care settings.

Please highlight any other outstanding challenges and gaps that the program is facing.

Where applicable, all USG teams are encouraged to use the Partnership for Supply Chain Management (SCMS) for commodities, including rapid test kits.

Please also describe how other USG or other donor TB resources contribute to accelerating TB/HIV collaborative activities, particularly in relation to National TB and HIV/AIDS program strategic plans. Specifically, country teams should describe how PEPFAR resources will leverage ongoing or planned non-PEPFAR USAID funding for TB and/or HIV/TB activities. To maximize USG resources and avoid duplication, we encourage USG teams to develop a USG-wide strategic plan in the area of HIV/TB and TB funding. There are a number of approaches to accomplishing this joint planning objective (e.g., joint visits by USAID bilateral TB TA and PEPFAR TB/HIV TA, interagency technical working groups, annual one-day planning retreats, interagency portfolio reviews, etc.) and TA is available to facilitate the process. We are hoping that these efforts to link all USG support to TB in a cohesive country strategy will also be reflected in the F/OP. While in future years, we would like to better integrate these processes, please note that for this year, we will be working with F to participate in the F/OP review for TB and hope to ensure that during the review, both PEPFAR and USAID resources and assistance will be



considered.

## ORPHANS AND VULNERABLE CHILDREN

### PROGRAM AREA DESCRIPTION:

Orphans and Vulnerable Children – activities are aimed at improving the lives of orphans and other vulnerable children (OVC) affected by HIV/AIDS, and doing so in a measurable way. Services to children (0-17 years) should be based on the actual needs of the child and could include ensuring access to basic education (from early childhood development through secondary level), health care services, targeted food and nutrition support, protection and legal aid, economic strengthening, training of caregivers in HIV prevention and home-based care, etc. Household-centered approaches that link OVC services with HIV-affected families (linkages with PMTCT, pediatric care and treatment, adult care and treatment, etc.) and strengthen the capacity of the family unit (caregiver) are included along with strengthening community structures which protect and promote healthy child development (schools, churches, clinics, child protection committees, etc.) and investments in local and national government capacity to identify, monitor and track children's well-being. Programs may be included which strengthen the transition from residential OVC care to more family-centered models. (See the OVC Technical Considerations and OVC Guidance for further details.) Programs that provide health facility-based care for HIV-positive children should be included in the pediatric care and treatment narrative.

### PROGRAM AREA SPECIFIC INSTRUCTIONS:

As part of the information which provides general program area context, please describe the following, if available. (Suggestions for activity-level descriptions are found in OVC Technical Considerations.)

#### Statistics:

- Estimates of the number of children orphaned as a result of HIV/AIDS, and number orphaned from other causes, such as armed conflict, famine, etc.
- Estimates of the number of other vulnerable children due to HIV/AIDS in your country.
- The estimated total number of OVCs due to HIV/AIDS in your country who need assistance during this planning period.

#### Services:

- Prior year services:
  - Describe the services which are provided through your OVC care programs.
  - Highlight your major program accomplishments from last year.
  - Which program models were your greatest successes?
  - What particularly successful program models do you intend to scale-up this year?
  - Please highlight outstanding challenges and gaps this program area is facing.
  - Describe how your activities further your country's National Plan of Action for OVCs due to HIV/AIDS, fit in your PEPFAR five-year strategy, and align with the PEPFAR OVC Guidance.
  - Please describe the role of the USG, relative to other key international partners in the sector (e.g., UNICEF, GFATM, and other key donors).
  - Review your overall strategy for reaching OVC, and cite any changes needed in that strategy for the coming year.
- Emphasis areas for 2009: The OVC TWG has 6 key foci for the coming year. Describe how your program will address each (See OVC Technical Considerations for more details):
  - **Focus on scale-up:** Increase the coverage of OVC programs to respond to the



enormous need of HIV/AIDS-affected children, their households and communities. Include the leverage of local and national public-private partnerships. Implement strategies or effective models for providing high-quality services to the greatest number of OVCs.

- **Improve quality:** Strengthen the consistency and effectiveness of services provided to OVC and caregivers. Establish efficient and effective service delivery methods to reach the most vulnerable OVCs and caregivers.
- **Coordinate Care:** Provide comprehensive OVC care that networks with and leverages resources (human, material, financial) across the spectrum of service areas - including education, child survival, water and sanitation, economic growth, agriculture, etc.
- **Reach especially vulnerable children:** Ensure that the broader OVC strategy reflects a developmental, life-cycle approach spanning the range from under-5s to older adolescents. Ensure that marginalized OVC subgroups (e.g., vulnerable girls, disabled children, those outside family care, etc.) are well integrated into the national OVC plan. Consider the country's contextual factors which may cause some children to be even more disadvantaged than other OVC (e.g., orphans forced into early marriage, exploitive labor, etc.)
- **Strengthen Capacity:** Strengthen the local and national structures to provide a long-term response to reaching the most vulnerable OVC with quality, comprehensive services.
- **Build knowledge:** Enhance strategic decision-making for OVC programming through improved data collection and use, building on lessons learned/emerging best practice, and south-to-south exchanges. Support related training and capacity building at all levels, from volunteers to professional education (e.g., curriculum of teachers, social workers etc.)

#### Referrals and Linkages:

All health programs working with HIV infected families (e.g. PMTCT, pediatric care and treatment, adult care and treatment, etc.) should establish linkages with OVC programs to ensure that the children's needs in these homes are being addressed comprehensively. OVC programs should also initiate these linkages, including counseling and testing and referral for appropriate HIV-related care if necessary.

#### Policy:

- Describe your plans to address national-level policy or legal barriers to caring for OVC.
- Describe your plans to work with specific national institutions and ministries in order to address issues related to system strengthening – e.g., training, monitoring and evaluation, management and supervision, etc.

Where applicable, please use program and activity narratives to describe your plans for coordinating PMI and PEPFAR resources in OVC programs.

## COUNSELING AND TESTING

### PROGRAM AREA DESCRIPTION:

Counseling and testing – includes activities in which both HIV counseling and testing are provided for those who seek to know their HIV status (as in traditional VCT) or where knowledge of their status would enable access to care and support. Funding for counseling and testing in the context of preventing mother-to-child transmission can be included under PMTCT or Counseling and Testing; targets should be included in PMTCT.

### PROGRAM AREA SPECIFIC INSTRUCTIONS:

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

**Statistics:**

- Please identify the targets for persons to be reached with CT and how this will contribute to both the national treatment and prevention goals. Please explain direct and indirect (downstream and upstream) targets.
- Please estimate the overall number of people accessing testing (with funding from USG and all other sources) and what percentage of the adult population this represents.
- Please indicate what proportion of them are accessing CT services in health settings versus community settings (such as standalone, outreach and mobile services).
- Please describe geographic coverage of counseling and testing services.

**Services:**

- Please comment, as appropriate, on how your programs are:
  - Creating a variety of CT approaches to give clients different options to learn their status;
  - Increasing access to CT in clinical settings (including male circumcision service delivery programs);
  - Increasing recruitment of, and access for, couples and families to CT services, with an emphasis on reaching discordant couples; and
  - Ensuring that CT programs have solid linkages to care, treatment, and other services.
- Please describe training programs for counselors and other health care workers providing counseling and testing.
- Please describe promotion programs to increase utilization of counseling and testing.
- Please describe CT services for children and adolescents.
- Please describe how HIV test kits will be procured and the supply chain management.

**Referrals and Linkages:**

- Discuss specific plans for linking HIV-infected persons to treatment, care, and other support services as well as providing methods for prevention for all CT clients with a specific focus on discordant couples.

**Policy:**

- Please describe any key policy barriers to scaling up or implementing CT and efforts to strengthen the policy environment.
- Discuss methods for maintaining a standard registry or recording system and for routinely reporting HIV testing information from clinical and community sites.
- Please describe any plans to address national-level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.

Please highlight any other outstanding challenges and gaps that the program is facing.

## ARV DRUGS

**PROGRAM AREA DESCRIPTION:**

HIV/AIDS treatment/ARV drugs– including distribution/supply chain/logistics, pharmaceutical management and cost of ARV drugs. All antiretroviral Post-Exposure Prophylaxis procurement for rape victims should be included within this program area. Purchase, distribution, and management of OI drugs, excluding TB drugs, should be included in the Adult Care and Treatment or Pediatric Care and Treatment narratives.

**PROGRAM AREA SPECIFIC INSTRUCTIONS:**

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

All USG teams are strongly encouraged to use the Partnership for Supply Chain Management (SCMS) for ARV and other commodity procurement when local systems are not functional. By leveraging the economies of scale created by USG pooled procurement, SCMS is currently at or below the lowest reported price for all ARVs, generic or innovator. A large part of the SCMS mandate is assisting and strengthening national systems, which includes working to help them access lower prices. SCMS can provide the full scope of supply chain management services, including overall management, procurement (including drug forecasting), freight and freight forwarding, quality assurance, information systems management, and in-country technical assistance and support. SCMS can assist countries with COP FY 2009 planning and assist with the development of a detailed national and/or USG procurement plan.

In the program narrative, USG teams should discuss the specific ARV regimes and drugs they expect to procure in the coming year and how the supply chain and procurement plan will be managed by the USG country team and its partners. Additionally, specific information regarding progress in the registration and importation of FDA-approved/tentatively-approved generics should also be included. Please note what percentage of USG-purchased ARVs were generic vs. innovator for FY 2008. The narrative should also briefly include the overall country context regarding ARV procurement and the roles of other stakeholders such as the Global Fund. When applicable, the narrative should discuss USG support and/or engagement in the national ARV planning and procurement process.

Regardless of the partners involved (e.g. SCMS, Crown Agents, Track 1.0, etc.), the narrative should include a description of USG's management and/or support for the steps of the procurement cycle. These steps include:

- Product Selection: quality assurance and national treatment guidelines considerations, appropriate packaging and cold chain requirements, coordination with other donor agencies;
- Forecasting/Quantification: educated estimates on future ARV needs, national forecasts with USG and any other donor funding ARV procurement, scale-up and pediatric considerations;
- Procurement: include estimated amount of funding for ARV procurement and number of current USG-supported patients on treatment and expected scale-up needs;
- Freight/forwarding and Importation: freight forwarding, importation challenges if any, average amount of time shipments spend in port, etc.;
- In-country warehousing and distribution: describe warehousing and distribution systems including cold chain and security needs and how they are addressed, and explain USG-supported distribution; i.e. to central warehouse or to sites, use of public sector warehousing and distribution systems;
- Logistics Management Information System: tracking, inventory management at warehouses and treatment sites, monitoring and evaluation.
- Capacity Building: strengthening local supply chain capacity, including training in logistics, warehouse/inventory management, forecasting

**LABORATORY INFRASTRUCTURE****PROGRAM AREA DESCRIPTION:**

Laboratory infrastructure – development and strengthening of laboratory 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 counseling and testing or PMTCT. Laboratory services supporting palliative care should go under adult care and support. Laboratory services supporting treatment should be included under adult treatment.

#### **PROGRAM AREA SPECIFIC INSTRUCTIONS**

In addition to the general program area context information, please describe the following if the information is available, highlighting plans for support in the upcoming year.

##### **Statistics:**

- Number of USG-supported labs at the levels of the network model
  - Reference level
  - Referral level
  - Health center level

##### **Services:**

- Please describe the tiered public health laboratory services structure(s) available in your country.
- Identify laboratory-specific unmet needs and policy or administrative issues that impede full implementation of laboratory programs.

##### **Referrals and Linkages:**

- Identify links to USG implementing partners and other major international donors/partnerships.

##### **Policy:**

- Discuss whether there is a national public-health laboratory strategic plan
- Indicate how these services link to your strategic planning for USG-supported laboratory activities.
- Also define the priorities of USG-supported laboratory services and their relevance to your country's 5-year plan. All programs are encouraged to use the Partnership For Supply Chain Management (SCMS) as the prime partner for purchase of laboratory commodities.
- Please describe any plans to address national-level policy barriers, training, monitoring and evaluation, management and supervision as well as other system strengthening.
- Where applicable, please use the program and activity narratives to describe plans for the coordination of PMI and PEPFAR resources in laboratory infrastructure programs.

## **STRATEGIC INFORMATION**

#### **PROGRAM AREA DESCRIPTION:**

Strategic information – Strategic Information is the cornerstone of evidence based planning and decision making for PEPFAR. The USG and its partners are committed to demonstrating progress toward the PEPFAR goals through continued support of the development and implementation of program area-specific information systems and routine monitoring and evaluation activities. Strategic Information activities include: HIV/AIDS behavioral and biological surveillance, facility surveys, monitoring partner results, reporting results, supporting health information systems, assisting countries and implementing partners to establish and/or strengthen such systems, and related analyses and data dissemination activities fall under strategic information.

#### **PROGRAM AREA SPECIFIC INSTRUCTIONS**

Sustained engagement in support of country surveillance, HMIS and M&E systems is a priority for 2009, including capacity building to ensure a well functioning national workforce in this area. To be successful

there must be adequate SI technical staffing coordinated by one SI liaison within the USG country team and a systematic process in place for supporting the USG country team and partner level information needs.

Please describe the three major strategic information challenges that you see in FY 2009 and briefly summarize your status on the following points:

Functioning of Strategic Information Team within the Country Team:

- Please provide a description of your strategic information team including the SI Liaison and coverage of HMIS, M&E, and surveillance functions.
- How does the SI team routinely provide results and surveillance information to the USG country team including any technical workgroups to inform decision making?
- How does the SI team assist the USG team with COP target setting and other COP requirements?

Overarching SI System:

- Has the government developed a strategy for the long-term development of a trained workforce in all areas of strategic information? If so, in which areas?
- Does the USG team have a strategy for turning over SI functions to either the government or local partner organizations?
- What mechanism exists at a national (or regional) level to coordinate SI functions and activities between the various stakeholders (government, NGOs, donors)? What process is used to coordinate and harmonize planning and reporting information?

Surveillance and Surveys:

- Please describe the status of any DHS, AIS or other population surveys being planned or in the field and the specific bio-markers included in them.
- Are ANC surveillance or other sentinel HIV sero-surveillance activities planned or in the field (e.g., TB clinics, STD clinics)?
- Please describe any behavioral surveys among most-at-risk populations and include any biologic specimen testing planned and which populations.
- Are any special lab-based surveillance activities planned such HIV drug resistance threshold surveys or recent infection assays (BED, Avidity)? If yes, in which populations?
- Are there plans to introduce HIV case reporting systems according to the new WHO guidelines?
- Are you supporting facility surveys (like SPA or SAM) and/or any mapping efforts?
- How is mapping of the epidemic with service coverage used in planning?
- If applicable, are you participating in the Health Impact Study sponsored by The Global Fund and PEPFAR?
- Has any surveillance related training been conducted in the past year and/or is any planned for the coming year?
- Have any of the surveillance systems at the national or regional level been formally evaluated in the past 3 years? Which and when?
- Have any surveillance reports been issued this past year or anticipated in the coming year?

Health Management Information Systems

- Is there an agreed upon government strategy for building a harmonized, interoperable health information system for HIV/AIDS which is either linked to or fully integrated into the broader national health information?
- What is the current status of a national information system for program reporting for (1) clinical

- services, (2) community services such as OVC?
- Does the USG have a long-term strategy for investing in one national reporting system? What do you expect to be accomplished within the next two years?
  - What is the information system that is being used to store USG partner results and portfolio review information.
  - Please describe how each USG funded PEPFAR partner information system relates or is linked to a national monitoring system. If the USG is funding partner client monitoring information systems that are not feeding information into a national system, please justify.

#### Monitoring and Evaluation

- What is your data quality improvement strategy both at the partner and national levels?
- How does your USG team evaluate partner performance, including evaluating partner results against targets?
- Please describe how you have used any monitoring and/or evaluation information for quality improvement of partner interventions in coordination with program staff?
- Do you have a dissemination strategy for sharing program evaluation and assessment results among partners?

## HEALTH SYSTEMS STRENGTHENING

### PROGRAM AREA DESCRIPTION:

Health systems strengthening– Health systems strengthening is an important foundation for ensuring sustainability of services and other interventions. Activities to include broad policy reform efforts and system-wide approaches, for example national procurement and logistics systems. Other policy support such as stigma reduction or widows/orphan protection should be included in this area. Broad support to construction and renovation can be included, however, it could also be incorporated although it can be included in specific program areas. Building organizations' capacity to do financial and program management are also key activities to include in this area.

### PROGRAM AREA SPECIFIC INSTRUCTIONS

Please provide a description of the general approach you are undertaking to strengthen health care systems to benefit HIV/AIDS programs and your approach to sustainability. Some of the activities and funding to support systems strengthening may be described and accounted for under specific program areas. This section, however, is intended to provide information about the overarching approach, including efforts to build on previous years' successes. Please describe how you are:

- Strengthening the capacity of host country government institutions to plan, manage, and implement HIV programs, including national procurement and logistics systems.
- Strengthening local partner organizations, particularly in management, leadership and policy development.
- Strengthening leadership and the policy environment to reduce stigma and discrimination, including addressing key gender issues.
- Strengthening leadership and policy environment to expand access to HIV care and treatment services for children. Document any positive outcomes from previous years' investments in this area (e.g., new policy or guidelines, new legislation, etc.)
- Strengthening the GFATM management structure and improving donor coordination.
- Support for construction and renovation.

Please highlight any other outstanding challenges and gaps that the program is facing.

Please note that it is critical that each activity describe a specific benchmark or outcome that will be achieved with the resources during the funding period, for example “law drafted”; “HCD assessment completed with recommendations included in MOH budget request to Ministry of Finance”; etc. This information should be included at the end of the program area summary

## Table 3.3      Activities

Each COP activity contains the following details:

- Funding Mechanism name
- Planned Funds
- New / Continuing Activity
- Activity Narrative
- Secondary Cross-cutting Budget Attributions
- Emphasis Areas

Please complete one entry for each Funding Mechanism/Prime Partner that will undertake activities in FY 2009 for the given program area.

In general, each unique funding mechanism outlined in Table 3.1 should have only one entry in each program budget code. However, if a specific funding mechanism/prime partner will undertake several activities in a given program budget code and you feel very strongly that these activities are sufficiently distinct that a single narrative would not provide an adequate description, you may put them into separate entries. Comprehensive programs may need to be broken up across several program budget codes. For more information, please see page 69.

Ongoing activities for which no additional FY 2009 funds are requested: In a few cases, there are partners/activities with a large pipeline or delayed implementation, which means they will not receive new FY 2009 monies, but will still be implementing activities. Please describe activities that will continue from FY 2008 to FY 2009 in the Activity Narrative, and designate the planned funding amount as \$0. **Do not update targets**, as there is no new funding to link to the targets. These activities will not be reviewed for approval during the COP review process. In most cases minimal time should be spent on ongoing activities, even those receiving FY 2009 funding, and their review will be equally brief.

### INSTRUCTIONS FOR ADDING CENTRALLY FUNDED ACTIVITIES:

#### CONTENT:

In FY 2009, country teams will enter all centrally funded activities in the COP to ensure a holistic presentation of the country program.

This section includes information on:

- Public Health Evaluation
- Public Private Partnerships
- Track One Activities
- New Partners Initiative

<b>Public Health Evaluation (PHE)</b>
---------------------------------------

Starting in FY 2009, PHE studies will no longer be funded out of country budgets. Starting in FY 2009, both new and continuing PHEs will be funded centrally and awards will be based on the merit of submitted proposals. The monies to support PHEs are additive to FY2009 country allocations. For focus country programs, awards for PHE activities will be subject to a per-country cap equivalent to 1.5% of country program budgets; countries may apply for a waiver. **Country program funds cannot be utilized to fund new or ongoing PHEs in FY 2009.** Similarly, implementing partners are not permitted to use program monies to conduct PHEs or other research activities.

Emphasis will be placed on addressing strategic priority questions of global significance that can inform and improve PEPFAR programming broadly, that PEPFAR is uniquely poised to address, that are of sufficient scale and scientific rigor, that can be addressed in a timely and efficient manner, and that take advantage of central coordination and support where appropriate. While we expect that questions will fall into the category of global significance, there may be some exceptions. Therefore, it is recognized that there is a need to allocate some funding to country-specific priority questions that respond to requests of host governments or address locally specific implementation challenges.

- *PHEs of global significance* are those studies that can inform and change how PEPFAR delivers programs globally and that PEPFAR is uniquely poised to address. The majority of funds will be allocated to these projects, which should be of sufficient scale and scientific rigor and reflect the diversity of PEPFAR programs and populations served, in order that the findings might be globally relevant. Where appropriate, these studies will be conducted across countries. The process will be competitive. Emphasis will be given to projects that address identified PEPFAR strategic priority questions, build capacity locally and across countries, and are implemented in settings that reflect PEPFAR's diversity. All country programs, regardless of PEPFAR funding levels, can propose and participate in these competitive PHEs of global significance.
- *Country-priority* PHEs are those studies that respond to specific requests of the host government, address specific local implementation challenges, and provide capacity-building opportunities for local researchers and local partner organizations, but do not necessarily rise to the potential of global significance. As with PHEs of global significance, country-priority PHE activities may only be approved if judged of sufficient scientific and technical merit.
  - Renewal funding for country-priority PHE activities, including those originally funded in FY 2008 or earlier, will potentially limit the ability of programs with significant out-year commitments from undertaking new country-priority PHEs.

### **PHE Application, Review and Approval Process**

Review and approval of new PHE activities will be based on scoring of technical merit, geographic diversity, country capacity, and record of progress and completion of previously funded PHE studies.



The timeline for submission and review of proposed PHE studies will be earlier for FY 2009, in order that the PHE process might be completed prior to COP submission. Progress reports for previously approved PHE activities continuing into FY 2009 are due on August 7<sup>th</sup>. The deadline for submission of new PHE concept papers to OGAC is August 15<sup>th</sup>. Final review and approval status will be reported back to country teams on October 15<sup>th</sup> for inclusion in their final COP.

Guidance on how to capture PHE in the new program area and secondary cross-cutting budget attributions is available on page 111.

Further details on the timeline, PHE submission requirements and the review process are detailed in Appendix 23. Additional details and templates are posted on the PHE page of the PEPFAR extranet.

## PUBLIC-PRIVATE PARTNERSHIPS

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

Leveraging significant resources may include financial resources, in-kind contributions and intellectual property. All in-kind contributions must be quantified. Significant resources are considered **greater than or equal to** a dollar for dollar or 1:1 match of partner(s) to PEPFAR resources. To meet the definition of a PPP, a minimum of 25% of the matching resources from partners external to PEPFAR must come from the private sector. The other 75% may be composed of other USG contributions (e.g., from the President's Malaria Initiative), multilateral donors (e.g., UNICEF), or other public resources (e.g., bilateral contributions from foreign governments).

Private-sector partners include a wide range of organizations such as: foundations, U.S. and non-U.S. private businesses, business and trade associations, unions, and high net worth individuals, venture capitalists, and social entrepreneurs. Non-governmental organizations and private voluntary organizations may play a role in implementing partnerships established between PEPFAR and private sector entities; however, they are *not* considered to be to be prime partners under a PPP arrangement.

In order to help countries better understand PPPs, there are a few types of programs that should **not** be included: workplace programs; interventions that engage or involve the private sector (e.g., private providers) without a specific, quantifiable contribution from that sector; traditional social marketing programs; and partnerships with less than a 1:1 leveraging of resources.

In order to reduce burden of COP development, we will not capture PPPs at the activity level. Instead, information will be captured in one place through an Excel spreadsheet and uploaded as a Supporting Document. Further information can be found in Appendix 26.

#### **TRACK 1.0 AWARDS**

Track 1: HQ will send a table to the field in late June providing each country's planned central funding for the five Track 1.0 program areas (i.e., AB, ART, Blood Safety, Injection Safety, and OVC). Table 3.3 will also identify the relevant implementing partner, mechanism, and USG agency and bureau/operating division for each Track 1.0 activity.

#### **TRACK 1.0 CENTRAL FUNDING FOR ANTIRETROVIRAL TREATMENT**

In FY 2009, central funding for Track 1.0 ART grantees will be straight-lined at FY 2008 central funding levels, not including any field funding transferred to Track 1.0 grantees in FY 2008.

FY 2009 country budgets must cover:

- The continuing treatment costs of anyone already on treatment using Track 1.0 resources that exceed those costs that can be covered by central Track 1.0 funding.
- The full cost of any expansion of treatment using Track 1.0 grantees.

#### **TRACK 1.0 CENTRAL FUNDING FOR OVC AND ABY**

It is HQ's intention to extend Track 1.0 OVC and ABY agreements to June 2010, to ensure adequate time to plan and implement an effective transition that minimizes the disruption in services being provided to program beneficiaries. This year country teams should include in the Track 1.0 OVC and ABY activity narratives a brief description of the transition plans and budget levels required to ensure continuity of services to the current OVC and ABY beneficiaries once the current Track 1.0 agreements end. (Examples may include a reference to a planned APS covering relevant program areas, plans for current or other bilateral partners to assume the Track 1.0 activities/beneficiaries, how project has built sustainability, etc.)

#### **TRACK 1.0 CENTRAL FUNDING FOR BLOOD SAFETY AND INJECTION SAFETY**

Additional information regarding the central funding (Track 1) for blood safety and injection safety will be included in a separate communication to country teams.

#### **NEW PARTNERS INITIATIVE**

The New Partners Initiative (NPI) began funding partners centrally in December 2006. In Round 1, NPI funded 22 partners to implement activities in 13 focus countries. These cooperative agreements are scheduled to end in December 2009. The FY 2008 COPs included the NPI partners' activities and targets; however, they were entered as \$0 as the funds were provided from prior year budgets. Prior year central funds have also funded Round 2 and Round 3. As a result, the same guidance still applies. Planned funding amounts for all NPI partners will be entered as \$0. The remainder of the activity level entry should be completed, including narratives and emphasis areas.

Country teams should set activity level targets for the NPI activities based on what the partner will achieve by September 30, 2010. These targets should be incorporated into the summary targets for the program area, as well as in Table 2. Round 1 partners have different considerations. Their funding is secured for only the first quarter of FY 2009; therefore, country teams should set activity level targets for the NPI activities based on what the partner will achieve by December 30, 2009. These targets should be incorporated into the summary targets for the program area, as well as in Table 2.

As the Round 1 NPI partner agreements will be ending in November 2009, it is important to consider the implications of the ends of these agreements and make decisions on the activities these partners are implementing. No decisions regarding future funding of these partners have been made, but it is important for the Missions and the administering agencies and offices (USAID and HRSA) to begin a dialogue about the future of the Round 1 partners so that decisions can be systematically and thoughtfully made before FY 2009 COPs are submitted. Once the COPs are submitted the options will become more limited.

#### **FUNDING MECHANISM:**

##### **CONTENT:**

This section has a drop down list of all the funding mechanisms that you entered in table 3.1. The drop down list is organized alphabetically by USG Agency, then by prime partner, then by funding mechanism name, then by funding source. To populate any of the tables in 3.3, you must first select the mechanism implementing the activity from this list. If the name does not appear on the list, you must return to Table 3.1 and add the mechanism.

You will not provide information by sub-partner in this table.

##### **DATA ENTRY:**

This field is a drop down menu with all the funding mechanisms that you entered in table 3.1. You must select only one option.

#### **PLANNED FUNDS:**

##### **CONTENT:**

Enter the amount of FY 2009 funding planned for this activity, rounded to the nearest dollar. The summary budget code total is generated automatically from this information, so rounding to anything above the nearest dollar would result in an inaccurate summary budget table.

For ongoing activities that do NOT require new FY 2009 funding, please enter \$0 for the planned funding.

##### **DATA ENTRY:**

Please enter the FY 2009 planned funding (in whole U.S. dollars) directly into the cell. You do not need to enter dollars signs or commas.

### NEW/CONTINUING ACTIVITY:

#### CONTENT:

For the purposes of the COP, a continuing activity is any activity continued from the previous year. If the program is expanding to reach more people, adding a new province, etc., the activity is continuing. However, the activity is new if the partner is taking on a totally new role in a new program area. For example in the past, a partner worked with orphans and vulnerable children, but is going to start providing care services to adult PLWHA, the activity in the Palliative Care program area should be marked new. In addition, if an umbrella is changing to conduct technical assistance in addition to its role as an umbrella, it would be new. If you have any questions about whether an activity is new or continuing, please contact your Core Team Leader.

All activities need to be selected as either a new activity or a continuing activity. If an activity is imported from the FY 2008 COP, it will select automatically as a continuing activity. If an activity is entered using the "Add Activity" button, it will select automatically as a new activity. You can change the default setting.

**Continuing Activities with FY 2009 Funds:** Please include the new funding requested in the Planned Funds box. As stated earlier, we anticipate minimal time and effort should be spent describing on-going activities, with attention mostly dedicated to changes in the activity and a brief description of what is new under these programs.

**New Activities:** Please ensure that the Continuing Activity button is unchecked and that you have included a funding amount in the Planned Funds box. If an FY 2008 funding mechanism is imported for use in describing a new FY 2009 activity, please uncheck the Continuing Activity button.

#### DATA ENTRY:

None, except to change the default setting.

### ACTIVITY NARRATIVE:

#### CONTENT:

The activity narrative is of particular importance, because COP reviewers depend heavily on the description in this narrative. Please give enough detail for reviewers to understand what the activity entails, and what this activity will accomplish in the program area.

Please include appropriate descriptive narratives for your Centrally funded activities as well. These activities are as important for reviewers as field activities. If you need assistance in getting sufficient information from the centrally funded partners to complete the COP data entry, please contact your Core Team Leader.

Each narrative should specifically mention:

1. Emphasis areas of the activity (please describe how you will address the emphasis area, rather than just listing);
2. Populations the activity is targeting;
3. How this activity will help you reach the vision outlined in the Program Area Context and address the opportunities and challenges outlined in your 5-Year Strategy.
4. Any linkages of the specific activity to other USG resources and/or other donor support.

Please see the Extranet for an example of an activity narrative.

HELPFUL HINT: For one activity that is divided into multiple activity narratives (for example, if the activity is a joint one done by multiple partners or if one activity is funded by multiple funding sources) you do not need to provide a different narrative for each entry. We encourage you to copy and paste one write-up into multiple activity narratives.

### **Activity Narratives for PHE**

The activity narrative does not need to be filled out, but should state that "This PHE activity, '[Title of PHE study],' was approved for inclusion in the COP. The PHE tracking ID associated with this activity is [reference PHE unique ID cited in the approval communication].' An electronic copy of the approved PHE activity proposal should be uploaded in the Supporting Documents Section of COPRS. Funding for these activities will be provided from central funds, but should also be included in the COP as an addition to the country's program allocation.

### **Activity Narratives for Ongoing Activities:**

Activities that are approved in FY 2008 and are ongoing in FY 2009 with little change do not need extensive revision, but please make sure that all narratives have been updated to reflect accurate information. Any data stored in the database should be accurate. If an activity is imported, but will not change scope, clearly mark that this narrative is from FY 2008 and has not been updated. Please use the following conventions in ALL CAPS:

- ACTIVITY UNCHANGED FROM FY2008
- ACTIVITY HAS BEEN MODIFIED IN THE FOLLOWING WAYS:

Each narrative box has been expanded by 5,000 characters to allow for an update, without having to change the whole narrative. If neither of above phrases appear, reviewers will assume the narrative has been fully updated.

If the country team does not have to complete narratives in a specific program area due to a "pass" in FY 2009, please delete the activity narrative text before submitting the COP. You should still import the activity from the COP to capture the planned funding and the secondary cross-cutting budget attributions. This also indicates that the activity is a continuing activity. If a country received a pass in FY 2008, but not in FY 2009, narratives will need to be submitted.

**DATA ENTRY:**

These narratives should be entered into activity text box provided. There is a 15,000 character limit (approximately three pages) for each narrative. We recommend that you write the narrative in Word, then paste the text into the text box in COPRS. You may also type directly into the box on the screen, but COPRS does not have a spell-check or character count function.

**EARLY FUNDING:****MODIFICATIONS IN THIS SECTION:**

The timeframe for FY 2009 COPRS data entry does not allow for early funding requests to be submitted through COPRS. **Therefore, FY 2009 early funding requests should be submitted by September 12<sup>th</sup> through a brief form on the PEPFAR Extranet.** In order to simplify the process, early funding requests will be submitted at the mechanism (or partner) level, with funding amounts being broken out for each early-funded activity (program budget code). All COP countries will submit an identical form.

**Please note:** Country teams are asked to submit early funding requests for the GHAI (or GHCS-State) funded-activities only, as OGAC is only able to notify for the one account. Early funding request for all other accounts should go through the associated agency process.

**CONTENT:**

Early funding requests are only for activities that will require funding before April 30, 2009, in advance of normal COP approval and Congressional Notification timelines. Please take into account three items as you decide on early funding requests:

1. Early funding can be requested under a Continuing Resolution but it must only be requested for ongoing activities.
2. If drug purchases need to be undertaken early in the year, the funding for these purchases must be included in the early funding request.
3. Only request the amount of funding to cover your activity until full funding arrives in-country. (There should be very few instances where you would request funding for an entire activity as early funding.)

In the early funding narrative, please describe what the early funds will be used for and why early funds are necessary. There will not be a set character limit for the early funding narratives, though narratives will be truncated to 1000 characters (approximately 1 paragraph) for financial analyses.

**DATA ENTRY:**

Detailed instructions on how to use the Early Funding Request Form will be sent to country teams when the forms are made available on the Extranet. Below is an illustrative example of the Early Funding Request Form. Country teams will be required to submit a minimum of the following pieces of information:

- Prime Partner
- FY 2008 Mechanism ID
- USG Agency
- FY 2008 Approved Mechanism Funding

- FY 2009 Proposed Mechanism Funding
- Early Funding Justification
- Early Funding Request Amount by Budget Code

Team Site Home Documents and Lists Create Site Settings Help

Early Funding FY2009  
Angola FY 2009 Early Funding Request: New Item

Save and Close | Attach File | Go Back to List

Title (For Country Tracking Purposes Only)

Country Name \*

FY08 Mech ID (Enter "New" if new) \*

Prime Partner \*

Continuing Activities Certification ☐ Our country team certifies by checking this box that early funding for this pair

USG Agency \*

FY08 Mechanism Approved Funding \*

FY09 Mechanism Field Proposed Funding \*

Early Funding Justification \*

01-MTCT Early Funding

02-PEDX Early Funding

03-HVAB Early Funding

Advanced HT

## ACTIVITY TARGETS:

### MODIFICATIONS IN THIS SECTION:

- Activity level targets will not be collected centrally for the FY 2009 COP. The fields have been eliminated in COPRS. **Please note that while country teams will not be required to upload activity level targets in COPRS, these targets will still be needed in order to track partner performance and to calculate the program summary targets.**

### DOWNSTREAM ACTIVITY LEVEL TARGETS:

Activity level targets will not be required at a central level for the FY 2009 COP. However, country teams will still need to set activity (or partner level) targets in order to track partner performance and to be able to calculate the program summary targets.

In the past, partners were asked to set downstream targets for the indicators that fell within their funded program areas. This guidance still applies.

### **Targets' Timeframe:**

Activity (or partner) level targets should reflect the same time period as the summary level targets (October 1<sup>st</sup> 2009 - September 30<sup>th</sup> 2010). These targets should reflect expected activity (or partner) results regardless of the funding year used to reach the targets.

By setting targets based on expected results within a given time period rather than based on a given budget, country teams will be able to compare partner level targets and reported results.

→ **NOTE:** This year we are recommending that country teams provide disaggregated summary level targets by sex, with the intention of requiring this change in the FY2010 COP. Please review *The President's Emergency Plan for AIDS Relief Indicators Reference Guide: July 2007* document to ensure that all necessary data are being collected throughout the year.

## **SECONDARY CROSS-CUTTING BUDGET ATTRIBUTIONS:**

### **MODIFICATIONS IN THIS SECTION**

This is a new section.

### **CONTENT:**

In FY 2009, we will be capturing funding information for seven new secondary cross-cutting budget attributions. These new codes allow us to capture more specific information on a few key topics in order to better respond to legislative requirements and Congressional inquiries. The seven secondary cross-cutting budget attributions are:

<b>Secondary Cross-cutting Budget Attributions</b>
<b>1.</b> Human Capacity Development
<b>2.</b> Public Health Evaluation
<b>3.A</b> Food and Nutrition: Policy, Tools and Service Delivery
<b>3.B.</b> Food and Nutrition: Commodities
<b>4.</b> Economic Strengthening
<b>5.</b> Education
<b>6.</b> Water

These secondary cross-cutting budget attributions will be entered at the activity level in FY 2009. The amount in the secondary cross-cutting budget attribution field should be equal to or less than the total planned funding for that activity. For example, if a partner is being funded \$1,000,000 for Pediatric Treatment, the total for Food and Nutrition commodities can not be



more than \$1,000,000. The Food and Nutrition commodities will be added across activities, so do not count the same Food and Nutrition commodity dollars in multiple activities.

#### **DATA ENTRY:**

1. Click on the Add/Edit CC Budget Codes/Emphasis Areas button.
2. You will be taken to a new page with the secondary cross-cutting budget attributions listed (this page will also be used to enter Emphasis Areas).
3. If a specific budget code is relevant, enter the value directly into the cell. You do not need to enter commas.

#### **DEFINITIONS:**

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### **Human Capacity Development**

For each activity, countries should estimate the amount of funding that is attributable to HCD activities, including:

- Human Resources for Health Strategy development/workforce planning
- Human Resource Information Systems (HRIS):
- Training
  - Pre-service training
  - Longer term training
  - Training of lay and community health workers for task shifting
- Performance Assessment
- Retention Strategies
- Twinning and volunteers
- Management and Leadership Development
- Support for salaries

Please note, in addition to providing information about funding for all HCD activities, countries should also fill out the Health Care Worker Salary Report worksheet, which is available on PEPFAR.net. This is the same worksheet that was required for the FY 2008 COP.

### **Public Health Evaluation**

Only PHE activities that are reviewed and approved through the formal PHE process prior to COP submission should be entered into COPRS. Once a PHE activity is approved, it should be included in the relevant program budget codes (Adult Treatment, PMTCT, etc). When you enter the activity in the budget code table, you should also indicate the same amount in the PHE secondary cross-cutting budget attributions cell. If an activity has multiple components, include only the approved PHE funding level in the PHE secondary cross-cutting budget attributions field.

Further information about the FY 2009 PHE process is available in Appendix 23.

### **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 – providing 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 – training for health care workers, home-based care providers, peer counselors, and others to enhance their ability to carry out nutritional assessment and counseling; developing appropriate nutrition-related curricula for inclusion in pre- and post-service training programs; development of appropriate job aids for health care workers.
- Nutritional Assessment and Counseling – 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; 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; nutritional assessment, counseling and referral linked to home-based care support.
- Equipment – procurement of adult and pediatric weighing scales, stadiometers, MUAC tapes, and other equipment required to carry out effective nutritional assessment; procurement, logistics and inventory control costs.

## **Food and Nutritional 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 – provision of micronutrient supplements 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 – 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 – 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 following section. Further information about food and nutrition programming is available in Appendix 12.

## 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.

Further information about economic strengthening programming is available in Appendix 12.

## 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 secondary cross-cutting budget attribution.

## 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.

### EMPHASIS AREA TICKBOXES:

#### MODIFICATIONS IN THIS SECTION

The “Emphasis Areas” now contain a shorter list of emphasis areas. We have added two target populations to this list, and eliminated the separate section for target populations. The definitions have been clarified and expanded, and we are no longer asking for a percentage of effort.

#### OVERVIEW:

OGAC uses these Emphasis Areas in responding to both Congressional and media inquiries and therefore it is critically important that they reflect the field reality as closely as possible. The FY 2009 COP has shortened the list.

You should ensure that each of these selections are justifiable, according to the definition. That is to say that you would be able to support each selection in the event of an audit. Additional guidance on the issues related to these emphasis areas is located in relevant Appendices.

- |   |  |
|---|--|
| <input type="checkbox"/> Construction / Renovation                                    | <input type="checkbox"/> Health-related Wraparound Programs    |
| <input type="checkbox"/> Gender   | <input type="checkbox"/> Child Survival Activities             |
| <input type="checkbox"/> Addressing male norms and behaviors                          | <input type="checkbox"/> Family Planning                       |
| <input type="checkbox"/> Increasing gender equity in HIV/AIDS programs                | <input type="checkbox"/> Malaria (PMI)                         |
| <input type="checkbox"/> Increasing women's access to income and productive resources | <input type="checkbox"/> Safe Motherhood                       |
| <input type="checkbox"/> Increasing women's legal rights                              | <input type="checkbox"/> TB                                    |
| <input type="checkbox"/> Reducing violence and coercion                               | <input type="checkbox"/> Refugees/Internally Displaced Persons |
| <input type="checkbox"/> Workplace Programs   | <input type="checkbox"/> Military Populations                  |

#### DEFINITIONS:

Please use the following definitions to determine whether an activity includes one of the emphasis areas.

**Construction and Renovation:** Construction of any new facility, or the change in use, square footage, technical capacity, or other infrastructure improvements to any facility. Please note that the definition of renovation is intentionally broader than the CDC definition used for funding renovations. See Appendix 15 for further guidance.

#### Gender:

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS programs
- Increasing women's access to income and productive resources

- Increasing women's legal rights
- Reducing violence and coercion

For more information on gender, please see Appendices 21 and 22.

**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.

**Health-related Wrap Arounds** - A wrap around 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. 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 wrap arounds, such as delivery of bednets through PMI, immunizations, or medications for neglected tropical diseases.

- **Malaria:** Strengthening the interface between PEPFAR and the President's Malaria Initiative (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.
- **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.
- **Safe Motherhood:** The goal of safe motherhood programs is to reduce maternal mortality and disability by following a continuum of care through the post partum 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.

- **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 funds may not be used to support family planning activities. The USG supports voluntary family planning programs largely through USAID's population and reproductive health program, while PEPFAR's mission is prevention, treatment, and care of HIV/AIDS. In any wraparounds between HIV/AIDS and family planning activities, PEPFAR funds may only be utilized to support HIV/AIDS activities.

### Refugees / Internally Displaced Persons:

- **Refugees:** Persons who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, are outside the country of their nationality, and are unable to, or, owing to such fear, are unwilling to, avail themselves of the protection of that country. (UNHCR)
- **Internally displaced persons (IDPs):** People who have similarly been forced from their homes, but have not crossed an internationally recognized state border. (UNHCR)

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

### DATA ENTRY:

Check the tickbox of the applicable emphasis area.

Several emphasis areas have subsets; if you check one of the subsets, COPRS will check the parent emphasis area for you.

- ☒ Gender
  - ☒ Addressing male norms and behaviors
  - ☐ Increasing gender equity in HIV/AIDS programs
  - ☐ Increasing women's access to income and productive resources
  - ☐ Increasing women's legal rights
  - ☐ Reducing violence and coercion

### TARGET POPULATIONS:

#### MODIFICATIONS IN THIS SECTION

This section has been eliminated. Two target populations, Refugees/IDPs and Military Populations, can be found in the Emphasis Areas section.

**COVERAGE AREA:**

**MODIFICATIONS IN THIS SECTION**

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This section has been eliminated.

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<b>MANAGEMENT AND STAFFING:</b>
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**BACKGROUND**

Management and Staffing with a strong emphasis on interagency coordination continue to be important priorities for PEPFAR. In FY 2008, country teams were asked to fully implement “Staffing for Results” (SFR). SFR is more than a staffing numbers exercise for COP planning, but is an on-going process that involves continuous attention to functioning PEPFAR country structures. Over the past two years many lessons have been learned that contribute to defining SFR and integrating it as a meaningful field-based process for improving interagency relations, programming and results. Countries that have made the greatest progress have the following characteristics: strong leadership/support from Embassy and Agency leadership, well-defined cross-agency structures with well-understood functional roles and responsibilities at each level, joint site visits, portfolio reviews, and partner meetings, periodic team building/strategic planning and operating norms that acknowledge agency comparative strengths and promote open discussions on difficult issues.

SFR formalizes the change in interagency structure and culture needed to fully integrate one USG team. SFR institutionalizes management and staffing decisions based on meeting the overall PEPFAR prevention, care, and treatment goals in the most efficient and effective way possible – instead of agency needs driving organization and staffing decisions. Under SFR, headquarters and field staffing decisions are based on having the optimal mix of staff across agencies to program, manage, and evaluate PEPFAR and its support of broader development goals given legislative and budget constraints.

Country team 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, and new technical staffing needs considered by the team rather than just one agency). Knowledge gained from five years of implementation experience should guide your team in creating the best mix of skills to create a footprint unique to each country's fight against HIV/AIDS. Implementing SFR will require considerable analysis and discussion by the country team and should be an ongoing process. Please note that it is widely recognized that countries have very different circumstances; thus this process must be largely driven by the country team, and the footprint may be different from country to country.

Countries that have already made significant progress toward achieving SFR should use the COP planning timeframe to assess the structural organization of the country team to see if it is meeting the interagency objectives. During this process, the team should make any adjustments necessary as well as identify any further ways to foster interagency team-building.

As part of the staffing analysis, country teams should consider their staffing needs to continue meeting the program management demands into FY 2009 and beyond. Teams should consult with non-program offices, such as human resources, management, and procurement, to ensure that there is sufficient administrative and structural support for the program staff. Focus countries should proceed on the assumption that their country's FY 2009 HIV/AIDS budget will not be lower than their FY 2008 budget with the understanding that, as in all years, the actual amount of funding is contingent on the overall appropriation.



## Staffing for Results Benchmarks and Deliverables for FY 2009

### 1) An implementation plan established for Staffing for Results; key tasks in developing the implementation plan include:

- a) Engaging the Chief of Mission or designee and Agency heads to support and lead this process;
- b) Identifying an interagency management group dedicated to Staffing for Results;
- c) Completing a functional mapping of the existing PEPFAR management and programmatic country team structure, which includes identifying the:
  - (1) core strengths of each agency working in the PEPFAR program,
  - (2) existing Agency management and organization, and
  - (3) existing PEPFAR team structure;
- d) Developing a plan for a team-building approach to define roles/responsibilities of functional cross-agency leadership/coordination;
- e) Identifying staffing gaps and developing strategies to address duplication and recruitment for both short- and long-term;
- f) Identifying a list of concerns and barriers (such as rightsizing and recruiting) and developing a plan to address those issues;
- g) Documenting the USG approach to communication and coordination for program management and implementation (both within the USG team and with partners and other stakeholders);
- h) Continuing and expanding existing joint planning and program oversight processes, including:
  - (1) Developing a plan for joint portfolio reviews and interagency partner monitoring, and
  - (2) Defining the structure for setting annual priorities and budget for management;
- i) Developing a plan to engage HQ and other identified SFR support, including Core Team Leads, regional platforms, etc.; and
- j) Capacity building planning: LE Staff empowerment activities such as training or career development opportunities, use of framework job descriptions.

### 2) Staffing Analysis Tools

As a part of the COP, country teams are again asked to submit the following completed tools: a functional staffing chart, a management chart for each agency, and a staffing database. These charts and database will be submitted as supporting documents to inform the information in the Management and Staffing program area. Additional guidance on upgrades to the staffing database will be disseminated separately.

### Peace Corps Volunteers

A Peace Corps Volunteer Matrix is **NOT** required this year. The number of PEPFAR-funded Peace Corps Volunteers should be indicated in the technical program area(s) where they are being funded; they should not be funded in the Management and Staffing program area. For each country and in aggregate, Peace Corps Washington will submit to OGAC the number of PEPFAR-funded:

- Volunteers on board as of September 30, 2008;
- Peace Corps Response Volunteers on board as of September 30, 2008;
- new Volunteers proposed in the FY 2009 COP;
- new Peace Corps Response Volunteers proposed in the FY 2009 COP;

This information included will be obtained from Peace Corps country programs by Peace Corps Washington.

Funding of Peace Corps Volunteers in FY 2009 - Three-year funding for Peace Corps Volunteers funded by PEPFAR must be included in the FY 2009 COP because Volunteers arriving in June 2009 will have expenses in FY 2009, FY 2010, and FY 2011. The FY 2009 COP must request funds to cover all of the expenses incurred in this timeframe. Peace Corps Volunteer services are not contracted or outsourced and costs are incurred before and throughout the Volunteer's 27-month period of service. For example, obligations incurred include those associated with recruitment, placement and training of the Peace Corps Volunteer prior to the beginning of his or her service and living allowance through the close of service.

Additionally, the continuing costs of Peace Corps Volunteers funded by PEPFAR in FY 2008 (who still have a year or more of service remaining) must be included in the FY 2009 COP, if not included in the FY 2008 COP.

### **Management and Staffing Funding Limit**

Please note that the requirement that management and staffing costs not exceed 7% of a country's budget applies to the overall PEPFAR budget for each country; it is not applied by agency. The approval of management staffing activities will take into account the in-country management of the funds going through the Partnership for Supply Chain Management. For example, the review of the fictional CDC/Ethiambia management and staffing budget will take into account their in-country responsibility for managing the procurement of lab reagents and related technical assistance even though those funds are not reported as CDC in the COP.

### **Technical Assistance-related Travel Costs**

In FY 2009, technical assistance-related travel costs of HHS/CDC HQ staff will be included in the PEPFAR Headquarters Operational Plan (HOP) and funded centrally. Under this model, costs for technical assistance travel by HHS/CDC staff should not be included in the countries' COPs. In addition, HQ will continue to cover the costs associated with technical assistance-related travel from HQ to assist the other bilateral countries.

### **Hiring PEPFAR Coordinators**

As of April 2008, the roles and responsibilities of an interagency PEPFAR Coordinator position have been approved. Position descriptions incorporating the roles and responsibilities have been developed and are posted on the PEPFAR Extranet. These should be the standard position description when recruiting new country coordinators. A key element of the position description is the delegation of day-to-day supervisory authority and performance review to the Ambassador or the DCM. The Coordinator position description is available on PEPFAR.net or through your Core Team Lead.

There are a number of options for hiring in-country PEPFAR Coordinators. These include USDH slots (FTE), local hire contractors, and international hire contractors.

USDH: Obtaining an FTE position a country PEPFAR coordinator is often challenging. State positions are few and far between, as are those from agencies such as HHS and USAID. We expect this option will only be available in exceptional circumstances. OGAC does not have USDH positions to offer for this purpose.

Local Hire Contractors: The preferred mechanism is using State's PSA authority for hiring coordinators who are residents of the host nation.

International Hire Contractors: Current practices are to recruit through USAID or CDC, with the understanding that the agency hiring mechanism is only for administrative purposes. Per the new approved PEPFAR position description, the position will report to the Chief of Mission and lead the interagency PEPFAR team.

## Content:

<b>PROGRAM AREA DESCRIPTION:</b>
<b>Management and Staffing</b> - costs of supporting USG mission staff to manage, support and administer HIV/AIDS programs including related training, salaries, travel, housing and other personnel-related expenses. Implementing agency/grantee staffing costs are coded under the appropriate functional category rather than under Management and Staffing.
<b>SECTION OBJECTIVES</b>
<p>This section of the COP has two objectives:</p> <ol style="list-style-type: none"> <li>1. To provide an overview of all USG staff working on PEPFAR; and</li> <li>2. To justify the USG Team in-country costs of managing PEPFAR. This program area is NOT to be used for reflecting personnel-related costs for the implementing partners who are involved in PEPFAR.</li> </ol>
<b>PROGRAM AREA SPECIFIC INSTRUCTIONS:</b>
<p>In the Management and Staffing overall narrative, please address each of the following points:</p> <ol style="list-style-type: none"> <li>1. Please describe how your team has implemented Staffing for Results and where your team sees itself in the process based on the implementation plan steps above. How has your team planned, managed, and implemented your PEPFAR program building on agency comparative advantages in FY 2008? Describe how tasks and roles have been designated across Agencies (core strengths). Address the following: <ul style="list-style-type: none"> <li>• Interagency management and TWG structures;</li> <li>• Staffing for Results (SFR) implementation plan and status (what kind of process did the team use to determine whether staff mix/size is appropriate for the upcoming year's program? How is the team advancing implementation of SFR? Did the team institute any new SFR-related processes in FY 2008? Has the team created efficiencies through interagency coordination? Have you implemented any innovations such as appointing</li> </ul> </li> </ol>

activity managers from another agency or co-location? How do staff working in the same program area interact?);

- Any changes to staffing planned for the future to meet programmatic goals (explain interagency decision-making); and
- Any issues, obstacles, or problems that currently affect the mission's management and staffing and ability to implement SFR fully or effectively manage and staff the program (i.e.: space or "rightsizing pressures," CAJEing, geography, etc). What is the average vacancy period?

In addition, describe how your team has conducted joint work planning, partner performance reviews, and overall program area reviews. How is your team working to improve team communication?

2. Describe your team's plans to continue/institutionalize interagency planning and management and to address any issues (described above) affecting your ability to implement SFR or effectively manage and staff the program. Please describe any areas where Headquarters support/intervention is requested. If there are upcoming rightsizing or mission-broad management initiatives or reviews, please describe here with the timeline.

3. Given much reduced annual increases in resources available for FY 2009-2013, are current resources (staff, space, etc.) sufficient to manage the program for the next 5 years? Describe how your team has worked with non-program offices (i.e. HR, Management/Executive, Procurement) of the mission to ensure there is sufficient support for staff and space.

4. Describe requested new staff: The information should explain the new staff information included in the staffing database. Descriptions of new positions should correspond to the position title and category of position requested in the database. Please describe in detail the specific skill sets (e.g. administrative, technical, program-area-specific care/prevention/treatment, etc.) requested and how you will fill those positions building on agency core competencies. For any new staff positions that are requested, there is an assumption that these have emerged from the SFR exercise and that there is consensus with the entire in-country PEPFAR team on the need, roles, and hiring agency.

5. Describe any existing vacancies and anticipated turnover during the upcoming fiscal year. What is the team's approach to addressing these issues? Explain the reasons for the vacancies and what efforts you have taken to document those reasons.

If extra space is required to fully describe your country team's SFR process, you may upload further text as a supporting document. In addition, while not required, countries may upload any other documents (such as terms of reference, vision, goals) that explain the team's SFR process to share with reviewers.

#### **PROGRAM AREA BUDGETARY REQUIREMENTS**

You should not allocate more than 7% of the total country budget (all program areas) for management and staffing. Exclude Track 1.0 funds in the denominator.

Only the M&S costs included in program area 19 are deducted from the total country budget

(central and field dollars) in the denominator for the single-partner funding limit (8% cap) calculation. The M&S-type costs included in the other program areas are considered to be program costs and, therefore, are not deducted.

#### **FUNDING MECHANISM:**

The funding mechanisms that should appear in the Management and Staffing program area are those that have either one of the six USG Agencies involved in PEPFAR as the Prime Partner or an M&S implementing partner, such as IAP Worldwide Services, as the Prime Partner. The funding mechanisms can also include central or locally procured activities. Please see additional information about separate mechanisms for each cost of business (i.e. ICASS, CSCS, IRM tax) below.

#### **PLANNED FUNDING:**

Please enter planned funding here in the same way that you did for the other program budget codes.

#### **ACTIVITY NARRATIVE:**

This narrative should be used to justify the management and staffing cost for the USG Agency or other M&S partner performing M&S functions, in keeping with the principles outlined in the program area description above.

If not included in the overall M&S narrative, please include information about agency program area functions and responsibilities building on agency core strengths.

In some HHS/CDC COGH country offices (e.g., in Kenya), there will be management and staffing costs associated with the overall HHS/CDC mission. These should be listed as a separate item in the COP.

#### **Costs of Doing Business (ICASS, CSCS, IRM tax)**

For each agency, please identify the ICASS, Capital Security Cost Sharing, and the IRM tax costs, as appropriate, and briefly describe what these costs are associated with, i.e. how many employees are associated with the ICASS charge to your agency, OR, what are the services paid for with the IRM tax. Please budget for your entire FY 2009 estimated ICASS, CSCS, and IRM tax costs in your COP.

**ICASS:** Each implementing agency, including State Dept., should request funding for PEPFAR -related ICASS costs within the M&S budget. It is important to coordinate this budget request with the Department of State Financial Management Officer, who can estimate FY 2009 anticipated ICASS costs by preparing a “what-if” ICASS budget using each PEPFAR agency’s anticipated ICASS workload. This FY 2009 ICASS cost estimate, by agency, should then be included in the M&S budget table and in a separate activity entry.

To enter ICASS as an activity, please select “USG Core” as the type of mechanism and use GHCS funds. For the agency, select your own agency (for example - HHS/CDC) and enter the activity in the management and staffing budget code. The only exception to this is if the charges are incurred for State Department employees. If that is the case, then enter “State

- OGAC" as the agency. The prime partner should be the Department of State. There will be NO opportunity to increase these funds from OGAC or your agency's headquarters later in the year.

***Capital Security Cost Sharing:*** Non-State Dept. agencies should include the Capital Security Cost Sharing tax in the M&S program area, except where this is paid by the headquarters agency.

***IRM:*** USAID should include the IRM tax on HIV-program-funded positions.

***ITSO:*** CDC should include the ITSO (IT support) tax on HIV-program-funded positions.

The entire "cost of doing business" for both M&S staff and program staff should be reflected in the M&S section and NOT in program areas. **Each USG agency as prime partner should have at least two entries:**

- ONE entry for all M&S budget details (salaries, travel, hiring PSCs, etc.) and
- ONE entry for each type of "cost of doing business" taxes such as ICASS, the IRM tax, and Capital Security Cost Sharing. **There should be a separate mechanism for each type; therefore, each type should be entered as a separate activity.** For consistency, please specify mechanism name as "ICASS Charges" or "CSCS Charges" and list the "Prime Partner" as State. All entries should have a brief activity description.

You may break up ICASS and CSCS across the program areas to disperse these costs and not centralize them in M&S. However, you must include separate activities for these charges for each agency in each program area.

Each activity may also have a different funding mechanism if the agency needs to differentiate between central and local procurement activities. This is similar to adding funding mechanisms in the other program budget codes. For example, CDC might have up to five entries if it is using both GAP/BASE and GHAI funding as well as differentiating between central and local procurement activities.

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 posts must include a 15% cost element in their budgets to cover this support in lieu of ICASS. These costs should be included in the program area it supports.

Otherwise, all USG agencies should reflect ICASS. These should be absorbed by the country budget, not headquarters.

## **Implementing Partners**

Any M&S implementing partners (non-USG agencies) should have their own separate entries. For example, if USAID (the USG agency) uses IAP World Wide Services as a prime partner for M&S services, you would have a new entry for IAP in addition to the USAID as the prime entry.

All M&S budget details (salaries, travel, hiring PSCs, etc.) should be combined and included as ONE entry for each M&S implementing partner.

Please ensure that your local administrative staff has been engaged in the development of the M&S budget.

The following are not applicable to the management and staffing program area. They will not appear as options: **Emphasis Areas, Secondary Cross-cutting Budget Attributions.**

## **Inclusion of USAID Direct and Indirect Costs**

### **Background**

On December 10, 2007, the Deputy Administrator of USAID and the U.S. Global AIDS Coordinator agreed on a set of principles by which USAID would be reimbursed for the administrative costs of implementing PEPFAR. The underlying principle of this agreement, with which the Office of Management and Budget (OMB) concurred in a separate meeting on February 6, 2008, was that PEPFAR should support USAID's direct staff costs, based on percentage of time engaged in PEPFAR implementation, incurred in the implementation of PEPFAR and indirect agency overhead costs associated with hiring and maintaining that staff.

In addition to this agreement on principles, the Deputy Administrator of USAID and the Global AIDS Coordinator concurred on a methodology by which the indirect administrative costs incurred by USAID in its implementation of PEPFAR will be calculated. This methodology was based on the FTE (% of time) working on PEPFAR of staff reported in the PEPFAR Headquarters Operational Plan (HOP) and COP staffing databases. Direct salary, benefit, and travel costs will be calculated based on the number of staff members reported in the annual COP and HOP staffing databases, and indirect costs will be calculated by applying a rate of 23.7% to the total direct costs (salaries and benefits) (excluding travel). Staff from OMB, USAID, and the Office of the Global AIDS Coordinator (OGAC) met to discuss this methodology on February 6, 2008 and reached consensus that it was appropriate as a basis for future budget planning.

### **Direct Cost Principles and Methodology**

Beginning with the FY 2009 HOP and COPs, PEPFAR program funds will support the portion of each USAID's staff member's salaries, benefits, and travel spent working on PEPFAR-related activities. Headquarters and Field Missions will report on all such staff through the annual HOP and COP staffing databases, and will include all related direct salary, benefit, and travel costs in the budgets contained within the accompanying HOP or COP. For Field Missions, funding for direct staffing costs will be transferred from OGAC to the field through the normal Congressional Notification and Memorandum of Agreement processes. For Headquarters, funding for direct staffing costs will be transferred from OGAC to USAID Headquarters through the Technical Oversight and Management line item in the Congressional Notification and Memorandum of Agreement.

### **Indirect Cost Principles and Methodology**

Beginning with the FY 2009 Headquarters Operational Plan and Country Operational Plan, indirect overhead costs related to the agency hiring and maintenance of PEPFAR-related staff will be funded through PEPFAR program funds. As agreed upon by USAID, OGAC, and OMB, an indirect rate of 23.7% will be applied to the total direct costs (excluding travel) of salary and benefits for all PEPFAR staff listed in Staffing for Results based on the portion of each USAID's staff member's salaries, benefits, and travel spent working on PEPFAR-related activities. (Travel costs will be excluded from the direct cost base to which the indirect rate is applied.) This cost should be budgeted within the relative operational plan and listed in the M&S program area and budget table under Indirect Cost (USAID only). Concerning USAID Direct and Indirect Costs, section 104A(f) of the FAA (added by section 301 of the Leadership Act) limits USAID administrative costs to 7% of funds appropriated to carry out section 104A on HIV/AIDS programs

### **Management and Staffing Budget Table (New for FY 2009)**

In order to capture the amount of program resources supporting USG management and staffing costs across all budget codes, a new budget table is required for FY 2009. In accompaniment to including the costs in an activity entry or narrative, the budget table itemizes each USG agency's M&S expenses by program area and fund account. This information will be entered annually with the COPs and be updated during reprogrammings as appropriate.

For FY 2009, an Excel spreadsheet will be used to capture the information on:

- USG Staff salaries,
- Indirect Costs (USAID only),
- USG Staff Travel,
- Overhead/admin,
- ICASS,
- Capital Security Cost Sharing (CSCS),
- IRM tax (USAID only), and
- ITSO (CDC only).

For each budget code area, please enter the amount of COP funding going to each of the M&S costs by agency and fund account.

A copy of the spreadsheet is available on the PEFAR extranet, and should be uploaded as a supporting document in COPRS.

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## Table 4 Summary Budget Report

Table 4 is generated automatically by the data system. You will not be able to input any information into Table 4 in the system.

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## Table 5 Planned Data Collection in FY 2009

### CONTENT:

Please answer each of the questions in this table in relation to data collection activities planned in your country during fiscal year 2009. This includes data collection that is being undertaken with any year or type of funding (this includes activities being undertaken by organizations other than the USG). Include ALL activities for which actual data collection efforts are going on during fiscal year 2009 (October 1, 2008 through September 30, 2009). Include ALL significant data collection efforts that are being undertaken by other donors or the host country government in addition to those being undertaken with USG funding.

In question 4, you are asked to indicate the number of service delivery sites that will be included in any ANC surveillance study. In question 5, you are asked to detail any other significant data collection activities that are not detailed in questions 1 through 4. Significant data collection activities could include a Multiple Indicator Cluster Survey (MICS), Priorities for Local AIDS Control Efforts (PLACE), Service Provision Assessment (SPA), Service Availability Mapping (SAM), HIV incidence testing, HIV drug resistance survey, national ART outcomes, or impact evaluation. A brief description should be included if any other significant data collection activities are being undertaken. Also, please tell us if you are planning to do an analysis or updating of the health care workforce or the workforce corresponding to other PEPFAR goals for your country.

### DATA ENTRY:

**Table 5: Planned Data Collection**

Please answer each of the questions in this table in relation to data collection activities planned in your country in fiscal year 2006. Include all data collection being undertaken, not just that being funded by USG money.

Add Comments Save

1. Is an AIDS Indicator Survey (AIS) planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, Will HIV testing be included?</i>	<input type="radio"/> Yes <input type="radio"/> No
<i>When will preliminary data be available?</i>	<input type="text"/>
2. Is a Demographic and Health Survey (DHS) planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, Will HIV testing be included?</i>	<input type="radio"/> Yes <input type="radio"/> No
<i>When will preliminary data be available?</i>	<input type="text"/>
3. Is a Health Facility Survey planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>When will preliminary data be available?</i>	<input type="text"/>
4. Is an ANC Surveillance Study planned for fiscal year 2006?	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, approximately how many service delivery sites will it cover?</i>	<input type="text"/>
<i>When will preliminary data be available?</i>	<input type="text"/>
5. Other significant data collection activity:	
Name:	<input type="text"/>
Provide a brief description of the data collection activity	
<input type="text"/>	

Most of the questions require only a yes/no answer. Please also include dates when preliminary data will be available from the survey, where applicable and when known.

## Support Documents

### REQUIRED SUPPORT DOCUMENTS:

#### MODIFICATIONS IN THIS SECTION:

FY 2009 is a transition year between the current COPRS system and a new IT system that is being developed. As a result, this year the supporting documents are critical to reviewers when they read your COP; without them, they will not have a complete understanding of each country's program. Please be sure to upload all required support documents to COPRS before submitting your FY 2009 COP.

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**Any uploaded tables must be live Word document or Excel tables.**

1. **Budgetary Requirements Worksheet** – Because reauthorization of PEPFAR is still pending with the U.S. Congress, it is not yet clear what mandatory budgetary requirements may be in force in FY 2009. Updated guidance will be provided as soon as possible. Once that guidance is provided, we will post a new Budgetary Requirements Worksheet to PEPFAR.net.
2. **Summary Targets and Explanation of Target Calculations** – In FY 2009, country teams will fill out all summary targets on an Excel template. There will also be narrative boxes in the template for country teams to explain how they calculated the summary targets and any other data quality issues that should be noted.
3. **HCD Program Area Narrative** – This year, all countries are required to submit an HCD program area narrative, detailing how human capacity issues are being addressed by your country program. Further information is available in Appendix 19.
4. **Health Care Worker Salary Report** – This document provides an estimate of the number of health care workers supported by the USG in the categories of clinical services staff, community services staff, and managerial and support staff.
5. **Gender Program Area Narrative** – This year, all countries are required to submit a Gender program area narrative, detailing how you are mainstreaming gender into all aspects of your country program. Further information is available in Appendix 21.
6. **Global Fund Supplemental** – This document summarizes the support your country provides to the Global Fund in-country. A template and specific instructions are found on the Extranet.
7. **Management and Staffing Budget Table** – This table itemizes each USG agency's M&S expenses by program area and fund account.
8. **Staffing Analysis** – This Excel file includes the staffing database data, the functional staffing chart, and a management chart for each agency. Additional guidance will be disseminated to country teams separately regarding the staffing database and upgrades for FY 2009.
9. **PPP Supplemental** – This table captures information about PPPs at the USG level and includes information on financial contributions by both the USG and the other partner.
10. **Budgetary requirement justifications** (if applicable)
11. **Single Partner Funding Justification** (if applicable)

**DATA ENTRY:**

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**Upload Supporting Documents** ⓘ

Upload Supporting Document:

Click "Browse" to select a file to upload

File must be of the following type:

- TEXT
- RTF
- WORD
- PDF

Description:  
**(Up to 500 characters)**

1. Enter Filename—Click on the **Browse** button to select appropriate Support Document file to upload from your local system to the HQ Data system (Document must be a text file, RTF, Word, or PDF).
2. Additional Description—Click on the **Additional Description** box and begin entering any additional information you would like included. You may enter up to 4,000 characters (approximately one page) in this section. You may want to enter the specific date or the author in this box.
3. Click on the **Upload File** button to upload the Support Document.
4. If you would like to delete a file that you have previously uploaded, click on the **Delete File** button on the list of uploaded files
5. If you would like to look at a file that has already been uploaded, select **Download**.

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## COP Submission Instructions

In order to complete final submission of the COP, you will need to have COP read/write/finalize access. Please make sure to check who in country has this access prior to November 14<sup>th</sup>. The following steps will guide you through the finalization and submission of your COP.

1. Run the Quality Assurance Report to ensure that all sections have been completed and errors have been corrected. For a list of items that are flagged by the QA Report, please see Appendix 11.
2. Click on **Mark COP Final and Ready for HQ Review and Approval**.
3. If there are critical errors in the Quality Assurance Report, you will see a warning, alerting you that there are still critical errors. You will still be able to submit the COP with critical errors.
4. Click Submit
5. Once the COP is submitted, a confirmation email will be sent to all individuals listed in the Country Contacts as well as the OGAC Lead. The COP will now be locked and country team will be unable to make any further changes.
6. Go celebrate the submission of your FY 2009 COP!