PEPFAR Country/Regional Operational Plan (COP/ROP) 2016 Guidance

December 2015

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

U.S. DEPARTMENT OF STATE

Contents

1.0 COP BASICS

1.1 Executive Summary

During the 2015 Sustainable Development Goals Summit and the 2015 United Nations General Assembly, President Obama set a bold course for PEPFAR by announcing new HIV prevention and treatment targets for 2016 and 2017. This announcement builds on the recent work of PEPFAR programs to focus on supporting sustainable control of the epidemic by pivoting to a data-driven approach that strategically targets geographic areas and populations where HIV/AIDS is most prevalent, and in which PEPFAR can achieve the greatest impact.

For COP 2016, PEPFAR teams will continue to advance progress toward sustainable control of the HIV epidemic by using data to validate strategic approaches developed in COP 2015 and identify additional areas for saturation by examining opportunities for increased efficiency and effectiveness of investment approaches and service delivery models. In addition, PEPFAR teams will amplify their consultation and engagement with external stakeholders (i.e., civil society, multilateral organizations and partner governments) in order to strengthen and enhance engagement and input on PEPFAR-funded activities and services.

Specifically, COP 2016 has been developed to maintain the use of data for decision making that was established in COP 2015 and improve the process in several key areas, including:

- Creation of a structured process to evaluate and determine required investments to support epidemic control through the following above site and site-level systems support activities funded through all budget codes: health system strengthening, laboratory, strategic information and human resources for health and others as listed in the section (see Section 3.1.4). ***Note:*** *There are five countries piloting the process between November 2015 and January 2016. Following those pilots, final guidance for this section will be distributed.*

- Establishment of annual target setting approach for achieving epidemic based on routine quarterly program monitoring through the PEPFAR Oversight and Accountability Results Team (POART) process.

- Greater integration with the restructured PEPFAR Technical Considerations which provide more streamlined guidance on key technical areas, including new areas and direction such as pre-exposure prophylaxis (PrEP) and service delivery innovations (see Section 4.2).

- Updated consultation guidance for PEPFAR teams engagement with external stakeholders and multilateral organizations (see Section 2.3.2).

- Expanded capacity of country and regional PEPFAR team's use of Ambassador's Small Grant programs to increase support for local civil society advocacy and community mobilization (see Section 2.3.5).

- Incorporation of the updated Sustainability Index and Dashboard (SID) 2.0, reflecting an improved and more targeted measurement of sustainability across 15 elements, which are organized under four domains: Governance, Leadership, and Accountability; National Health Systems and Service Delivery; Strategic Investments, Efficiency, and Sustainable Financing; and Strategic Information (see Section 3.1.1).

- Updated guidance and expectations for PEPFAR teams to use as they conduct analysis of their interagency staffing and organizational structures to facilitate successful implementation of PEPFAR 3.0 (see Section 8.1).

Finally, over the course of the last year, the Office of the U.S. Global AIDS Coordinator and Health Diplomacy received feedback about the COP 2015 guidance and process from a range of stakeholders, especially Chiefs of Mission, civil society, partner governments, multilateral partners and PEPFAR agencies and implementing partners. We have sought to incorporate and respond to many of the suggestions for improvement, clarification and transparency as well as to strengthen our core engagement model. As the COP 2016 process is implemented, comments and suggestions for how to improve our program and approaches continue to be most welcome and encouraged.

1.2 What is a COP?

The Country Operational Plan (COP)[1] documents U.S. government (USG) annual investments and anticipated results in the global fight against HIV/AIDS and is the basis for approval of annual USG bilateral HIV/AIDS funding in most partner countries. The COP also serves as the basis for

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

Congressional notification, allocation, and tracking of budget and targets and as an annual work plan for the USG activities in global HIV/AIDS. Data from the COP are essential to the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) transparency and accountability to all stakeholders.

The COP 2016 builds on business process changes initiated in 2014, especially the emphasis on the use of data to improve decision-making and to enhance program focus. COP 2016 also incorporates the quarterly review and data analysis interagency process known as the POART (PEPFAR Oversight and Accountability Response team). The POART is an ongoing dialogue throughout the year that routinizes data use and transparency, which are critical to a successful HIV response. The actions generated by the POART reviews should guide a country's COP development.

Figure 1.2.1
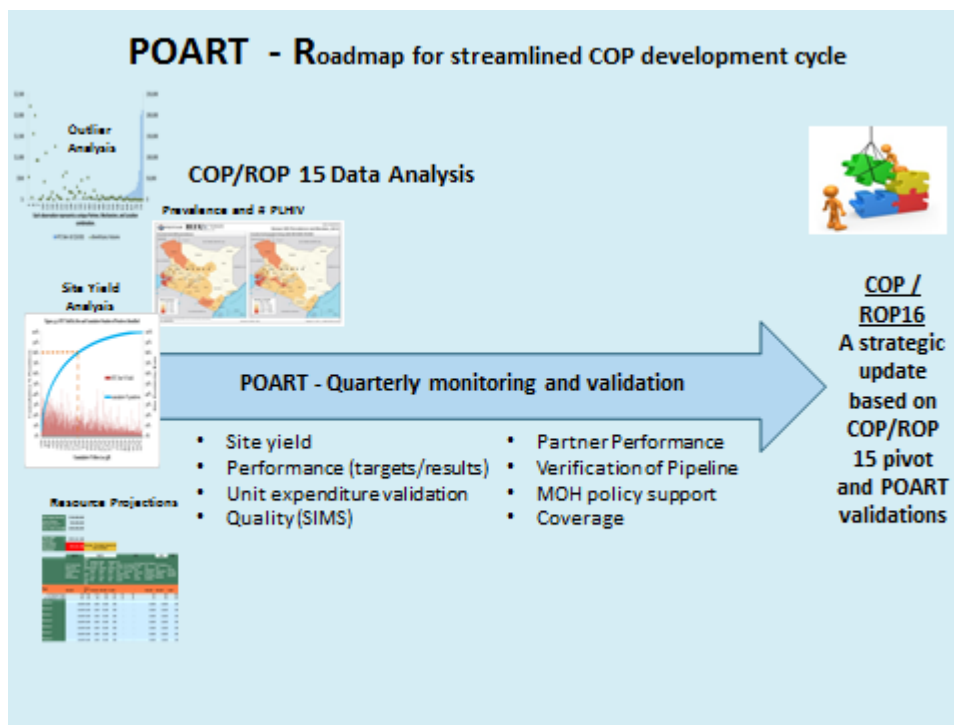
As described in September 2015 communications to PEFAR field teams and external stakeholders, the POART process will allow PEPFAR headquarter and field staff to analyze and review program (MER), quality (SIMS) and financial data on a quarterly cycle to ensure PEPFAR and agency specific COP / ROP approved deliverables and targets are achieved in the most efficient manner possible. Results from the quarterly data analysis form the basis of a corrective action and/or the sharing of best practices across the PEPFAR community, including external stakeholders (CSOs, MOH, GF,

UNAIDS). A Corrective Action Summary (CAS) is shared with the PEPFAR team and, over the course of a year, will form the basis of annual COP guidance for each individual country.

1.3 Which Programs Prepare a COP?

The following programs are required to complete a Fiscal Year (FY) 2016 COP: Angola, Botswana, Burma, Burundi, Cambodia, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Papua New Guinea, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zambia and Zimbabwe. ROPs are required from the Asia Regional Program (China, Laos, Thailand), and Caribbean (Antigua & Barbados, Bahamas, Barbados, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St Vincent & the Grenadines, Suriname, Trinidad & Tobago), Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama) and Central Asia (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan) field teams.

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

1.4 COP Timeline

Following the December POART consultation, country teams should continue their ongoing dialogue about current implementation and strategic direction for COP 2016.

Key dates for COP 2016 are provided in the following table:

	GROUP 1 (ASIA)	GROUP 2 (Africa1)	GROUP 3 (Africa2)	GROUP 4 (LAC)
DC Management Meeting Dates	Feb 23-Feb 26 2016	Mar 1-Mar 4 2016	Mar 8-11 2016	Mar 15-18 2016
COP/ROP 2016 Due Date	31-Mar-16	14-Apr-16	21-Apr-16	21-Apr-16
In-Person Review Location	Bangkok	Johannesburg	Johannesburg	Miami
In-Person Review Dates	April 27-29	May 18-20	May 23-25	June 1-3
OU				
Angola			X	
Asia Regional	X			
Botswana		X		
Burma	X			
Burundi				X
Cambodia	X			
Cameroon		X		
Caribbean				X
Central America				X
Central Asia	X			
Cote d'Ivoire			X	
DR				X
DRC		X		
Ethiopia			X	
Ghana			X	
Haiti				X
India	X			
Indonesia	X			
Kenya			X	
Lesotho		X		
Malawi		X		
Mozambique		X		
Namibia			X	
Nigeria			X	
PNG	X[1]	*		
Rwanda				X
South Africa		X		
South Sudan			X	
Swaziland			X	
Tanzania		X		
Uganda		X		
Ukraine	X			
Vietnam		X		
Zambia		X		
Zimbabwe			X	

* PNG will attend the DC management meeting with Group 2; the COP due date for PNG will be April 7

1/ PNG in-person review will take place on April 25 and 26 in Bangkok.

1.5 Required COP Elements Checklist

Table 1.5.1 below outlines which elements are required for the FY 16 COP/ROP. For a full list of required supplements, templates, and instructions, see Section 9.0.

1.5.1 Required COP Elements Checklist	
COP Element	**Required/Optional**
Strategic Direction Summary (SDS)	Required
Data Pack	Required from all OUs
Targets:	
National Level Indicators	Required from all OUs
Technical Area Level Indicators	Required from all OUs
Implementing Mechanism Level Indicators	Required from all OUs
Site level indicators	Required from all OUs
Implementing Mechanism Details:	
Partner name	Required for all IMs
G2G check box and Managing Agency	Required if applicable
Funding Agency	Required for all IMs
Procurement Type	Required for all IMs
IM Name	Required for all IMs
Mechanism IDs	Required for all IMs
Agreement Timeframe	Required for all IMs
TBD check box	Required if applicable
New IM check box	Required if applicable
Construction Renovation check box and project plans	Required if applicable
Motor Vehicles check box and numbers	Required if applicable
Funding Source allocations, including applied pipeline figure	Required for all IMs
Budget Code Allocations	Required for all IMs
Crosscutting Budget Allocations	Required if applicable
Crosscutting Budget Allocation: Gender Activity Checklist	Required if Gender-GBV or Gender Equality crosscutting is ticked
Crosscutting Budget Allocation: Key Populations Checklist	Required if Key Populations crosscutting is ticked
Vehicle Information	Required if applicable
Construction or Renovation Project Plan	Required if applicable
Government to Government Funding	Required if applicable
PPP	Required if applicable
Management and Operations	
Agency Costs of Doing Business, including total and applied pipeline figures	Required from all OUs
Facts Info Staffing Data Module	Required from all OUs

Agency functional staff charts	Required from all OUs
Chief of Mission Letter	Required from all OUs
Financial Supplemental Worksheet	Required from all OUs
Summary of Gender Analysis	Required from all OUs
Justification for partner funding	Required if partner exceeds 8 percent of budget
Local Civil Society Planning and Participation Overview in FY 16 COP	Required from all OUs
Laboratory Construction or Renovation Project Plan Supplemental	Required for BSL-3 and enhanced BSL-2 laboratory projects
Activity Table for New IMs and all G2Gs	Required from all OUs
Implementation Science and Impact Evaluation Concept Note	Required if conducting research/evaluations
Site Improvement through Monitoring System (SIMS) Action Plan (SAP)	Required from all OUs
Sustainability Index and Dashboard (SID) 2016	Required for all COP programs; strongly recommended for 1-2 countries within ROP OUs
Systems and Budget Optimization Review Template	Required from all OUs
PEPFAR Budget Allocation Calculator (PBAC)	Required from all OUs
Human Rights Agenda	
Report on inclusion of non-discrimination into PEPFAR trainings	Required from all OUs
Summary Status of Gender & Sexual Diversity (GSD) Training	Required from all OUs
Legal Environment Assessment (LEA)	Required from all OUs
Stigma and discrimination Assessment	Required from all OUs
Stakeholder planning/review meeting on findings and recommendations from LEAs and stigma assessments	Required from all OUs
Evaluation Plan	Required from all OUs that fund evaluations

2.0 PEPFAR'S APPROACH TO PROGRAM PLANNING AND DECISION-MAKING

2.1 Global Overview and Context

The Joint United Nations Programme on HIV/AIDS' (UNAIDS) *Fast-Track – Ending the AIDS epidemic by 2030* report sets clear 2020 targets for treatment, prevention, and discrimination that will "break" the epidemic in order to reach the 2030 targets of 95 percent treatment coverage, reduced new infections so that AIDS is no longer a global health threat, and zero discrimination.[2] By fast-tracking the AIDS response in low- and middle-income countries, the world would avert 28 million new HIV infections between 2015 and 2030 and 21 million AIDS-related deaths between 2015 and 2030. To reach the 2030 Fast-Track targets, "…the number of new HIV infections and AIDS-related deaths will need to decline by 90 percent compared to 2010."

During the 2015 Sustainable Development Goals Summit and the 2015 United Nations General Assembly, President Obama set a bold course for PEPFAR by announcing new HIV prevention and treatment targets for 2016 and 2017 as well as that PEPFAR is now investing nearly half a billion dollars to support an AIDS-free future for adolescent girls and young women, including strategically aligning $300 million in prevention investments in support of our DREAMS partnership and related efforts. Specifically, the President announced that, through PEPFAR, the United States will:

- By the end of 2016, achieve a 25 percent reduction in HIV incidence among adolescent girls and young women (aged 15-24) within the highest burden geographic areas of 10 sub-Saharan African countries.
- By the end of 2017, achieve a 40 percent reduction in HIV incidence among adolescent girls and young women (aged 15-24) within the highest burden geographic areas of 10 sub-Saharan African countries.
- By the end of 2016, PEPFAR will provide 11 million voluntary medical male circumcisions for HIV prevention, cumulatively.
- By the end of 2017, PEPFAR will provide 13 million voluntary medical male circumcisions for HIV prevention, cumulatively.
- By the end of 2016, PEPFAR will support a total of 11.4 million children, pregnant women receiving B+, and adults on life-saving anti-retroviral treatment.

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[2] UNAIDS. (2014). *Fast-Track: Ending the AIDS Epidemic by 2030.* Geneva, Switzerland: Author.

- By the end of 2017, PEPFAR will support a total of 12.9 million children, pregnant women receiving B+, and adults on life-saving anti-retroviral treatment.

On September 30, 2015, the World Health Organization (WHO) released their "Guideline on when to start antiretroviral therapy and pre-exposure prophylaxis for HIV." This guideline expands the eligibility criteria of life-saving treatment to all persons living with HIV (PLHIV) and highlights new developments in HIV combination prevention, including pre-exposure prophylaxis (PrEP). The WHO guideline is transformative to achieving epidemic control. Short of an HIV vaccine or cure, the WHO guideline provides the critical tools we need to create an AIDS-free generation utilizing the UNAIDS Fast-Track strategy, particularly the focus on global targets for "breaking" the AIDS epidemic by 2020. Building on the new PEPFAR targets and the new WHO guideline, we must seize this moment and chart a bold course together to end AIDS as a public health threat.[3]

2.1.1 PEPFAR's Role and Response

For COP 2016, the goal for PEPFAR is to reach the President's ambitious targets for 2016 and 2017. Teams will capitalize on the momentum created by the WHO guidelines to advance sustainable control of the HIV epidemic and ultimately achieve an AIDS-free generation. Success will be measured and monitored at the site level (e.g., with the most granular data available).

Our success will be measured by how effectively we target and tailor our efforts, together with our partners, toward sustainable control of the epidemic. Teams should continue to refer to *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation,* which describes how **PEPFAR can best support sustainable control of the epidemic by pivoting to a data-driven approach that strategically targets geographic areas and populations where HIV/AIDS is most prevalent, and in which we can achieve the greatest impact for our investments.**[4] The report outlines PEPFAR's five action agendas that advance the five core principles of the *PEPFAR Blueprint,* support achievement of PEPFAR's new HIV prevention and treatment targets, and provide a pathway toward sustainable control of the epidemic:

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[3] World Health Organization. (September 2015). *Guideline on When to Start Antiretroviral Therapy and On Pre-Exposure Prophylaxis for HIV.* Retrieved from:
http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf?ua=1

[4] The Office of the U.S. Global AIDS Coordinator. (2014). *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation. Retrieved from*
http://www.pepfar.gov/documents/organization/234744.pdf

- **Impact Action Agenda** – Do the right things, in the right places, right now.

- **Efficiency Action Agenda** – Increase transparency, oversight, and accountability across PEPFAR and its interagency partners.

- **Sustainability Action Agenda** – As services are expanded to reach epidemic control, ensure that the factors required to sustain control are in place.

- **Partnership Action Agenda** – Share responsibility with our partners to achieve an AIDS-free generation.

- **Human Rights Action Agenda** – Respect human rights and address the human rights challenges faced by those living with and affected by HIV/AIDS.

Through the Impact Agenda, PEPFAR is focused on delivering ***the right things, in the right places, right now, in the right way***. Specifically, this means:

- The **right things** means expanding access to a combination of HIV/AIDS prevention, treatment, and care services that are most effective and efficient in preventing new HIV infections and saving lives. This includes: antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), voluntary medical male circumcision (VMMC), HIV testing services(HTS), condoms, and targeted prevention, treatment and care, for key and priority populations.

- The **right places** means targeting our resources and HIV/AIDS services to the geographic areas and populations with the highest HIV/AIDS burden, including at the sub-national level..

- **Right now** means positioning countries to control their epidemics as quickly as possible and, ultimately, achieve an AIDS-free generation, as continually fighting an expanding epidemic is not programmatically or financially sustainable.

- **Right way** means respecting human rights, especially challenges faced by those living with, and affected by, HIV/AIDS.

To continue PEPFAR's data-centered business model in the 2016 COP planning process, PEPFAR teams will conduct a series of enhanced data analysis and interpretation steps. The purpose of this approach is to enable teams to validate that PEPFAR programs are optimally focused to accelerate the scale-up of combination prevention interventions in prioritized populations and geographic areas. Importantly, the analysis and interpretation process will provide teams with the information needed to ensure that **PEPFAR programs are focused within countries on the <u>locations</u> and <u>populations</u> with the highest burden of HIV disease.**

Further, the PEPFAR Technical Considerations have been restructured for the 2016 COP to provide more streamlined guidance on key technical areas, including new areas and direction including pre-exposure prophylaxis (PrEP) and service delivery innovations. The SIMS Core Essential Elements have been mapped to the corresponding areas of the PEPFAR Technical Considerations to facilitate use of the Technical Considerations in supporting quality program improvement.

2.2 Defining program goals to accelerate epidemic control

PEPFAR defines **epidemic control** in standard epidemiologic terminology; *the point at which new HIV infections have decreased and fall below the total number of deaths among HIV-infected individuals.* Epidemic control is a critical milestone for achieving an AIDS-free generation and should be a central focus of all PEPFAR planning and monitoring activities. Achieving and sustaining epidemic control will stem the global pandemic, reduce the disease burden on communities and health systems, decrease the future costs of care and treatment, and enhance economic stability in resource-constrained settings by increasing the productive potential of people living in these areas.

The availability and use of high-quality data is a critical component of epidemic control. Data on HIV **incidence,** mortality, and other key elements are essential to evaluating progress toward the achievement of epidemic control. In settings representing the highest burden of HIV, these data are often unavailable, not collected in sufficient detail (i.e., sub-nationally or by population), or collected too infrequently to inform short-term program decisions. Together with host country governments, PEPFAR and other stakeholders are working to improve the frequency and quality of key epidemiologic markers; however, implementing these studies and building surveillance systems requires substantial planning and resources. The HIV Impact Assessments will provide necessary data to monitor coverage and impact of programs and will be a valuable in understanding the gaps to reach epidemic control. Given the urgency in achieving the goal of epidemic control and the necessity for constant monitoring and course correction when needed, HIV program planners need a set of indicators that can serve as a proxy for epidemic control and can be routinely collected and analyzed to monitor program results. Within PEPFAR, teams are asked to design activities and set targets aimed at accelerating epidemic control and enhance the systematic gathering, analysis, synthesis, and interpretation of program data to more routinely measure progress. PEPFAR has defined a core

set of indicators to be collected and reviewed at least quarterly, as well as adopted the **UNAIDS 90-90-90** global targets for "breaking" the AIDS epidemic by 2020 as a framework for program planning.

In the 2014 publication, "*90-90-90 An ambitious treatment target to help end the AIDS epidemic[5],*" UNAIDS presents a compelling case for increasing global targets to achieve rapid scale-up of critical interventions proven to be most effective in reducing HIV transmission.   As the figures below demonstrates, achieving the UNAIDS Fast Track Targets can prevent 21 million AIDS-related deaths, 28 million infections can be averted, 5.9 million infections among children can be averted and 15-fold return on investment.

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[5] UNAIDS. (2014, December).   Fast-Track: ending the AIDS epidemic by 2030. Retrieved from http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report

Figure 2.2.1 New HIV infections in LMIC, 2010-2030, with achievement of ambitious Fast-Track Targets, compared to maintaining 2013 coverage
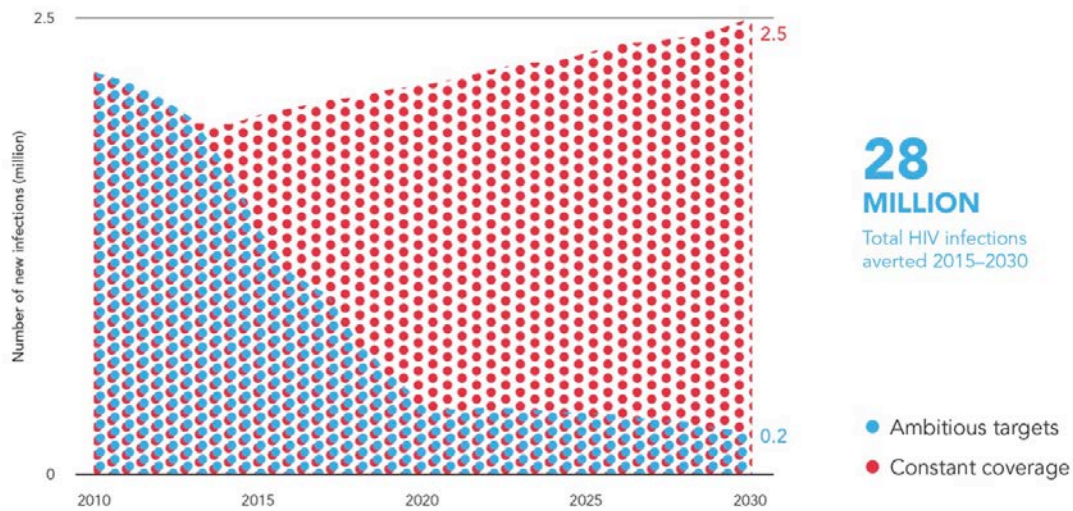
Figure 2.2.2 AIDS-related deaths in LMIC, 2010-2030, with achievement of ambitious Fast Track Targets, compared to maintaining 2013 coverage
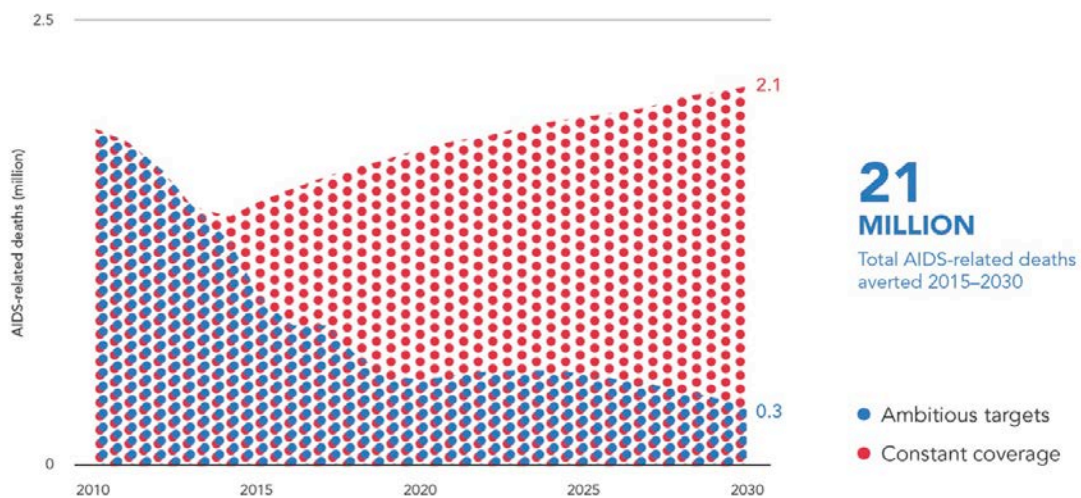
As the UNAIDS report outlines, achieving an end to AIDS by 2030 requires investments in a number of proven strategies, including those interventions known to be most effective in preventing transmission. These include the provision of ART, PMTCT, HTS, VMMC, condoms, and targeted prevention for key and priority populations—referred to jointly as '**combination prevention[6].**' In addition, barriers for uptake and access of combination prevention, such as stigma and discrimination and health systems limitations, must be addressed to achieve the 2030 goals. Though all of the aforementioned strategies are critical, the report clearly emphasizes the requisite scale-up of ART and improvements in adherence and retention if incidence is to fall as rapidly as models purport; i.e., "It will be impossible to end the epidemic without bringing HIV treatment to all who need it."[7] At the United Nations General Assembly 2015, the UN's 193 Member States endorsed the target of ending of the AIDS epidemic by 2030 as part of their unanimous adoption of the Sustainable Development Goals.

Recognizing the centrality of increasing ART coverage for epidemic control and elimination, UNAIDS has proposed ambitious global treatment targets for 2020. These include:

- *By 2020, 90 percent of all people living with HIV will know their HIV status.*
- *By 2020, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.*
- *By 2020, 90 percent of all people receiving antiretroviral therapy will have viral suppression.*

"Modelling suggests that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits."[10] These targets focus on increasing enrollment of people living with HIV (PLHIV) in ART programs and virologic suppression. It is important to note that modeling to derive estimates for incidence and mortality by 2030 also assumes rapid scale-up of other, critical combination prevention interventions, notably VMMC, condoms, and targeted prevention for key and priority populations.

The 90-90-90 treatment targets outlined above are meant to be inclusive of all countries and PLHIV; however, PEPFAR teams are asked to apply the same framework to specific locations and populations as a way to contextualize current program coverage, focus on the areas and populations

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[6] Please refer to the PEPFAR Technical Considerations 2014 for more detail on each component of combination prevention.

[7] UNAIDS. (2014, October). *90-90-90 - An ambitious treatment target to help end the AIDS epidemic.* Retrieved from http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

with the largest gaps and highest burden of disease, and more routinely monitor progress towards epidemic control and elimination. Given the differential impact of HIV geographically and by population group, the UNAIDS 90-90-90 framework for targeting should be applied with specificity to ensure programs are scaling testing and treatment first in areas with the highest unmet need and serving populations most likely to contribute to new HIV infections. **PEPFAR field teams should continue to employ the 90-90-90 framework in conjunction with epidemiologic data at the lowest sub-national unit available when setting targets and designing program activities**.

Employing the 90-90-90 framework specifically means translating those targets into specific percentages of PLHIV identified, enrolled and virally suppressed in each country. The UNAIDS 90-90-90 treatment targets translate to 81 percent of all PLHIV on ART (90% x 90%=81%) and 73 percent of all PLHIV virally suppressed (90% x 90% x 90%=73%). The resources required to diagnose, enroll in care, and treat over 80 percent of all PLHIV with ART in most countries are substantial. PEPFAR is often one of the largest funders of the HIV response in countries and regions in which we operate and USG resources are not sufficient to fully finance the gap between current ART coverage and 81 percent in any PEPFAR operating unit. This underscores the need for our investments to be tightly focused on the areas and populations where the number of new infections is likely to be highest and well-coordinated with others in the national response. It also requires that each dollar be invested in the optimal mix of interventions and support for a given context, and that programs are implemented with increasing efficiency and quality, as demonstrated by routine results and performance data.

PEPFAR recognizes countries are on different paths in the progression towards epidemic control. As such, PEPFAR teams are asked in planning for this year's COP to mobilize all available data, systematically engage with the host country government and key stakeholders to comprehensively outline the national/regional context for the HIV response, and define tangible goals for sustainable epidemic control in the near term. Specifically:

PEPFAR teams are expected to submit COPs that are strategic and include targets that will assist host country governments to reach 80 percent coverage of PLHIV on ART by the end of USG fiscal year 2017 (September 30, 2017)*..*

The biggest change is that shared responsibility means more than just fiscal co-investment, it also means implementing the key policies needed to break the back of the pandemic, including: implementing Test and Start, and updating the service delivery paradigm to

differentiate care based on patient characteristics (e.g., scheduling routine appointments for well patients to occur every 6 months or more, including refills).

Teams will need to balance and align the priority for achieving 80 percent ART coverage in specific geographic areas and populations with goals of scaling other critical combination prevention interventions and alleviating gaps and barriers that impede sustained success. Achieving 80 percent coverage of PLHIV with ART should not be the only component of a plan to achieve sustained epidemic control; however, **it is a minimum requirement for locations and HIV-infected populations selected for focus.**

Understanding where and in what populations new infections are most likely to occur and the barriers to reaching program scale will likely require new ways of gathering, analyzing, synthesizing and interpreting data to best inform program decisions. Interagency decisions about geographic and population focus and the optimal mix of services and support to achieve the stated goal for sustained epidemic control should be data driven and anchored in science, standards of practice, and implementation realities. In particular, to justify and guide investments for key and priority populations data solely for risk behaviors will not suffice, and data showing elevated HIV prevalence and where possible to obtain these data about HIV incidence relative to the general population as well as size estimates need to be obtained. PEPFAR supports countries and regions through a variety of program activities at various levels in the health system. Though the types of services and support are often different between targeted assistance (TA) and technical collaboration (TC) and long-term strategy (LTS) operating units, the ultimate goal remains the same—epidemic control in a subset of locations and populations by the end of USG fiscal year 2017. In TA/TC countries, this means that PEPFAR investments should be associated with demonstrable increases in, and sustainability of, coverage of testing, treatment and prevention services, even if PEPFAR is not directly paying for those services.

In order to define data-driven, near-term, and achievable goals for sustained epidemic control, it is recommended PEPFAR field teams adopt an enhanced strategic approach to program planning and COP development. This approach requires adequately addressing six primary questions in each unique program context:

1. What does it take to get to achieve and maintain epidemic control in 12 months?
2. How will PEPFAR invest more strategically to maximize impact of the program?
3. How will decisions be monitored throughout the year with data and deliverables?

4. How are the key challenges for a sustainable national response being addressed, especially through health diplomacy, technical support and/or other interventions?

5. How were civil society and other key stakeholders, including the partner government and the Global Fund, engaged in COP development?

6. How are significant human rights issues for key and priority populations being addressed by the PEPFAR team?

Sufficiently addressing each of these questions requires key data elements, analytics, and process milestones. The subsequent sections in this chapter will focus on questions 1-5. Recommended approaches to adequately address questions 6 can be found in section 2.3.

2.3 Coordination and Strategic Communication with External Partners during COP Planning

To achieve sustained control of the HIV/AIDS epidemic and, ultimately, an AIDS-free generation, it is essential that PEPFAR teams actively and routinely coordinate and communicate with our external partners. These partners include host country governments, multilateral organizations, bilateral donors, the private sector, civil society, and faith-based organizations. Teams are encouraged to leverage multi-stakeholder forums for sharing routine PEPFAR information, including POART data and for COP planning.

2.3.1 Host Country Governments

PEPFAR is committed to strengthening and maintaining its partnership with host country governments to ensure alignment between PEPFAR contributions and national priorities and investments. Collaborative planning between PEPFAR and host country governments is critical to ensuring; prioritized interventions are pursued, geographic priorities are shared, and that all available resources for HIV/AIDS in the country are optimally utilized. Country teams should regularly consult and communicate with the Ministry of Health (at various levels), the National AIDS Control Authority (or its equivalent), other relevant Line Ministries and other relevant government leaders, e.g. Office of the President and/or Prime Minister. This engagement is critical to ensure that PEPFAR's role in the national response, as well as its strategic focus on achieving and sustaining epidemic control, is well-understood.

For COP planning purposes, consultation should start at the very beginning of the planning process, ideally with the initiation of the Sustainability Index and Dashboard development (see Section 3), and continue at regular intervals throughout the COP's development to maximize its utility in informing PEPFAR and host country government planning. Throughout COP development, teams should review data analysis and results with host country counterparts and discuss interpretation. This engagement should continue throughout the annual implementation cycle, particularly during POART, the quarterly program monitoring of results, quality and financial data for enhanced impact.

2.3.2 Multilateral and Private Sector Partner Engagement

Multilateral Partners

During the COP development process, teams should continue to coordinate with multilateral partners to ensure alignment between their investments and PEPFAR investments to achieve the shared vision of 90-90-90 by 2020. As noted in section 3.1.1, teams are encouraged to collaborate with UNAIDS country offices to co-convene the multi-stakeholder process for completing the Sustainability Index and Dashboard (SID). External partners will also be invited to fully participate throughout the in-country COP preparation process and during the COP Review/Approval in-person meeting. As with COP 2015, PEPFAR teams should work with multilateral organizations to identify in-country representatives to attend their COP Review meeting. PEPFAR country teams should also engage multilateral partners at other stages in the PEPFAR operating model, including; before and after POART calls, during organization of site visits and technical assistance visits (TDYs).

Section 2.3.3 includes best practices to ensure engagement with multilateral partners and civil society organizations is meaningful.

Private Sector Partners

No one government or entity can address the HIV epidemic alone, success relies on building meaningful and wide-ranging partnerships with the private sector at the global and local levels. Scalability and sustainability of programs is more likely to be achieved with support and collaboration of the private sector, and as such teams are encourage to build partnerships with a diverse set of private sector stakeholders.

Private Sector Engagement (PSE) strategies and Public-Private Partnerships (PPPs) are enablers that leverage resources (in-kind, cash, or other) to achieve epidemic control. PEPFAR defines PPPs as collaborative endeavors that coordinate public sector resources with private sector resource contributions (financial or in-kind) to accomplish HIV/AIDS prevention, care, and treatment goals. It is essential to align PPPs with core programmatic goals and work collaboratively with other technical areas including sustainability, domestic resource mobilization (DRM), human resources for heath (HRH), program quality, etc. to accelerate outcomes and results. All country teams are strongly encouraged to engage private sector stakeholders as early as possible during the COP process to help explore strategies, resource commitments, and the possibility of aligning proposed co-investments with core and near-core priorities.

Accountability of PPPs is essential and integrated within the routinized processes for reporting of results for PEPFAR programs. Entering into non-binding Memoranda of Understanding (MOU) is a critical tool in which all partners are expected to outline in detail roles, responsibilities, as well as procedures for addressing ongoing PPP activities throughout the life cycle of the partnership. For PPPs and their respective proposed MOUs that involve the State Department, The Office of U.S. Global AIDS Coordinator and Health Diplomacy, and other State Department offices, have additional oversight responsibilities.   Therefore, the Office of U.S. Global AIDS Coordinator and Health Diplomacy must be consulted on all such proposed PPPs (including any proposed MOUs) to ensure appropriate State Department approval.

Further guidance on aligning strategies, assessing contributions, and developing investment profiles within the COP are outlined in the Sustainability Index and Dashboard (SID) 2.0 Private Sector Engagement domain. Please see Appendix 7 for more details on the available PPP toolkit to help support country teams with private sector engagement and PPP development during the COP.

2.3.3 Active Engagement with Civil Society

The full participation of civil society in every stage of our programming and planning, from their advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global

effort to combat HIV.[8] Civil society has been a leading force in the response to HIV since the beginning of the epidemic, and this longstanding involvement has resulted in expertise and relationships with local communities that non-indigenous organizations often struggle to achieve. It is key to ensure that civil society engagement is commensurate with where the HIV burden lies and with proportional voice at the table.

Civil society organizations (CSOs) provide services that are crucial to realizing donor strategies. They work closely with and advocate on behalf of beneficiary populations, promote human rights including combatting stigma and discrimination, help identify challenges to and gaps in health care delivery, collect data, provide independent oversight of programming and processes, and promote transparency. Furthermore, from an ethical and human rights perspective and from a program quality standpoint, it is imperative that affected populations have a voice in how the programs that serve them are designed and implemented. Therefore, active engagement with local civil society organizations remains an important requirement of the PEPFAR program and the feedback provided to us by civil society representatives has informed the guidance that follows.

Who to Engage?

The mix of CSOs should reflect the HIV disease burden of the country and among populations affected by HIV. Establishing linkages with credible networks and coalitions is important to achieving broader civil society representation. Civil society organizations include: local and international non-governmental organizations; networks/coalitions; professional associations; activist and advocacy groups, including those representing key and priority populations; organizations representing people living with HIV/AIDS; groups representing other populations highly affected by the epidemic, such as persons with disabilities and woman and girls; PEPFAR program beneficiaries or end users; faith-based organizations; community associations; and not-for-profit organizations at national, district, and local levels.

PEPFAR teams should seek the inclusion of a diverse range of civil society organizations in consultations, taking into account that this process likely will require proactive outreach to ensure all

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[8]UNAIDS & Stop AIDS Alliance. Communities Deliver: The Critical Role of Communities in Reaching Global Targets to End the AIDS Epidemic. Geneva and Hove: 2016. Available from http://www.unaids.org/en/resources/documents/2016/JC2725_communities_deliver.

key and priority populations are represented. Additionally, PEPFAR teams should include organizations from within and outside of the capital (e.g., by phone) and should ensure that both rural and urban interests are represented. The presumption should be to include all groups that voice interest in engagement; if teams become concerned that the number of organizations being engaged is growing too large, strong consideration should be given to hosting quarterly consultations remotely (i.e. by phone or webinar, as is outlined below) to allow maximum participation.

In 2016, external partners will be invited to fully participate throughout the in-country COP preparation process and during the COP Review/Approval in-person meeting. Rather than making the selections themselves, PEPFAR teams should ask local civil society to select up to two representatives to attend their COP Review meeting and should plan to use management funds or the ambassador's small grants program or existing implementing mechanisms to support the costs associated with supporting civil society participation at all levels of planning to facilitate ongoing and active participation and dialogue. For concentrated epidemic countries, it is recommended that at least one of the representatives should be from a key population's civil society organization to represent the interests and concerns of the population(s) that may be driving the epidemic.

Ensuring Meaningful Engagement

PEPFAR teams are expected to expand their collaboration with local civil society, including activists, advocacy groups, and service delivery organizations, to ensure that they are actively engaged in PEPFAR processes and in the country-level HIV/AIDS response. PEPFAR teams should proactively solicit input from civil society regarding their goals, priorities, targets, and budgets for COP 2016 well before starting to draft the document. PEPFAR teams also should be mindful of the need to include both funded and non-funded organizations; being funded does not inherently conflict with an organization's representation of the community, nor should it be expected to influence the organization's advocacy. Particular attention should be given to including civil society and activist groups who are not funded directly by PEPFAR, as they can provide an important outside perspective. Additionally, civil society partners must be informed that they can and should share frank assessments of and feedback about PEPFAR programming with the PEPFAR team without fear of losing access to PEPFAR processes or resources. As reflected in the Step 1 of the guidance below, PEPFAR teams are also encouraged to establish terms of reference for the engagement of their local partners, inclusive of needed conflict-of-interest guidelines.

As PEPFAR countries transition to local ownership, many national governments will depend on civil society to an even greater extent to meet the health needs of their citizens. Meaningful engagement with PEPFAR builds the capacity of local CSOs to meet this challenge, better preparing them to play a leadership role now and in the future.

The steps below outline the four minimum steps PEPFAR teams must take to ensure meaningful engagement with civil society organizations. These steps can also be applied toward engagement with multilateral partners (see Section 2.3.2).

1. Develop a plan for engaging different organizations: Each country should prepare a plan for engagement, including engagement specifically related to the quarterly POART process and for COP development. PEPFAR teams should ensure that organizations have a clear understanding of the USG PEPFAR team's expectations regarding their input in PEPFAR processes (e.g., quarterly POART review and COP development), the purpose of each meeting, which documents and data they can expect to be provided to them prior to the meeting, and when their feedback is due to the PEPFAR team.

2. Convene engagement meetings: Formally structured consultation meetings must occur on at least a quarterly basis before the POART calls. The consultation meetings may be conducted in person or remotely (i.e., by phone). For in-person meetings, the meeting location should be agreed upon by the PEPFAR team and organization representatives; whenever possible, these meetings should be held outside of the embassy unless the representatives would prefer to meet there or doing so is necessary in order to maximize USG engagement. For remote (i.e., by phone) meetings, PEPFAR teams must permit all members of civil society to participate. PEPFAR teams also should ensure that there exists a mechanism for sharing information with, and receiving input from, those not able to attend any in-person consultations.

Regardless of whether meetings are held in person or remotely, PEPFAR teams may

1) issue open invitations and facilitate engagement

2) support and partner with civil society networks to convene the meetings;

3) partner with UNAIDS to convene civil society and facilitate the consultation meetings;

4) schedule their engagement meetings around Global Fund's CCM meetings to take advantage of the fact that many representatives may already be gathered in one place for the latter. In addition to independent consultations, PEPFAR teams are encouraged to schedule a joint dialogue with multilateral organizations, civil society, and partner government representatives.

Consultation meetings should, if possible, be conducted in person. PEPFAR teams also should ensure that there exists a mechanism for sharing information with, and receiving input from, organizations not able to attend any in-person consultations. Relevant documents and data that are to inform the discussion should be shared as early as possible in advance of the meeting, a minimum of one week. Additionally, PEPFAR teams should strive to ensure that organizations have a good understanding of the data being shared with them. In some cases, this may entail providing one or more training sessions (where feasible) to build CSO capacity.

In addition to the formally structured POART quarterly consultation meetings, there should be ongoing engagement and dialogue throughout the year. Engagement around topics such as COP/ROP development and reviews, and ongoing program monitoring and evaluation will further build CSO capacity.

3. Solicit written feedback: PEPFAR teams should solicit written feedback from organizations on the proposed COP goals, budgets and targets, and current performance. As is noted above, it is the team's role to ensure that organizations have sufficient information about the program for this process to be meaningful; this will entail disseminating relevant documents and data to them in a timely manner and ensuring that they understand the data that were sent to them.

4. Provide written feedback: PEPFAR teams must provide timely written responses to any written feedback received. For feedback specific to the COP, the responses should inform the representatives as to which inputs will be incorporated into the draft and which will not, and should explain why these decisions were made. Once the COP is approved, teams should convene a meeting to provide organizations with details regarding the approved 2016 plan.

In the case of civil society, S/GAC requires PEPFAR teams to share the written feedback provided to civil society representatives with their Country Lead. Additionally, PEPFAR Country Teams should submit written feedback that they provide to civil society as annexes to the *Local Civil Society Planning and Participation Overview*, which is to be submitted with the 2016 COP.

Civil Society Engagement Process Documentation Requirement

PEPFAR teams are required to respond to a series of questions about their civil society engagement process. The completed two-page summary, "*Local Civil Society Planning and Participation Overview*" should be submitted as a supplemental document in FACTS Info at the time of COP submission, along with copies of written feedback to/from civil society. Section 3.3.2 contains the *Local Civil Society Planning and Participation Overview* template and a check-list that teams can use as they plan their engagement with civil society.

2.3.4 Coordination among U.S. Government Agencies

A key feature of PEPFAR is its whole-of-government approach that rests on a robust and productive U.S. government interagency response. All agencies working in a country or region are expected to work together to gather and analyze all available programmatic, epidemiologic and financial data, which will include partner work plans, and partner and site level data. The data should be used to help inform planning and implementation of a unified country program as one U.S. government team. In most cases, a PEPFAR Coordinator facilitates a process that supports this principle. **It is essential that all USG agencies working on HIV/AIDS programs in a country be included in all levels of discussion regarding the COP.** For agencies that have in-country programs but no direct in-country presence, this includes communication through email and telephone. Country programs may have several sources of USG HIV/AIDS funding (e.g. State, USAID, GAP funds); however, all HIV/AIDS programming decisions are to be made as an interagency U.S. government team with final coordination and approval by S/GAC.

The quarterly reviews and data analyses with the interagency PEPFAR Oversight and Accountability Response (POART) teams at headquarters require routine interagency discussion, facilitating the one U.S. government approach that will ensure a well-vetted COP is reached prior to submission. The POART is an ongoing dialogue throughout the year that routinizes data sharing and transparency, which is critical to a successful COP process. The actions generated by the POART reviews should guide a country's COP development. If any agency does not have staff or activities in-country, the country team may still draw on the expertise of a non-presence agency to benefit the program and may use the POART and COP processes to solicit that agency's expertise.

In preparing the COP and throughout the year, PEPFAR programmatic staff should consult with relevant non-program offices in all agencies, such as human resources, management, financial, general services, scientific review, acquisition, grants, general counsel, and policy officials at the appropriate levels to ensure that there is sufficient administrative and management support to facilitate PEPFAR activities. For example, the Embassy Management and Human Resources Offices are key partners in evaluating current and planned staffing for program management, oversight and accountability. Similarly, all procurement and assistance actions must be coordinated with the appropriate agency's procurement office prior to COP approval and during implementation. Each agency must utilize any established agency financial forecasting systems during COP implementation. It is the onus of the agency to ensure approved COP activities can be funded and implemented in accordance with their own agencies' timelines.

Finally, it is a recommended best practice and it is expected, that draft scopes of work for any new/renewed procurements will be carefully reviewed in an interagency manner at the country level before being included in the COP and/or being submitted into official agency acquisition and award processes.

2.3.5 Human Rights

Reaching the goal of an AIDS Free Generation not only requires robust clinical interventions, but simultaneously requires addressing social, cultural and legal barriers that result in hostile environments creating barriers to equal access to health services for all people living with and affected by HIV. This requires not only the training of those at all levels of service delivery to reduce stigma and discrimination but also building the capacity of civil society organizations, engaging host country governments, and working in concert with our multilateral and other bilateral partners to create an enabling environment. In these partnerships and throughout all of our programs, we are committed to ensuring that grantees receiving PEPFAR funds implement their programs in a way that supports promotion, protection, and respect for human rights.

Stigma, Discrimination and Human Rights

Stigma and discrimination as well as harmful laws and policies reduce access to and use of essential health services and undermine efforts towards effective responses to HIV/AIDS. PEPFAR is committed to joining others to end stigma and discrimination against people living with HIV/AIDS, vulnerable and key populations and to increasing their access to, and uptake of, HIV prevention, treatment, and care services.

Using the frameworks of good public health and human rights, we strive to reach all affected populations with core HIV services without discrimination, even when facing difficult cultural contexts, severe stigma, or challenging security environments.

Working together, we have made considerable gains in preventing new HIV infections and reducing AIDS-related deaths globally. Yet, in the context of addressing stigma and discrimination and respecting human rights, much work remains to be done.

To control the epidemic and, ultimately, achieve an AIDS-free generation it is imperative that we identify and understand the often complex dynamics driving stigma and discrimination, and develop innovative, community-led approaches to address them.

PEPFAR also recently completed gender and sexual diversity trainings for PEPFAR countries, except Burundi. The training focused on the epidemic's disproportionate impact on gender and sexual minorities, key terminology, local context, and responsible engagement. PEPFAR trained over 2,700 PEPFAR staff at headquarters and throughout the field, implementing partners, other U.S. government staff, and UN staff.

While each of the actions outlined in this guidance is discrete, they are all part of a framework to promote human rights and address stigma and discrimination by creating an enabling environment (e.g., social and legal) where access to HIV prevention, treatment and care is possible.

In this context, four core principles should be considered in all PEPFAR programs and service delivery points**:**

- **Availability:** Are there functioning HIV facilities, commodities, services, and programs in sufficient quantity to meet the needs of the affected populations?

- **Accessibility**: Are HIV services accessible, including facilities, signs and medical equipment with accommodation for the physically, visually or hearing impaired? Is information provided in an accessible way (for example, in plain language that the individual can understand)?

- **Acceptability:** Are services respectful of human rights: including informed consent, privacy rights, culturally appropriate, and sensitive/respectful to age, gender, sexual orientation, occupation, and present or past drug use?

- **Quality:** Are HIV service delivery, research, and data gathering practices scientifically and medically appropriate? Are all patients treated with respect in the provision of high-quality services?

To achieve these principals, PEPFAR's human rights framework will focus on these key areas:

- Reducing stigma and discrimination in HIV service delivery/health care settings.

- Ensuring that environmental assessments and data for decision making are gathered to optimize patient care, improve program monitoring and strengthen access to and quality of services provided.

- Supporting advocacy initiatives and educational programs to promote human rights, Patient Rights and Access to Quality Services, and community mobilization to address social, cultural and legal customs that create barriers to achieving an AIDS-free generation.

COP 2016 Requirements and Recommendations for Human Rights Agenda

The following are **Required** Actions for all PEPFAR field teams.

Trainings on Non-Discrimination

1. Include a section on non-discrimination in all PEPFAR trainings, including but not limited to, trainings held for direct service providers receiving PEPFAR funds. With the COP submission include a summary detailing how non-discrimination was included in all PEPFAR-sponsored trainings (additional information on the summary is available on the COP 16 page of pepfar.net).
2. Establish an in-country, interagency point-of-contact and a date for a refresher of the annual Gender and Sexual Diversity (GSD) training for all country team staff. Implementing partners should be invited as appropriate. At least one refresher GSD training should be conducted within the calendar year. All materials from Health Policy Project's GSD training will be made available as a resource for all teams to use in the facilitation of the in-country training. With the COP each team should submit their proposed timeline for conducting the training for staff and the selected implementing partners.
3. After the GSD training has been conducted, the team will submit to their Country Lead a brief summary of the training, including but not limited to number of participants and overall response of the participants.

Data for Decision Making and Creating an Enabling Environment

4. Conduct a Legal Environment Assessment (LEA) if it has not been done in the last three years. An LEA analyzes the extent to which the legal, regulatory and policy framework in a country supports or hinders effective national and local responses to HIV and AIDS.

    o   If a LEA has been conducted in the last three years, convene, create or support a process to implement the assessment's recommendations and monitor achievements in collaboration with civil society organizations, domestic human rights institutions, human rights defenders and multilateral partners.

5. Conduct a stigma assessment within your country if it has not been completed in the last 3 years. A stigma assessment is used to document and assess the prevalence of experienced discrimination in healthcare settings providing HIV services.

    o   If a stigma assessment has been conducted in the last three years, convene, create or support a process to implement the assessment's recommendations in collaboration with civil society organizations, faith-based organizations, multilateral partners and members of populations most impacted by the epidemic including PLWHA, key populations, and other vulnerable populations.

6. Conduct a stakeholder meeting as a component of the COP/ROP planning to review existing findings and recommendations from stigma assessment and Legal Environment Assessment (LEA) (or other relevant materials if these do not exist or are not current) to determine opportunities to reduce stigma and discrimination through diplomacy or programmatic efforts. Provide summary of meeting findings and recommendations and how PEPFAR will engage.

Supporting Patient Rights and Access to Quality Services

7. Ensure that all clinics and other PEPFAR-supported settings where HIV-related services are provided display information on the rights of patients (display information is available on pepfar.net). In coordination with Global Fund, develop regular review process of service delivery and discrimination complaints, and enacted plans to address patient rights violations.

Expanded Focus on Human Rights, Democracy and Governance & Ending Discrimination

Ambassador's Small Grants Program to Support Local Civil Society Advocacy and Community Mobilization

PEPFAR is committed to the role of community advocacy and mobilization toward achieving an AIDS-free generation and the UNAIDS Fast Track goals.

For the past three years PEPFAR has provided support to the Robert Carr civil society Networks Fund (RCNF) to strengthen global and regional networks in addressing critical factors for scaling up access to HIV prevention, treatment, care and support and vulnerable individuals and members of key populations across the world. Since 2012, the RCNF has supported 54 global and regional networks and consortia of such networks to advocate and build local level capacity for improved HIV prevention, care and treatment and the promotion of human rights. A list of grantees can be found at www.robertcarrfund.org/grantees.

Along with the RCNF, PEPFAR launched the Local Capacity Initiative to support local NGOs in 14 PEPFAR countries/regions in building their capacity to address the HIV/AIDS epidemic through legal and policy advocacy; stigma and discrimination reduction; and planning and implementation of country programs.

Recognizing the need for additional methods to support the development of local civil society, community mobilization and advocacy, PEPFAR is establishing an Ambassador's small grants program specifically to support local civil society advocacy and community mobilization. This is in addition to the current PEPFAR-funded Ambassador's small grants program.

3.0 MODULAR PLANNING STEPS TO IMPLEMENT ENHANCED STRATEGIC APPROACH

3.1 Modular Planning Steps

Successful implementation of the enhanced strategic approach requires a series of key analyses and decision points that necessitate interdisciplinary engagement from all technical areas within a PEPFAR team. Given the unique context of each PEPFAR operating unit (OU) and availability of data elements, prescription of a single step-wise approach to decision making is not possible. However, there are clear steps that every PEPFAR OU should complete to meet planning requirements and draft a technically strong Strategic Direction Summary (SDS). The steps, not intended to be followed in prescribed order, are as follows:

1. Understand the current program context
2. Assess alignment of current PEPFAR investments and program focus
3. Determine priority locations and populations for epidemic control and set targets
4. Determine program support and system-level interventions in which PEPFAR will invest to achieve epidemic control
5. Determine the package to sustain services and support in other locations and populations and expected volume
6. Project total PEPFAR resources required to implement strategic plan and reconcile with planned funding level
7. Set site, geographic and mechanism targets and budgets
8. Determine monitoring strategy for planned activities in accordance with requirements and assess staff capacity

Each planning step is intended to be modular, meaning, as stated above, there is not a prescribed order in which to complete each step. There are, however, certain dependencies between steps. For example, it would not be prudent to complete Step 7—setting site mechanism targets and budgets—until other steps have been completed. Further, it is likely several steps will be iterative (need to be revisited) as scenarios are compared and decisions are made. Section 3.2 below outlines these dependencies and a recommended workflow for successfully completing the steps.

Regardless of order, each planning step will require review of essential data and specific analysis techniques to be successfully completed. To improve ease of reference, call-out boxes are inserted within each planning step to highlight the following:

- **Key data elements and potential sources**

- **Tools, templates, and frameworks (TTFs)** available to assist country teams organize or analyze key data
- **Targeted assistance (TA) and Technical Collaboration (TC) special considerations**
- **Regional operating plan (ROP) special considerations**

Critically, within each step, there are *milestones* identified that each OU should complete in order to meet SDS and COP planning requirements in 2016.

Each PEPFAR OU is encouraged to be innovative in their approach to program design and planning, as this helps us collectively develop new insights. There are, however, specific activities/analyses that OUs are expected to complete, at minimum, to satisfy the requirements for enhanced strategic planning. These include updating core, near-core and non-core classification of program activities; civil society engagement and method documentation; site yield/volume analysis for HTS, PMTCT, and ART (where site-level data available); efficiency analysis of enhanced program focus; outlier analysis using EA results; and resource projections. The approach to completing these analyses are described in the methods portion of this section (3.3) and are essential to COP/ROP planning.

Wherever possible, the detailed descriptions for activities required to complete each planning step have been indexed to the SDS template to indicate where data, findings and decisions should be documented in the COP submission. For ease of reference, linkages to the SDS template are highlighted in grey.

3.1.1 Planning Step 1:
Understand the Current Program Context

To determine how PEPFAR should optimally invest to maximize impact, PEPFAR teams must:

- Review demographic, epidemiologic and national/regional program data to the lowest sub-national unit (SNU) possible.
- Demonstrate a clear understanding of how the response is funded and implemented, including the Global Fund Principal Recipient(s) and host country government.
- Identify critical sustainability gaps and weaknesses that may impede scale-up to achieve the stated goal for sustained epidemic control.

These reviews were first conducted by OUs for the FY 15 COP, and these assessments should be updated, incorporating new data and analyses. The results of these assessments should be described in the SDS, Sections 1.1-1.3. Additional detail on each critical element in this step is described below.

Review of Demographic, Epidemiologic and Program Data

PEPFAR teams are asked to update, gather, review and present key data describing the HIV burden of disease in the national/regional context, including percent HIV positives (# HIV positive and # tested for HIV) at sites and current program performance.

The purpose of this activity is to better understand the magnitude of the epidemic and current progress towards achieving adequate coverage of **combination prevention** to achieve epidemic control. Significant effort was made in COP 2015 planning to establish SNUs of focus for scale-up to saturation by the end of FY 17. Reviewing key epidemiologic and program data is important to understand if course corrections are needed, to establish if acceleration to program saturation is happening at a faster pace than anticipated, and to identify SNUs that could be the focus of program scale-up should resources from within the COP funds become available through efficiencies. Two standard tables in the SDS should be populated with key data to provide context for planning decisions.

Standard Table 1.1.1 outlines demographic and epidemiologic data for the national/regional context in which each PEPFAR OU operates. The table is organized to capture the key data points that should, at minimum, be reviewed prior to making program decisions. The data are disaggregated by age and sex (*note that data on female sex workers do not require age disaggregation*). This disaggregation is

increasingly critical as evidence mounts regarding the importance of focusing HIV activities on the populations with the highest HIV burden and unmet need, and therefore those most likely to transmit and acquire HIV.[9] Further, these populations will vary by country and region, and PEPFAR field teams should make every effort to populate this table in its entirety using any data available of reasonable quality. Cells indicated in grey do not require information to be entered. ***It is understood that not all countries will be able to populate every cell in the table; however, this exercise is also designed to highlight the areas where significant data gaps exist and where PEPFAR may need to invest to fill these gaps to better measure progress towards epidemic control.***

Every PEPFAR OU should, to the extent it is safe, collect data on prevalence within key populations and estimate the size of those populations. Data for four groups are required for all PEPFAR OUs: men who have sex with men (MSM), female sex workers (FSW), transgender people (TG), and people who inject drugs (PWID). Weaknesses in these data should be noted in planning and data collection methods planned to address these weaknesses should be in included in the COP. See UNAIDS Monitoring and Evaluation Guidance for protection of these data.

Field teams are also asked to identify specific priority populations on which they will focus in the coming cycle, and include an additional row for total size estimate *and* an additional row for HIV prevalence within each population listed.

NOTE: *For each priority population selected for targeting in the coming cycle and identified in Section 4.1 of the SDS, an associated size estimate and HIV prevalence value is expected in Table 1.1.1.*

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[9] UNAIDS. (2014, September). *The Gap Report*. Retrieved from
http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport

What is the difference between priority and key populations?

UNAIDS defines key populations as men who have sex with men, transgender women, sex workers, and people who inject drugs (UNAIDS guidance for partnerships with civil society, including people living with HIV and key populations, 2011). PEPFAR follows this guidance and also recognizes that other populations may need to be prioritized for HIV prevention, care and treatment, based on local epidemiology. For example, in many sub-Saharan African countries, females 15-24 are at substantially higher risk of acquiring HIV than males of the same age. These girls and women should be a priority population for PEPFAR programs. Priority populations should be chosen not just by risk behaviors, but by prevalence data. These populations should be targeted with comprehensive packages of HIV prevention interventions, and with ART for those living with HIV.

Figure 3.1.1 below demonstrates the heterogeneity of key and priority populations by location. This will also be relevant for geographic areas within a country.

Figure 3.1.1

People living with HIV (children and adults) are included as members of all of the featured populations. They are implicitly included in this map as they must have universal access to services.
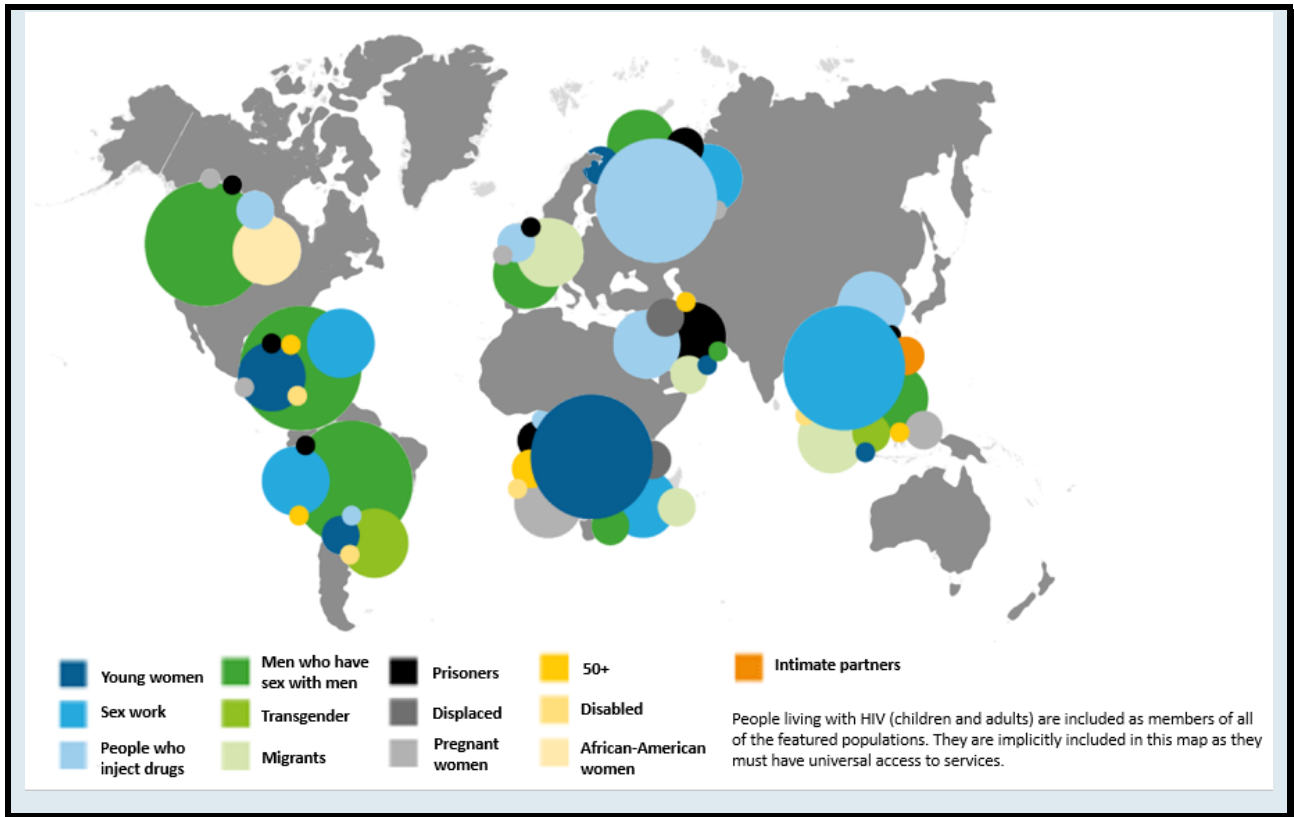
For every entry cell in Table 1.1.1 (except for those colored grey), PEPFAR teams should enter a numerical value or one of three letter codes:

1. **NA**: "not available"—indicates no data are available from any source
2. **IQ**: "insufficient quality"—indicates data are available, but the quality does not meet reasonable standards
3. **LG**: "limited generalizability"

Key Data Elements and Potential Sources for Standard Tables 1.1.1 and 1.1.2	
Data Inputs	**Potential Source**
Demographic data (national and subnational)	Central Statistics Agency, U.S. Bureau of Census, Demographic and Health Surveys
HIV Epidemiologic data (national and subnational)	Ministry of Health surveillance, Estimates from

	UNAIDS Spectrum and Subnational Estimates of HIV Prevalence Report, Surveillance Studies supported by PEPFAR
National Program Statistics Ministry of Health, TB Reports	Ministry of Health, UNAIDS, WHO
Estimates for Program Services (ART, Orphans, TB/HIV)	UNAIDS, WHO, DHS, MICS
Key Populations, HIV and size estimates (MSM, FSW, PWID)	Ministry of Health, UNAIDS, Surveillance Studies supported by PEPFAR and other surveillance reports
Priority Populations, HIV and size estimates	Ministry of Health, UNAIDS, Surveillance Studies supported by PEPFAR and other surveillance reports

Standard Table 1.1.2 provides data on the cascade for HIV prevention, diagnosis, care and treatment for the most recent 12-month period available. The purpose of this information is to better understand in a standardized fashion how effectively different populations are reached with combination prevention services, diagnosed, linked and retained in ART, and ultimately, achieve and maintain virologic suppression.   Identifying critical gaps in the clinical cascade can help PEPFAR and national/regional programs tailor activities to more effectively respond to unmet need and implementation realities.[10]   Monitoring these data over time establishes a critical feedback loop informing planners if program choices are moving the country or region closer to the goal of 90-90-90 by 2020 or if course corrections are needed. Table 1.1.2 will be populated in the Data Pack using data submitted for APR15 (e.g. PLHIV). If countries have more recent data from the most recent 12-month period available this data should be incorporated into the Data Pack and used in Table 1.1.2.

Cascade data in Standard Table 1.1.2 are disaggregated by population, necessary to effectively target based on burden of disease. The first row, "Total Population," should be inclusive of all subsequent rows and represents summary national cascade information across all populations. Rows 2 – 4 are a subset of the total population; "Population less than 15 years," "Pregnant Women," and "TB Patients & HIV Services Coverage among TB Patients." Sex workers are a key population in every epidemic and

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[10] World Health Organization. (September 2015). *Consolidated strategic information guidelines for HIV in the health sector*. Retrieved from: http://apps.who.int/iris/bitstream/10665/164716/1/9789241508759_eng.pdf?ua=1&ua=1

data on prevalence and population size should be included by every OU. Where data on MSM are available and can be safely presented, it should also be included. In all countries where prevalence is over 1 percent in the general population, data on pregnant women should be presented. In countries and regions where it is known that the epidemic is concentrated in PWID, data on this population should be presented. In addition, country teams should include a row and associated data for each priority population selected for PEPFAR program focus in the implementation cycle.   The priority populations listed should match those described in Standard Tables 1.1.1 and 4.1.4. With respect to care, treatment, retention and viral suppression, teams should include these data for key and priority populations when available and when it is safe to do so.

For every entry cell in Table 1.1.2, PEPFAR teams should enter a numerical value or one of three letter codes:

1. **NA**: "not available"—indicates no data are available from any source
2. **IQ**: "insufficient quality"—indicates data are available, but the quality does not meet reasonable standards
3. **LG**: "limited generalizability"

Standard Tables 1.1.1 and 1.1.2 are intended to present national data. PEPFAR-specific data may be substituted where national data are not available; however, this distinction should be clearly indicated with a footnote.

Concentrated Epidemic Considerations

PEPFAR programs in concentrated epidemic settings need not complete portions of Standard Table 1.1.1 related to PMTCT, OVC or Male Circumcision.

ROP Considerations for Standard Tables 1.1.1 and 1.1.2

Regional programs are expected to know the epidemiology and gaps in all countries where they work. However, they are not expected to submit Standard Tables 1.1.1 and 1.1.2 for each country in their region. Instead, regional programs should select the top 2-3 countries within their region, with both the largest PEPFAR investment, and the largest HIV burden.

The following is a recommended list of countries for each program to feature in Standard Tables 1.1.1 and 1.1.2. If the PEPFAR field team feels they should feature different, or additional countries, they should discuss their proposal with their CL.

Asia Regional: Thailand, China, Laos

Caribbean Regional: Jamaica, Trinidad and Tobago, Suriname, Guyana

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Central America: Guatemala, El Salvador, Honduras

Central Asia Regional: Tajikistan, Kyrgyz Republic, Kazakhstan

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Milestone: Complete Standard Tables 1.1.1 and 1.1.2 in the SDS template and adequately address guiding questions in Sections 1.1 of the SDS template.

Outline the Program Investment Profile

Regardless of program type or size of investment, the success of PEPFAR programs are dependent on the resources, management, and support contributed by the host country government and other key stakeholders in the HIV response (e.g., the Global Fund). In order to minimize duplication across funders/implementers, increase allocative and technical efficiency, and maximize impact on the epidemic, PEPFAR must have a clear understanding of how the current program is being funded and potential dependencies on other partners for success in achieving the stated goal for epidemic control. This includes, at minimum, data describing total investment by key program area and source of support, as well as data describing how critical commodities are procured. Country teams are expected to provide information describing and referencing as necessary other existing work plans for how central initiatives such as ACT, DREAMS, DREAMS Test and Start, DREAMS Innovation, VMMC, and viral load, as well as other partnerships (e.g., SMGL) are aligned with the priority questions to be addressed in these sections including transition planning expected by the conclusion of the initiative.

Two tables are provided in the SDS template to assist field teams with presenting these data (which are also a key input into the Sustainability Index) and are described in more detail below. Financial information should align with the appropriate designations within the investment portfolio section Standard Tables 1.2.3 and 1.2.4 as well as in the program area (1.2.1) and procurement profile (1.2.2) summary to fully describe activities, targets, results.

Standard Table 1.2.1 is required of all PEPFAR OUs and outlines the investment profile of the national/regional HIV response.

Key Data Elements and Potential Sources	
Data element(s)	**Potential Sources**
Total Expenditure by Program Area and Funder	National AIDS Spending Assessment (NASA) National Health Accounts (NHA) Other formal national resource tracking activities (e.g., Resource Mapping) Meeting proceedings and joint planning/analysis activities across funders (e.g., Investment Approach, etc.) Global Fund Annual Financial Reporting (AFR) (*HQ will provide the expenditure data for GF) PEPFAR Expenditure Analysis (EA)

Data should be disaggregated by the program areas listed in the first column and by funder in each subsequent column. Columns for the following funders are required at minimum:

- **PEPFAR**
- **Global Fund Principal Recipient(s) (GF)**
- **Host national government**
- **Other**

Additional columns by funder may be included if data are available. The total investment by program area and overall should be listed in the column titled, "Total Expenditure." In each funder column, the percentage contribution of the total expenditure should be recorded, both by program area and overall.

Potential sources of data are listed above. Many PEPFAR OUs operate in countries that recently completed a NASA or NHA. Though the results of these data are likely unpublished currently, teams are encouraged to reach out to their UNAIDS, World Health Organization (WHO), and host country counterparts to determine if these results can be accessed to improve joint, strategic planning.

Strategic planning should reflect Global Fund grant implementation. Itemizing Global Fund planned budgets against specific program areas matched to the COP 2016 implementation period will provide clarity of donor funds available in addition to PEPFAR resources. Many of the inputs to these processes will require similar data that should be accessed whenever possible to successfully complete this planning step.

Some additional guiding principles teams should consider when gathering and reviewing investment and expenditure data:

1. To the extent possible, all data should be derived from the same source to improve comparability
2. Data across funders should be presented in the same currency for the same discreet time period and clearly indicated (e.g., 2012 USD)
3. Data should be from the most recent period available

For every entry cell in Table 1.2.1, PEPFAR teams should enter a numerical value or one of two letter codes:

1. **NA**: "not available"—indicates no data are available from any source
2. **IQ**: "insufficient quality"—indicates data are available, but the quality does not meet reasonable standards

Standard Table 1.2.2 is required of all PEPFAR OUs and outlines the procurement profile for key commodities. The purpose of this table is to highlight current procurement arrangements for commodities required to sustain the HIV response and continue to increase scale.

Key Data Elements and Potential Sources	
Data element(s)	**Potential Sources**
Total Expenditure by Commodity Category and Funder	National AIDS Spending Assessment (NASA) National Health Accounts (NHA) Other formal national resource tracking activities (e.g., Resource Mapping) Meeting proceedings and joint planning/analysis

	activities across funders (e.g., Investment Approach, etc.) Global Fund Grant Agreements Quantification and forecasting data from commodity procurement agents (e.g., SCMS, national medical stores, etc.)

Data should be disaggregated by the commodity categories listed in the first column and by funder in each subsequent column. Columns for the following funders are required at minimum:

- **PEPFAR**
- **Global Fund (GF)**
- **Host national government**
- **Other (if applicable)**

Additional columns by funder may be included if data are available. The total investment by commodity category and overall should be listed in the column titled, "Total Expenditure." In each funder column, the percentage contribution of the total expenditure should be recorded, both by commodity category and overall.

Achieving the stated goal for epidemic control may require program shifts that impact other USG (non-PEPFAR) or external platforms (non-COP) resources in country. As such, PEPFAR teams are asked to complete Standard Tables 1.2.3 and 1.2.4 in the SDS. These tables should reflect total USG non-PEPFAR funded investments and PEPFAR non-COP investments; how much of those investments are co-funding PEPFAR activities, and outline PEPFAR central initiatives contributing to program achievements. *The USG programs and platforms listed in the sample table in the SDS are for illustrative purposes only. The actual list of non-PEPFAR USG activities and PEFAR non-COP activities will depend on OU context and should be comprehensive of all funding streams.*

Guiding principles for completing Standard Table 1.2.3:

- Standard Table 1.2.3 should include:

- All USG non-PEPFAR health funding planned for implementation during the COP 2016 implementation period.

Note: Country teams may have to work with headquarters to obtain this information.

Standard Table 1.2.3 should not include:

- Other donor resources (e.g. DFID, Global Fund); and
- Private sector resources

Column definitions and instructions for Table 1.2.3:

1. Funding Sources – List all relevant funding sources (within the parameters described above)
2. Total USG Non-PEPFAR Resources – This is the total USG investment in country from each source, regardless of whether or not the activities are integrated with PEPFAR
3. Non-PEPFAR Resources Co-Funding PEPFAR IMs – Of the total non-PEPFAR investment (column 2), how much is invested in IMs that are also funded with PEPFAR COP resources
4. # of Co-Funded IMs – How many implementing mechanisms is the funding in columns 3 & 5 spread across?
5. PEPFAR COP Co-Funding Contribution – How much PEPFAR resources are being invested in the IMs being co-funded by PEPFAR and non-PEPFAR resources?
6. Objectives - What is the objective of the integrated/co-funded activities?

Guiding principles for completing Standard Table 1.2.4:

- Standard Table 1.2.4 should include:

  - All PEPFAR non-COP health funding planned for implementation during the COP 2016 implementation period. These include but are not limited to:
  - Central Initiative funding (e.g., DREAMS, ACT, VMMC)
  - All private sector investments tied to PEPFAR funds for each program and/or procurement area
  - HOP-funded activities

Column definitions and instructions for Table 1.2.4:

1. Funding Sources – List all relevant funding sources (within the parameters described above)
2. Total PEPFAR non-COP Resources – This is the total non-COP PEPFAR investment in country from each source

3. <u>Total Non-PEPFAR Resources</u> – This is the total investment of non-PEPFAR resources from the source

4. <u>Total Non-COP Co-funding PEPFAR IMs</u> – Of the total non-COP resources investment (column 2), how much is invested in IMs that are also funded with PEPFAR COP resources

5. <u># of Co-Funded IMs</u> – How many implementing mechanisms is the funding in columns 3 & 5 spread across?

6. <u>PEPFAR COP Co-Funding Contribution</u> – How much PEPFAR resources are being invested in the IMs being co-funded by PEPFAR and non-PEPFAR resources?

7. <u>Objectives</u> - What is the objective of the integrated/co-funded activities?

Once Standard Tables 1.2.2, 1.2.3 and 1.2.4 have been populated, the PEPFAR team should concisely communicate key findings in the narrative portion of the SDS, Section 1.2. Given these data represent a static point in time, teams should use the narrative to contextualize the information provided and identify any potential changes or risks that may need to be addressed in the planning process. Specifically, teams should report in the narrative the year of the commodity expenditure data reported, any changes that have occurred in the country since these data were collected, and any planned changes in which funder will be supplying each commodity in the next 1-3 years. This is particularly important for commodities, as a stable supply of ARVs and other drugs and supplies for combination prevention is necessary to sustain existing programs and a pre-requisite for any planned expansion.

Milestone: Complete Standard Tables 1.2.1, 1.2.2, and 1.2.3 and adequately address guiding questions in Section 1.2 of the SDS template.

TTFs: The *Data Pack* provides a place to organize data for Standard Tables 1.2.1, 1.2.2 and 1.2.3 on the "Investment Profile" worksheet.

Sustainability Agenda and Analysis within COP Planning

As an emergency response to the AIDS pandemic, PEPFAR has made immense achievements in the past ten years. Moving forward, PEPFAR 3.0 is solidly focused on ensuring that progress towards epidemic control is accelerated, and that the program's achievements and gains are consolidated and sustained. PEPFAR's business model and platform regards sustainability as a key dimension for PEPFAR teams and in-country stakeholders' (government and civil society) agendas for reaching epidemic control. By elevating the focus on sustainability, PEPFAR can influence technical gains in country, and foster greater accountability, transparency and use of evidence to accelerate country progress towards epidemic control.

As country teams apply a sustainability lens to their 2016 investment planning, they should seek to advance several objectives:

- Identifying sustainability vulnerabilities via the SID as a means to inform and prioritize areas for investment
- Ensuring interventions and models such as Test and START, reduced clinical visits and ARV pickups, and new testing strategies are not only effective but also contribute to more efficient service delivery
- Increasing local partner capacity and leverage funding mechanisms and approaches such as G2G to support local systems Identifying opportunities to support increased domestic resource mobilization for HIV

To help meet these objectives in 2016, teams are expected to analyze the sustainability of the national response at both the national level and within specific technical areas.

National Level Sustainability for Epidemic Control Analysis: Sustainability Index and Dashboard

To assist PEPFAR Teams and government partners in making informed investment decisions around sustainability, all COP OUs completed the inaugural Sustainability Index and Dashboard (SID) during COP 2015 to assess the current state of sustainability of the national HIV/AIDS response in PEPFAR countries and track its progress over time. Building on this initial "learning year", the SID has been

revised and refined for COP 2016, reflecting feedback from S/GAC headquarters staff, subject matter experts from the inter-agency technical working groups, field staff, multilateral partners and representatives of civil society. As a result of the revision process, this "SID 2.0" reflects an improved and more targeted measurement of sustainability across 15 elements, which are organized under four domains: Governance, Leadership, and Accountability; National Health Systems and Service Delivery; Strategic Investments, Efficiency, and Sustainable Financing; and Strategic Information. This more refined SID 2.0 is intended to function as the baseline for year-to-year comparison going forward. For an overview of notable changes from SID 1.0 to SID 2.0, please see Appendix A of the SID 2.0 Guidance document.

The SID serves multiple purposes as part of the annual COP process, including:

1. Helping countries better understand their sustainability landscape by involving them in a dedicated effort to assess the sustainability of the national HIV/AIDS response;
2. Informing priority areas for PEPFAR investment by identifying sustainability vulnerabilities in countries;
3. Serving as a diplomatic advocacy or negotiation tool to dialogue with partner government and multilateral counterparts; and
4. Communicating progress towards sustained epidemic control to external stakeholders

For COP 2016, all LTS, TA and TC COP countries are expected to complete the SID 2.0. Regional programs are not expected to complete the SID 2.0 for the entire region; however, they are strongly encouraged to complete the SID for 1-2 countries within the regional program, prioritizing countries that represent the preponderance of PEPFAR regional funding and/or where donor funds for HIV/AIDS are already or are soon projected to decline.

Whereas a participatory process for completing the SID was recommended but not required during COP 15, PEPFAR Teams will be expected to engage diverse country stakeholders to complete the SID as part of the COP 16 process. UNAIDS Geneva has offered for its country offices to co-convene with PEPFAR the process for completing the SIDs. PEPFAR teams are encouraged to reach out to their UNAIDS counterparts in-country at the earliest convenience in order to begin planning the needed activities to gather and prepare all resource material, organize the SID-completion workshop, and in facilitating the multi-stakeholder meeting.

After completing the tool in a participatory manner using the SID 2.0 guidance, PEPFAR teams should briefly describe the major findings of the diagnostic that shaped sustainability investments for the

coming implementation year in Section 1.3 of the SDS.   At a minimum, the following questions should be addressed:

- What was the process used for completing the SID?
- What SID elements were identified as sustainability strengths?
- Among those SID elements identified as sustainability vulnerabilities, which does the team regard as priorities?   Based on the indicators that comprise these elements, what specific aspects of these elements require attention during COP 16?
- To date, have PEPFAR and/or other donors (i.e. Global Fund) been invested in these areas?

It is recommended that the SID 2.0 be completed as early as possible so that its results may inform COP/ROP 2016 decision-making, including the Systems and Budget Optimization Review (SBOR) and Template that teams will use to determine the COP/ROP 2016 program support and systems level interventions in which PEPFAR will invest to achieve sustained epidemic control.   In short, the SBOR serves as the bridge between the SID results and COP 16 investment decisions on program support and systems-level interventions.   The SBOR process is described in Planning Step 3. It is important to note that countries are not expected to limit program support and systems level activities to ONLY those identified through the SID, nor are countries expected to address all of the gaps identified in the SID.

The completed SID should be submitted as a supplementary document into FACTS Info. Consistent with PEPFAR's commitment to transparency, and as previewed last year, S/GAC intends to make SID dashboards, questionnaire tabs, and the narrative cover sheet available for all OUs beginning this year with SID 2.0. The completed SIDs will be posted on PEPFAR.gov simultaneous to the posting of approved final Strategic Direction Summaries. If the country team believes it has compelling reasons that warrant exemption from this requirement in 2016, it should submit a memo at the time of its COP submission requesting a waiver and articulating its case for why public release of SID results would not be appropriate at this time. The waiver request will be reviewed and decided upon by the U.S. Global AIDS Coordinator.

For more detailed instructions and information on SID 2.0, please reference the SID 2.0 Guidance document located on the "Sustainability Index and Dashboard" page on pepfar.net (https://www.pepfarii.net/Project-Pages/collab-47/SitePages/Home.aspx).

Technical Level Sustainability for Epidemic Control Analysis

While the SID provides a higher-level portrait of the sustainability of the national HIV/AIDS response, it also is critical to analyze sustainability issues within particular technical areas. Program support and systems-level strengths, weaknesses, and gaps within specific technical areas will be assessed as part of the SBOR. That process is described in further detail in section 3.1.4.

Identification of Barriers through PEPFAR Gender Analysis

The 2014 Updated PEPFAR Gender Strategy states that "Each interagency PEPFAR country team – with the input of government partners, local civil society organizations, bi-lateral and multilateral donors, and other partners – is now required to conduct a gender analysis specific to the HIV response, to inform the design of projects and activities." The information gathered through the gender analysis will help teams understand the program context and inform more intentional and strategic decisions to remove barriers, close gaps, and address harmful norms which may inhibit progress towards HIV epidemic control.

Country teams should have a <u>draft</u> version of the gender analysis completed by the COP/ROP DC Management Meeting in order to inform COP 16 planning priorities. The <u>final</u> version of the gender analysis is due at the same time as the COP/ROP.

3.1.2 Planning Step 2:
Assess Alignment of Current PEPFAR Investments to Epidemic Profile

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In COP 15 PEFPAR teams compared PEPFAR expenditure data by lowest SNU available to burden of disease, as measured by total PLHIV to determine if the PEPFAR program was most effectively aligned to reach the areas and populations with the highest number of HIV infections. In order to reassess or verify priority locations and populations for epidemic control selected in COP 2015, PEPFAR teams must understand how current investments are aligned to the epidemic profile. This task again involves comparing the most recent PEPFAR expenditure data by lowest SNU available to burden of disease, as measured by total PLHIV. In the SDS, PEPFAR teams are asked to include a figure which compares PEPFAR expenditure data by SNU to PLHIV by SNU generated from the EA-Epi Comparison Tool to depict this relationship in an easy-to-reference format. The purpose of this analysis and graphic is to help teams reassess or verify if the PEPFAR program (as of the most recent fiscal year and COP 2015 pivot) is most effectively aligned to reach the areas and populations with the highest number of HIV infections. An illustrative example graph is displayed below.

1.4.1 Percent of PLHIV by SNU and PEPFAR 2015 Expenditure Per PLHIV (illustrative example)

Spend per PLHIV 2015   Percent of PLHIV
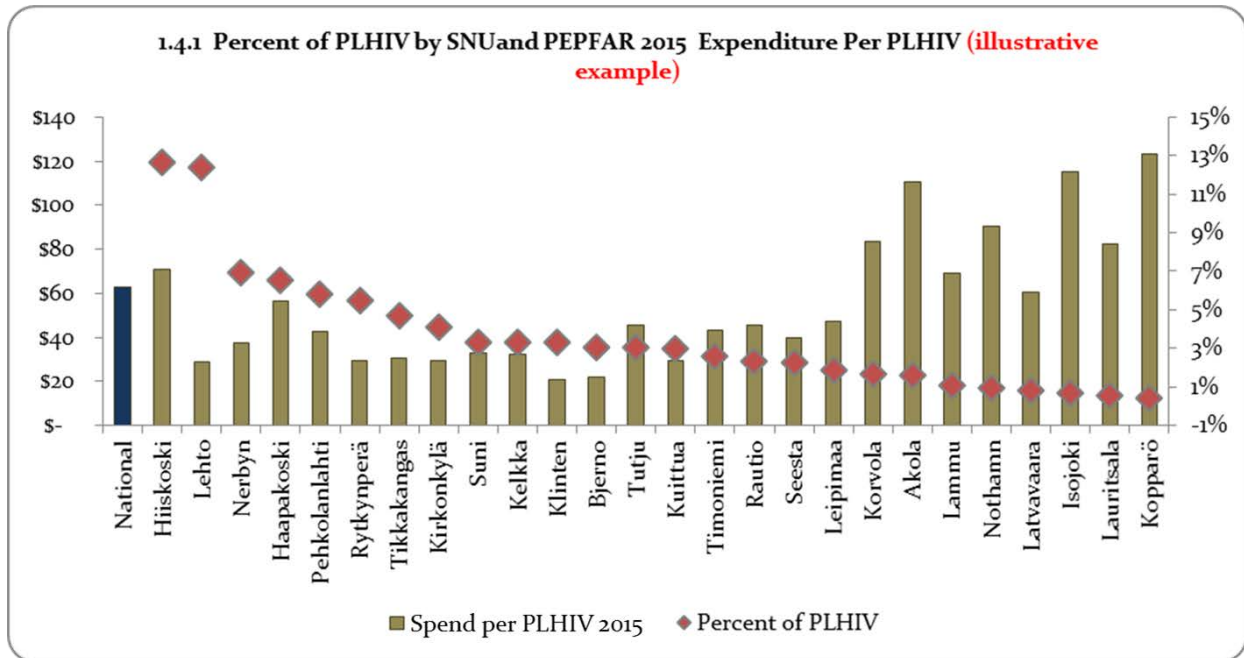
TTFs: The *EA-Epi Comparison Tool* is provided to PEPFAR teams to generate a standard graphic that shows the relationship between PEPFAR expenditures and PLHIV by SNU. The tool will be pre-populated with expenditure data from 2015. Teams may need to insert data on total PLHIV and by SNU if not included in the version received.

In addition to comparing the PEPFAR investment to total PLHIV by SNU, the *EA-Epi Comparison Tool* allows teams to compare the PEPFAR investment for key and priority populations across SNUs when data are available. Population groups available for this analysis are pregnant women, MSM, FSW and PWID. Total expenditure for prevention programs devoted to these groups is taken from EA results. For these graphs to populate, PEPFAR teams should enter an estimate of the total size of each population group by SNU. The tool will calculate the PEPFAR spend per population by SNU for comparison. *Note: the total size estimate is different than the total number reached by PEPFAR as measured by MER reporting.* This analysis is optional, but may be useful for TA/TC programs and those with a heavier focus on key populations.

Considerations for interpretation:

PEPFAR expenditure per PLHIV is another way to display the relative share of total PEPFAR resources that have been allocated to each geographical unit based on the relative share of HIV

burden. We expect some variability in spend per PLHIV given support is likely adjusted to the needs and gaps for each SNU.

Field teams should consider the range of values for expenditure per PLHIV in the program context and determine if this range is acceptable or how it can be explained by other factors, like investments from the host country government and other donors and/or variance in program scope or intensity. These factors should be investigated and assumptions validated internally using empirical data wherever possible. Teams should consider if the historical distribution of PEPFAR resources and intensity of spend per PLHIV is best aligned to achieve epidemic control in highest-burden areas in the near term. The relative share of HIV burden, as measured by PLHIV, is plotted on the secondary access (red diamonds in the figure above) provides additional context for this interpretation. After decisions have been made about program prioritization in the coming cycle, teams should think about how they would expect this graphic to look in the future.

The graphic is intended to highlight PEPFAR investments by SNU classification and initiate discussion and further investigation. Specific questions to consider include:

- Where should PEPFAR increase spending because it is an SNU with high burden and few other funders?
- In which high burden SNUs will PEPFAR spending per PLHIV continue to be low due to economies of scale (i.e., the ability of the existing service delivery platform to accommodate more patients with minimal additional cost)?
- In which high burden SNUs will PEPFAR spending per PLHIV continue to be low due to complementary funding from other sources?
- In which low burden SNUs will PEPFAR be decreasing support in order to align better with epidemic control needs?
- In which SNUs do you anticipate continued high PEPFAR spending per PLHIV because the SNU is important to epidemic control and PEPFAR is the major funder (i.e., there are no other sources of support)?

Teams should communicate key findings from this analysis in the narrative of Section 1.4 in the SDS as a way to frame program priorities and decisions in COP 2016.

ROP Considerations for Table 1.4.1

Regional programs should create Figure 1.4.1 for 2 – 3 select countries with the largest PEPFAR investment and the largest HIV burden in the region. PEPFAR teams should be familiar with the coverage and investment profiles in all countries in their region, but are not expected to submit figures for each country. Please see the suggested list of countries to include on page 37.

Milestone:

(1) Complete Figure 1.4.1 and insert in SDS

(2) Adequately address guiding questions in Sections 1.4 of the SDS template

3.1.3 Planning Step 3:
Determine Priority Locations and Populations for Epidemic Control and Set Targets

In the FY 15 COP, PEPFAR teams were asked to design programs that accelerate progress toward epidemic control. This requires setting targets to achieve accelerated coverage of combination prevention interventions in a subset of high-burden locations and populations by the end of USG fiscal year 2017 (country teams should assume flat funding at FY 15 levels or other trajectory based on communications from S/GAC for this calculation.) Targets along the clinical cascade were to be set to support at least 80 percent coverage of ART for geographically bounded areas and defined populations. Given current treatment coverage levels and budget constraints, achieving this goal will require field teams to review previous decisions from COP 15 and make any required changes about which **locations** (sub-nationally) will be selected for scale-up to saturation or aggressive scale-up and which **populations** within those locations will be targeted. These decisions should be data-driven, focused on HIV disease burden and unmet need, and grounded in program cost. In addition, the recent recommendations from WHO regarding the shift toward treatment for all PLHIV underscores the relevance of using total PLHIV as the denominator for 80% coverage calculations. This planning step is both the most important and most dependent on other steps in the process.

The following definitions should be used for prioritization:

> **Scale-up Districts:** Scale-Up Districts will receive a package of services designed to accelerate progress toward at least 80% antiretroviral treatment (ART) coverage in a subset of high-burden locations and populations. These Scale-Up activities include: PEPFAR-supported facility- and community-based activities, including demand generation; prevention and care community activities; facility-based testing, treatment, adherence and retention, as well as site, district, and national level quality monitoring. Scale-Up Districts have been further divided into <u>Scale-Up to Saturation</u> Districts and <u>Aggressive Scale-Up</u> Districts. Importantly, this approach will lead to the 90/90/90 goals set by UNAIDS for 2020.

> ☐ **Scale-Up to Saturation** Districts receive intensive PEPFAR support with a target of reaching 80% of people living with HIV (PLHIV) on ART by 2017 and 2018.
> ☐ **Aggressive Scale-Up** Districts receive intensive PEPFAR support with an overall goal of an increased rate of 'new on ART' but not reaching 80% of PLHIV by 2017 or 2018.

Sustained Districts: Sustained Districts receive a package of services provided by PEPFAR that are different in each country and include passive enrollment via HIV testing and counseling on request or as indicated by clinical symptomology, care and treatment services for PLHIV, and essential laboratory services for PLHIV. As the high burden Scale-Up Districts are saturated, Sustained Districts will be aggressively scaled to reach 90/90/90 goals by 2020.

Central Support Districts: In Central Support Districts, site-specific activities will transition to government or other support by the end of September 2016 and by no later than March 2017. Central Support Districts will continue to receive PEPFAR national support for overarching activities, such as quality assurance and quality improvement (QA/QI) to ensure that patients continue to receive quality services.

This FY 16 COP will provide a platform for OUs to review progress toward these FY 17 goals and to consider which sites or sub-national units are to be considered for saturation scale-up in FY 2018. Figure 3.1.3 shows the continuous nature of prioritization at the SNU level.

In this example, SNU 1, 2 and 3 were prioritized in COP 15 to get 80% ART coverage (saturation) by APR17. In COP 16, new ART slots should be allocated to SNU1, 2 and 3 to be able to reach 80% coverage by APR 2017. The next districts should be identified for saturation by APR 2018. SNUs that were identified as Aggressive Scale-up in COP 15 should be revisited to see which ones can become saturated by APR2018. In the example prioritization, SNU 4 and 5 were Aggressive Scale-Up in COP 15 and there are enough new ART slots to be able to saturate these districts in COP 16.

Figure 3.1.3: Example of ART Coverage Prioritization

SNU	Prioritization Level	APR16	APR17	APR18	APR19
SNU 1	Scale-Up to Saturation	50%	80%	80%	80%
SNU 2	Scale-Up to Saturation	60%	80%	80%	80%
SNU 3	Scale-Up to Saturation	50%	80%	80%	80%
SNU 4	Aggressive Scale-Up	30%	50%	80%	80%
SNU 5	Aggressive Scale-Up	40%	60%	80%	80%
SNU 6	Aggressive Scale-Up	40%	60%	80%	80%
SNU 7	Aggressive Scale-Up	20%	30%	50%	70%
SNU 8	Aggressive Scale-Up	20%	30%	50%	70%

Note: *The targets submitted as part of the SDS and site, mechanism and technical level target requirements are for FY 17 only. The Data Pack will provide an opportunity to set FY 17 and FY 18 targets to achieve 80 percent coverage.*

There are several critical elements to completing planning Step 3, including describing/mapping the HIV epidemic and unmet need sub-nationally/regionally and by population; selecting locations and populations for program focus; and setting targets to achieve epidemic control. Each element is described in greater detail below.

Describing/mapping the HIV epidemic sub-nationally and by population

TTFs: The *Data Pack* is available to assist teams with importing and organizing their epidemiologic and national/regional program data using the methods described below.

As a first step in prioritizing locations and populations, teams should gather the following data elements to the lowest SNU available.

<table>
<tr><th colspan="2">Key Data Elements and Potential Sources</th></tr>
<tr><th>Data element(s)</th><th>Potential Sources</th></tr>
<tr><td>Total population
HIV prevalence and trends
Total number of PLHIV</td><td>Ministry of Health surveillance, Estimates from UNAIDS Spectrum and Subnational Estimates of HIV Prevalence Report, Surveillance Studies supported by PEPFAR
Central Statistics Agency, U.S. Bureau of Census</td></tr>
</table>

Once key data elements have been organized, the teams should rank SNUs by completing the following steps:

1. Sort SNUs largest to smallest by total number of PLHIV
2. Calculate percentage of total (national/regional) PLHIV in each SNU
3. Calculate the cumulative burden by SNU by summing and recording the percent of total PLHIV for each SNU entry

*If using the **Data Pack**, steps 2-3 will be calculated automatically on the "Epi Summary" worksheet.*

Next, teams should include current national/regional coverage data to calculate unmet need for combination prevention interventions, including ART, PMTCT, comprehensive prevention packages for key and priority populations, and VMMC.

For ART, coverage should be represented as a percent for each SNU. Unmet need should be calculated using **total PLHIV** as the denominator, consistent with recent recommendations from WHO. Although the number currently eligible has been an important factor in some countries to consider in operationalizing plans for scale-up, initial estimates of unmet need and program focus for epidemic control should be based on **total burden**, as measured by number of PLHIV. Countries will continue to integrate these new WHO guidelines into their own definitions of treatment eligibility.

*If using the **Data Pack**, unmet need will be calculated automatically on the "ART Cascade for Epi Control" worksheet.*

Teams should calculate (validate) the **net new patient slots** required to achieve 80 percent coverage of ART for PLHIV by SNU by end of APR 2018. In determining the required targets to achieve 80 percent coverage in select SNUs, PEPFAR teams will need to adjust for scale-rate and expected loss to follow-up (LTFU). OUs should also provide 80% saturation targets for those additional scale-up sites or sub-national units to be addressed in APR 2018.

*When using the **Data Pack**, teams can calculate automatically the required net new patient slots on the "ART Cascade for Epi Control" worksheet by entering percent achievement in year 1, percent coverage goal for saturation, and projected loss to follow-up.*

As background to prioritization decisions, teams should describe these data in Figure 1.4.2 in the SDS. This figure is not required to be in standard format, but does require key elements to be displayed. Minimum elements for display include: **HIV prevalence by SNU**, **total PLHIV by SNU**, and **coverage of total PLHIV with ART**.

Teams should also calculate unmet need for PMTCT and VMMC. The **Data Pack** provides space for these calculations on the associated worksheets.

ROP Considerations for Table 1.3.2

Regional programs should create Figure 1.3.2 for 2 – 3 select countries with the largest PEPFAR investment and the largest HIV burden in the region. PEPFAR teams should be familiar with the coverage and investment profiles in all countries in their region, but are not expected to submit tables for each country. Please see the suggested list of countries to include on page 37.

Selecting locations and populations for program focus

Multiple data sources and a number of program/contextual factors must be considered when PEPFAR teams select areas and populations for focus in COP 2016. **The goal of this analysis is to program resources where the host country has the highest probability of attaining epidemic control.** This will require focusing on specific areas and targeting specific population groups where the most new HIV infections are likely to originate.

With currently available data, it is not always apparent which information should take precedence, what thresholds should be applied, and what weight should be given to each individual criterion. Due to a general lack of data and poor geographic specificity in the data available, we have to use a combination of the following proxies to develop a more focused operational plan: HIV prevalence, population, total number of PLHIV, coverage of combination prevention services, and key and priority population size/location estimates.

Each country context will be different and one method or standard selection criteria should not be applied across the board; however, there are some guiding principles PEPFAR teams should follow when selecting locations and populations for scale-up:

1. <u>High-burden areas and populations take precedence</u>.

   Epidemic control is not attainable until areas and populations with the highest density of PLHIV are saturated with combination prevention services (HTS, PMTCT, ART, VMMC, condoms, and other targeted prevention for key and priority populations). Total number of PLHIV should be the first criterion applied, followed by current coverage of combination prevention interventions.

2. <u>Program scale-up of combination prevention should be in areas with high HIV transmission and acquisition, not necessarily entire SNUs</u>

   Percent coverage should be applied within a specific bounded area—i.e., sub-national administrative unit (state, province, region, district, ward, etc.) or city/township. In selecting areas and populations for epidemic control in the near term, teams should use data to the lowest SNU available. Additional context/information, however, will need to be taken into account prior to making resource allocation decisions. For example, prevalence and HIV burden of an SNU may be driven entirely by a limited number of smaller bounded areas (e.g., counties, districts, cities, townships) or by specific populations. Similarly, a district with a relatively low burden of HIV (as measured by total PLHIV) may have areas with high HIV transmission pockets, or **micro-epidemics**. In the event trade-offs need to be made within or between focus SNUs (and granular epidemiologic data are not available) efforts should focus on high density locations, such as urban and peri-urban centers.

Likewise, populations should be prioritized within high-burden SNUs. Often, available Epidemiologic information will not be sufficient to guide effective and focused programmatic responses. For example, while Demographic and Health Surveys (DHS) data may indicate that females 15-24 have substantially higher prevalence than male peers, it will not be efficient to target all females in that age range with comprehensive services. PEPFAR teams should use program data, published literature and ANC surveillance data to narrow broader populations and drive focused programming.

This level of focus should apply to both prevention and treatment programs. ART programs should set targets for the general population and for those populations at greatest risk of transmitting HIV. Where data on key populations cannot be collected safely (e.g. for MSM), programs should still work intentionally to make services friendly and accessible to those populations, and to develop proxy measures of success.

Finally, If a site within a sustained SNU has been categorized as a hotspot based on epidemiologic data and has a high yield of HIV positive persons identified, the SNU in which it is located must be categorized as a scale-up SNU but only the hotspot site(s) within the SNU can be assigned scale-up targets. The hotspot area should have a specific PLHIV denominator to be able to identify current coverage and target coverage. Teams should provide an explanation of why other sites within the SNU are not a focus for program scale-up and indicate, with data, how they intend to achieve 80% coverage of ART and/or accelerated coverage of combination prevention in the hotspot(s) within the SNU. Teams can provide the additional data in the narrative of Section 4.1 or as a footnote in Standard Tables 4.1.1-4.1.4.

3. **Saturation** equates to 80 percent coverage of those in need of combination prevention services.

In accordance with the UNAIDS 90-90-90 goal, PEPFAR teams are asked to design programs and set targets to achieve 80 percent coverage of **total PLHIV** on ART *in geographic focus areas and priority populations*.

In addition, teams will need to assess current coverage of other combination prevention interventions in these areas/populations and consider how these programs complement efforts

to achieve ART coverage goals. With respect to targeted prevention interventions for key and priority populations, targets should be set based on population size estimates, when available, and represent realistic coverage goals. Given the typical size of target prevention populations and the complexity in reaching them, coverage of 80 percent may not be attainable. However, teams should be able to describe how prevention investments in the coming cycle will translate to increases in coverage of key and priority populations with core services (see Section 3.3.1on defining core, near-core and non-core interventions within program areas).

Note. Following the recent release of guidance by WHO supporting treatment for all PLHIV, determining coverage of ART should be based on a denominator of all PLHIV for all countries. Although some countries may not have yet updated their own protocols of ART eligibility, it is expected that this transition will occur soon.

To complement the UNAIDS 90-90-90 targets for HIV-positive individuals, UNAIDS has released global HIV prevention targets through 2020 that contribute to epidemic impact goals by 2030. The target for VMMC is 80 percent circumcision prevalence among males 15-29 years of age by 2020, with sustained coverage at that level through 2030. PEPFAR will continue to support the UNAIDS strategy, as we have in the past. While VMMC is a priority intervention, it may not be possible to achieve the stated 80 percent coverage target specified within five years in all OUs with PEPFAR resources alone, if doing so diverts funding away from the 80 percent ART coverage target that takes primacy. In such instances of resource limitation, the VMMC coverage gap should be defined, by SNU, age group, and FY (2016-2020), so that different funding sources can be determined.

Finally, in a scale-up SNU, if a core intervention has reached a coverage level of 80% or higher, that specific intervention should revert to sustaining coverage but not scaling coverage. However, the aim is to accelerate coverage of ALL core interventions relevant to the SNU and populations within the SNU in order to have impact (decrease HIV transmission). The SNU should remain a priority SNU and continue to scale (as resources allow) other core interventions following the relevant sections in the 2016 Technical Considerations.

> **Milestone:** Describe the choices made for program focus in the implementation year by location and population group and address all guiding question in Section 3.0 of the SDS.

Setting targets for accelerated epidemic control in priority locations and populations

PEPFAR field teams are asked to set targets for combination prevention interventions that assist host country governments achieve accelerated epidemic control in a subset of high-burden locations and populations in the near term. Generally, targets should:

- Be in accordance with the OUs stated goal for epidemic control and teams should specify how PEPFAR investments will translate to expected increases in coverage in the COP 2016 implementation period, FY 16 and beyond[11].

- Facilitate saturation of combination prevention interventions.

- Be prioritized by location, population and intervention should be data-driven and grounded in program context, program cost, and implementation realities. This means that intervention and services packages will likely necessarily differ by location and population.

- Please also consider centrally-funded initiatives as you set targets (e.g., ACT and DREAMS).

*This section is **not** comprehensive guidance on how to set targets for every indicator measured by PEPFAR.* Rather, the guiding principles and instructions below pertain to targets highlighted in the SDS that provide a snapshot of how field teams have prioritized locations, populations, and interventions for epidemic control.

PEPFAR teams should use this guidance to inform program choices and subsequently document targeting decisions in Section 4.1 of the SDS, which includes five standard tables (4.1.1-4.1.5). Each table is described below in the context of the related combination prevention or support intervention. Tables 4.1.1 – 4.1.5 and 5.1.1 should should be generated from DATIM, and "COP 16 Target Table Favorites" will be available.

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[11] For example, these targets will achieve 80% coverage in the 20 highest burden communities

In setting targets to accelerate epidemic control and completing the relevant section in the SDS, teams should keep several guiding principles in mind:

1. Targets for epidemic control are distinct and mutually exclusive of expected volume to sustain support in other locations and populations.

   In Section 4.1 of the SDS, PEPFAR teams will present targets outlined in the five standard tables *for priority locations and populations **only***. In many OUs, we expect PEPFAR resources dedicated to scale-up to shift to prioritized areas and interventions; however, PEPFAR teams will need to budget for continued support to existing ART and PMTCT patients and OVC beneficiaries in other locations as programs are transitioned. To determine the required resources to support sites in other locations, PEPFAR teams should use program data to calculate the expected volume of beneficiaries in those areas. Expected volume should be recorded in Standard Table 5.1.1 in the SDS, not Standard Table 4.1.1. Methods for this analysis are described in section 3.1.5 below.

   The sum of targets included in both Sections 4.1 and 5.1 of the SDS should equal the technical area target[12] for each indicator. For example, a PEPFAR team has determined the program can support 300,000 current on ART by APR 2016 in selected priority areas. This figure should be recorded in Standard Table 4.1.1. The team has also calculated there would be an expected volume of 200,000 current on ART by APR 2016 in other areas as programs are transitioned. This figure would be entered in Standard Table 5.1.1. The total current on ART expected for APR 2016 would then equal the current on ART in priority areas (300,000), *plus* the current on ART in other areas (200,000). In this example, the summary technical area target for APR 2016 is 500,000.

2. Target timeframe should be framed by goals beyond implementation in COP 2016.

   Strategic planning requires PEPFAR teams to think beyond the implementation year associated with COP 2016 (FY 17). In this COP the Data Pack will support calculating two-

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[12] See section 5.4 on target definitions.

year strategic targets (e.g. APR 2017 and APR 2018), however teams are *not* expected to submit site-level targets beyond what will be achieved by APR 2017.

In COP 15, for ART coverage specifically, teams were requested to select priority locations and populations in which coverage of 80 percent is possible by the end of FY 17. Since areas have already been identified for 80 percent coverage in FY 16 and FY 17, in COP 16 teams should identify the areas for 80 percent coverage by FY 2018. This timeframe is intended to provide a near-term goal post for PEPFAR teams to guide decisions as they set targets to accelerate ART coverage in priority areas. Targets recorded in Standard Table 4.1.1, however, will only outline targets for achievement in 2017 towards this forward-looking goal.

For other combination prevention and support targets defined in Section 4.1 of the SDS, teams must estimate coverage by APR 2016 in the Standard Tables, but are not expected to set targets that result in 80 percent coverage of the target population if not achievable during this time frame.

3. <u>Program costs and trade-offs should be taken into account when setting targets for priority locations and populations.</u>

Achieving targets outlined in Section 4.1 represents a cost to PEPFAR programs. In determining targets for ART, other combination prevention activities, and OVC, teams should use empirical cost data to assess what is feasible within the current funding envelope (see section 3.3.6 on resource projections). Teams should also keep in mind that achieving targets in one technical area (e.g., ART) has an impact on funding available to achieve targets in another technical area (e.g., VMMC). There is not specific guidance applicable to all PEPFAR OUs on the most appropriate percentage allocation of funds between combination prevention and support activities; however, teams are expected to meet legislated budget code earmarks (see section 7.3), should consider any central funding that may be available to assist with achieving targets in specific technical areas, and consider the type and magnitude of support provided by the host country government and other stakeholders. The ultimate goal is to achieve epidemic control in selected areas and populations in the shortest timeframe possible. The optimal mix of combination prevention interventions will vary by context and teams should use any data or modeling available that can inform these decisions.

Setting Targets for ART in Priority Locations and Populations

PEPFAR teams are requested to set targets for ART that will assist the host country government achieve 80 percent coverage of PLHIV on ART by the end of USG fiscal year 2017 (September 30, 2017) in high-burden areas and/or populations. Given available USG resources and taking into account contribution of PEPFAR to the national treatment program, PEPFAR teams will likely need to prioritize specific areas where the attainment of 80 percent ART coverage is possible in two years. Teams should record proposed ART targets for priority locations and populations in Standard Table 4.1.1 in the SDS.

<u>Guiding principles for completing Standard Table 4.1.1</u>:

1. <u>Populations should be assigned to geographic locations with the exception of military</u>.

   Data to the lowest SNU available should be used to determine where PEPFAR will focus geographically. Because current epidemiologic data are typically not available to most efficiently target and program resources, other contextual information must be taken into account. Selection of an SNU for program focus does not mean the PEPFAR team will focus in all sub-areas or on all populations within the SNU. Even within SNUs, priority for scale-up of combination prevention should be assigned to areas and populations where the most new HIV infections are likely to occur. Site-level PMTCT prevalence data will be essential for this analysis.

   Recognizing the data limitations and that population focus may be more granular than the SNU level, in Standard Table 4.1.1 PEPFAR teams are required to assign targets to a specific SNU. The SNU level chosen in column 1 should be the lowest SNU level where data on HIV burden (as measured by total PLHIV) are available. For each SNU chosen for focus, teams should demonstrate that PEPFAR targets will contribute to achieving 80 percent coverage of all PLHIV estimated for that SNU within 2 years, or qualify in the narrative which sub-areas or populations within the SNU have been targeted to achieve the 80 percent coverage goal.

   Military populations are the one exception to this rule. Due to the migratory nature of military populations and potential sensitivities associated with identifying their location, PEPFAR teams are permitted to include a row for "Military" in Standard Table 4.1.1 that is not tied to a specific SNU. If this option is chosen, teams should be able to quantify the estimated number of PLHIV and how coverage of ART will change with PEPFAR investments.

2. Eligibility criteria based on national guidelines should be taken into account when setting ART targets.

As countries adopt WHO guidelines for Test and START (making all persons living with eligible for ART) it is expected there will not be a conflict between targeting based on total PLHIV and the ability of PEPFAR and the host country government to achieve targets based on national ART guidelines. However, in this COP cycle teams should use any clinical data available to determine if the current national guidelines would prevent achieving 80 percent ART coverage goals in focus SNUs identified. Any foreseen challenges in scale-up pertaining to national ART guidelines should be described in the narrative.

3. Commodities and other inputs required for effective provision of ART should be taken into account.

As described in planning Step 1 above, part of understanding the program context is determining any dependencies on other sources of support as PEPFAR plans activities and scale-up. This is particularly true for ART. In setting targets, PEPFAR teams should consider what inputs are required that are currently not funded by PEPFAR. Commodities, specifically, are often funded by the Global Fund or other entities. Teams should assess the ability of other stakeholders to scale support at a pace commensurate with PEPFAR in determining targets for priority SNUs and the program as a whole.

Column definitions and instructions for Standard Table 4.1.1:

1. Sub-national Unit – List all sub-national units *selected for focus in COP 2016*. A row is permitted for "Military" is applicable. A "Total" row is required.
2. Total PLHIV – Enter the number of total PLHIV estimated for each SNU chosen and the total for *all SNUs chosen for focus.*
3. Expected current on ART (2016) – National program data should be entered in this column, *not* PEPFAR results only. Enter the expected number of current on ART at the end of USG fiscal year 2016 (September 30, 2016) for each SNU chosen and the total across selected SNUs.
4. Additional patients required for 80 percent coverage – Calculate and enter the required additional patients needed to achieve 80 percent ART coverage of PLHIV for each SNU chosen and the total across selected SNUs.

5. <u>Target current on ART (APR 2017)</u> – Enter the proposed *PEPFAR* target for current on ART to be achieved by APR 2017 for each SNU chosen and the total across selected SNUs.

   Note: *The total current on ART for selected SNUs is not the same as the total current on ART target for the PEPFAR technical area in APR 2017. The sum of current on ART for priority locations and population (Table 4.1.1) and the expected volume in other locations and populations (Table 5.1.1) should equal the PEPFAR technical area target for APR 2017.*

6. <u>Newly initiated in FY 17</u> –Enter the expected number of patients that will be newly initiated in USG fiscal year 2017. To accurately calculate this number, teams will need to adjust for LTFU over the implementation year.

TTFs: The *Data Pack* is available to assist teams complete Standard Table 4.1.1. In the workbook, users are able to designate SNUs to be chosen for focus. These selections will be displayed on the worksheet labeled "Targets for Priority Areas." If all data inputs have been populated correctly in the workbook, columns 2-6 will populate automatically. Adjustments to the target for focus below SNU (i.e., achieving 80 percent coverage of sub-areas and/or specific populations and not the SNU as a whole) are possible and should be calculated in the Data Pack in new entry columns for consistency.

TA/TC Considerations for Target Tables 4.1.1-4.1.

TA/TC programs may have pilot/demonstration projects that include setting direct targets; however, these teams are not expected to set PEPFAR targets for epidemic control in the same way as LTS programs. TA/TC programs are encouraged to include national data, where possible, in target tables outlining the selected areas and populations the PEPFAR team has chosen for program focus to further contextualize coverage of combination prevention interventions and gaps that may still remain by APR 2017.

In addition to setting targets for current on ART and ART enrollment (newly initiated) by SNU, PEPFAR teams should outline in Standard Table 4.1.2 how they will meet the enrollment target

proposed by entry stream for ART. At minimum, 4 entry streams should be considered and included as rows in Standard Table 4.1.2:

1. Clinical care patients not on ART

   The most efficient way to increase enrollment of ART programs is to transition PLHIV currently receiving clinical care (or pre-ART) to ART. Of course, this will depend on national guidelines and other structural constraints or resource gaps. PEPFAR teams are asked to estimate the number of clinical care patients expected to become eligible and initiate ART in USG fiscal year 2017 and 2018 using data on CD4 declines per year.

2. TB-HIV patients not on ART

   Another entry stream for ART enrollment that should be included is the cohort of TB patients diagnosed with HIV. PEPFAR teams should estimate how many individuals currently receiving TB treatment and prophylaxis at TB sites will receive HIV testing and be linked effectively to ART sites as newly initiating ART patients.

3. HIV-positive pregnant women and HIV-exposed infants

   HIV-positive pregnant women receiving care and support through PMTCT outlets will initiate ART over the period. Teams should estimate the number of women newly initiated on ART through PMTCT programs as a key entry stream for ART enrollment targets. Early infant diagnosis (EID) of HIV-exposed infants is another important opportunity for case finding and ART initiation.

4. Other priority and key populations

   Outside of transitioning current clinical care patients, enrolling co-infected TB patients, and initiating HIV-positive pregnant women, most PLHIV are initiated through HTS programs linked to prevention platforms. Strategic testing of high-yield populations through provider initiated testing and counseling (PITC) and index-based testing are also important opportunities for case finding, linkage, and ART initiation. PEPFAR teams should be able to describe with data how many newly initiating ART patients can be expected from entry streams 1-3 above. The remaining treatment slots necessary to achieve the enrollment target will need to come from PEPFAR HTS and prevention program activities.

Column definitions and instructions for Standard Table 4.1.2:

1. Entry streams for ART enrollment –List all entry streams expected to contribute to ART enrollment. At minimum, the 4 streams described above should be included. A "Total" row is required.

2. Tested for HIV –Enter the total number receiving HTS for each entry stream and the total across all streams identified.

> **TTFs:** The *Data Pack* should be used to calculate the required number receiving HTS for "Other priority and key populations" using a cascade analysis approach.

Note: *The number tested for HIV for the "TB-HIV patients not on ART" stream should include only those tested in TB sites. HIV patients newly initiated on ART (and found to have TB) currently receiving clinical care through ART sites should already be identified HIV positive.*

3. Identified positive –Enter the expected number identified HIV positive as a subset of column 2 for each stream and the total across all streams identified.

   Note: The number identified positive for HIV for the "TB-HIV patients not on ART" stream should include only those tested in TB sites.

4. Newly initiated on ART –Enter the number of patients expected to be enrolled on ART for each stream and total across all streams identified. The total number newly initiating across all entry streams should equal the total number newly initiated in FY 16 in column 6 of Standard Table 4.1.1.

Setting Targets for VMMC in Priority Locations and Populations

New modeling tools are available to assist countries in identifying age groups of males at higher risk of acquiring HIV for VMMC to maximize the immediacy and magnitude of epidemic impact by 2030. In most countries, this is achieved by prioritizing VMMC coverage among males 15-29 yrs. Countries should articulate strategies to reach 80 percent circumcision prevalence: first, among males in the high burden SNUs/micro-epidemics; and, second, within those SNUs, among males in the highest priority age bands. Geographic areas and age groups with higher current levels of unmet need should be prioritized within the overall strategy, i.e., between SNUs of equivalent HIV burden, the SNU with lower

circumcision prevalence should be prioritized (similar for age bands). PEPFAR teams are asked to present targeting decisions by priority population in Standard Table 4.1.3 of the SDS.

If targets have been set for areas outside of those selected for program focus, teams will need to explicitly state their rationale in the narrative portion of Section 4.1.

Column definitions and instructions for Standard Table 4.1.3:

1. Target populations –List each target population for VMMC focus in COP 2016 by age band.

2. *Population size estimate (priority SNUs)* –Enter the size estimate for each target population identified and the total across all target populations. *Size estimates and targets in this table should be restricted to priority locations selected to accelerate epidemic control.*

3. Current coverage –Enter the estimated current percentage of males circumcised in each identified target population within priority SNUs.

4. APR 17 target –Enter the proposed targets for VMMC as intended to report in APR 2017.

5. Expected coverage APR 17 –Enter the expected percent of males circumcised in each identified target population as of the end of USG fiscal year 2017 (September 30, 2017).

> **TTFs:** The ***Data Pack*** should be used to calculate the current coverage of VMMC by age band, set targets, and estimate coverage as of APR 17.

Setting Targets for Prevention Interventions in Priority Locations and Populations

Once teams have identified priority and key populations for focus in the selected SNUs, they should develop best-possible estimations of population size. See the indicator reference sheet for PP_Prev in the MER Indicator Guidance and the 2011 Guidance for Prevention of Sexually Transmitted HIV Infections for more information on size estimation. Teams should then develop a basic package of interventions for each population based on existing guidance from the above documents, and set coverage targets for each population based on an evidence-based hypothesis about the levels of coverage necessary to achieve population-wide reductions in incidence. For guidance on prevention for females 15-24, please see the PEPFAR DREAMS Guidance for Preventing HIV in Adolescent Girls and Young Women (forthcoming).

On October 1, 2015 WHO released guidance recommending pre-exposure prophylaxis (PrEP) which recommends considering PrEP as a part of comprehensive prevention for persons at substantial risk of HIV (estimated HIV incidence above 3%).

Column definitions and instructions for Standard Table 4.1.4:

1. <u>Target populations</u> –List each population for program focus in SNUs prioritized for accelerated epidemic control in COP 2016. PEPFAR teams may add as many rows as needed to accommodate selected populations; however, *three populations are required to be included in the table: MSM, FSW, PWID*. A "Total" row is required.

2. <u>Population size estimate (priority SNUs)</u> –Enter the estimated population size of each populations selected for focus. *Estimates of population size should only be inclusive of priority SNUs.* If data for selected SNUs are unavailable, PEPFAR teams should include one of two letter codes:

   NA: "not available"—indicates no data are available from any source

   IQ: "insufficient quality"—indicates data are available, but the quality does not meet reasonable standards

3. <u>Coverage goal</u> –Enter the percent of the selected populations for focus PEPFAR intends to reach in USG fiscal year 2017. This percentage to correspond to the value in column 4.

4. <u>APR 17 target</u> –Enter the proposed target for beneficiaries reached for each selected population. This value should correspond to the percentage in column 3.

Setting Targets for OVC

Based on a comparison of current PEPFAR OVC coverage and estimates of the OVC population and inputs such as situational analyses, PEPFAR teams should describe/map the OVC situation, select locations and populations for program focus; and using the definitions provided in the indicator reference sheets set targets for both OVC_SERV and OVC_ACC in the Data Pack. Teams should provide a brief description of the data sources used and assumptions made.

Population Data for OVC: Country teams should use these assumptions to calculate the denominator for OVC population data in Table 1.1.1.

Orphans and other vulnerable children, as a distinct population, is defined in PEPFAR's legislation as "children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects." Calculating that total may be done in a number of ways depending on country context and data sources. Orphans (maternal/paternal/double) have a standard definition, which is further discussed below. Defining "other vulnerable children" may focus on the characteristics of their parents or caregivers, which raise risks for poor child outcomes, or the actual risks or vulnerabilities faced by children across multiple domains. DHS and MICS typically identify the percentage of children who have a very sick parent or live in a household where an adult has been very sick or died in the past 12 months, which they label "vulnerable children." National OVC situation assessments and other surveillance methods may use different definitions of vulnerability, commensurate with national policies, to estimate prevalence or population size or may be linked to rates of adult HIV prevalence and household size. Where these data are available and of sufficient quality, they should be used in program planning because they align most closely with PEPFAR's legislative definition cited above.

Orphans (maternal/paternal/double) refer to children (aged 0-17) whose mother, father, or both parents have died. Orphan prevalence rates (at both national and sub-national levels) are typically available through both DHS and MICS, which can be combined with child population figures from the national census or other sources to estimate the orphan population. Orphaning has been strongly correlated with HIV prevalence in the generalized epidemics common in sub-Saharan Africa, even when the actual cause of parental death is undetermined. Because these data are widely available from population-based surveys, they are important proxies for estimating the size and distribution of OVC populations for PEPFAR program planning, though orphaning is only a partial subset of all children affected by HIV/AIDS.

AIDS orphans are defined as the estimated number of currently living orphaned children aged 0-17 years who have lost one or both parents to AIDS. National estimates are typically only available through UNAIDS models based on demographic and epidemiological data; sub-national disaggregations are not usually available. The scope and quality of these data may make them less useful for PEPFAR program planning. However, this is one of the only standardized population level indicators relevant to calculating the total number of orphans and other vulnerable children due to HIV/AIDS systematically reported globally (by UNAIDS and MDG 6).

Milestone: Complete Standard Tables 4.1.1-4.1.5 in the SDS template and adequately address guiding questions in Section 4.1.

3.1.4 Planning Step 4:
Determine Program Support and System-Level Interventions in which PEPFAR will invest to Achieve Epidemic Control

Program and system support activities are those in which PEPFAR invests based on systematic review of the gaps and bottlenecks and structural and cultural barriers to achieving epidemic control. These activities include health systems strengthening (human resources for health, governance, finance, systems development, institutional and organizational development), strategic information, laboratory, and service delivery as articulated below in Table 3.1.4.

To determine COP/ROP 2016 program support and systems level interventions in which PEPFAR will invest to achieve epidemic control, PEPFAR teams will utilize the **Systems and Budget Optimization Review (SBOR)** and Template. The SBOR captures traditional health systems strengthening (HSS) activities, and other cross-cutting program support activities such as strategic information (SI) laboratory strengthening, and human resources for health (HRH) support at all levels. Further, the SBOR captures all above site and site-level systems support activities funded through all budget codes.[13] The SBOR should also apply the results of the SID described in 3.1.1 and ensure that investment decisions in program and systems support activities in COP/ROP 2016 consider the priority vulnerabilities identified in the SID.

The SBOR and Template will assist PEPFAR teams to: (1) identify all program and systems support activities, across all budget codes, within the approved COP/ROP 2015 portfolio of activities using Table 3.1.4 as well as definitions included in the Expenditure Analysis guidance; (2) categorize each identified program and systems support activity into one of the eight program and systems support technical areas listed in Table 3.1.4; (3) review the funding for program and systems support activities to identify any possible double counting; (4) asses the relevance and priority of each activity for supporting COP/ROP 2016 strategies using a decision algorithm uniquely designed specifically for the SBOR; and (5) strategically align the program and system support portfolio of activities for COP/ROP

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[13] Includes activities funded through HLAB, HVSI and OHSS budget codes as well as those activities funded through other program budget codes e.g., HTXS, MTCT, HBHC, etc…). US Government (USG) management and operations (M&O) will not be included in this review.

2016 development, with greater clarity on government-to-government and non-government partners, both local and international, in all PEPFAR supported systems areas as well as the expected deliverables.

In order to develop the SBOR, S/GAC is currently field testing a structured methodology and core materials (review process, data reporting template, and decision algorithm) in a select number of PEPFAR countries: Ethiopia, Kenya, Mozambique, Viet Nam, and Haiti. Based on the outcome of the field testing, S/GAC will distribute a final guidance with associated materials (data template and decision algorithm) in mid-December. In addition to the guidance and materials, S/GAC will provide further direction on attaining TA (e.g., in person and virtual) to complete the SBOR process, and expectations for completing and presenting SBOR findings and COP/ROP 2016 system level activities and budgets as part of the COP/ROP 2016 planning process.

Table 3.1.4: Activities Included in SBOR

Included Activities	*Excluded Activities*
HSS: Human Resources for Health (HRH)	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments; HR information systems; and other HRH activities not classified as above	N/A
HSS: Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A

HSS: Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A

HSS: Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level

HSS: Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A

Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A

Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (viral load, early infant diagnosis (EID)); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included

Service Delivery: Site/Community-Level	
In-service training across all program; all HRH support at clinical and community sites across all program areas	Other clinical and community site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities

Note: Additional information required for Section 6 of the SDS Template: Evaluation Standards of Practice

After going through the SBOR process, planned evaluations should also be identified in Section 6 of the SDS Template. Only key information consistent with the table requirements should be included. This obligation applies to ALL evaluations planned for support in FY 2016, including any Impact Evaluations/Implementation Science studies submitted for consideration. These data requirements do not supersede those associated with the IE/IS submissions. More detailed and additional information (detailed in the Evaluation Standards of Practice document) regarding planned, ongoing, and completed evaluations will be collected in conjunction with the APR.

3.1.5 Planning Step 5:
Determine the Package to Sustain Services and Support in Other Locations and Populations and Expected Volume

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PEPFAR is obligated to ensure standards of care are upheld for the patients we support with life-saving care, treatment and support services. In the current environment there is an urgent need to shift program resources on the locations and populations where most new HIV infections are likely to occur. However, redirecting resources to enhance program focus must be accomplished through responsible financial and program planning with the host country government or other sources of support. In COP 2016, PEPFAR teams are expected to define a package of services needed to sustain support for locations and populations not prioritized for accelerated epidemic control.

Guiding principles:

1. PEPFAR should no longer support sites with HTS services where an adequate number of HIV positives are not identified.

    In addition to discontinuation of PEPFAR-supported HIV testing at sites with less than four positives identified in the last 12 months, PEPFAR teams with site-level indicator data are expected to complete a full site yield analysis for HTS, including testing conducted at PMTCT sites. The purpose of this analysis is to determine where the majority of positives are identified and quantify potential cost savings or increases in yield that result from enhanced program focus on high-burden areas and populations. A full description of methods to conduct a site yield analysis can be found in section 3.3.3.

2. PEPFAR should work with the host country government and other stakeholders to transition support for low-volume ART sites or refer current patients to higher volume sites to improve quality of care.

PEPFAR-supported ART sites that provide services to a low volume of ART patients may not be able to provide the same quality of care as sites with higher volume and greater capacity. If resources for scale-up are to be focused in high-burden locations and populations, PEPFAR teams will need to determine which treatment sites in other locations PEPFAR will continue to support with a core package of services (see next subsection) and which sites will be selected for transition.

PEPFAR teams with site-level indicator data are expected to conduct a site volume analysis for ART. The purpose of this analysis is to identify low-volume sites and determine the cost savings or additional patient slots that could be supported if PEPFAR resources are redirected to higher volume sites. A full description of methods to conduct a site volume analysis can be found in section 3.3.3.

3. Program costs and trade-offs should be taken into account when determining sustained support for other locations and populations.

Continuation of support to sites in areas not selected for prioritization in COP 2016 represents a cost to PEPFAR. After the site yield and volume analysis are conducted and interagency decisions are made about which sites will continue to receive PEPFAR support in the coming cycle, teams will need to estimate the required resources necessary

to sustain support of the program (i.e., sites/program activities outside of the selected priority locations). To the extent possible, this should be driven by program data, expenditure data, and the expected volume of beneficiaries. For PEPFAR-supported ART sites, teams should factor in an estimate of passive enrollment and continuation of care for current patients supported with clinical care and ART. These calculations are described in more detail in section 3.1.5.

Resources needed to support the current volume of beneficiaries in *priority areas*, plus the resources needed to support the current volume of beneficiaries in *other locations* that will be sustained in COP 2016, represent the total dollars required to sustain the current program, or the 'carrying costs.' Given a finite budget, this carrying cost will affect the resources available for other program activities and the magnitude of scale-up that can be achieved in priority locations. Section 3.3.6 describes methods for resource projections that can be applied to assist with estimating this resource requirement.

> **TTFs:** The ***PEPFAR Budget Allocation Calculator (PBAC)*** is a resource projection tool that PEPFAR teams are required to use to estimate and document the required resources to fund program activities based on historical expenditure or cost data. PEPFAR teams must provide clear documentation and the data on which they made their adjustments. The final version of the PBAC should be saved with COP documents on pepfar.net for reference.
>
> When projecting resources, teams should consider changes in costs if patients are picking up drugs every 6 months, versus every three months, and the reduced need for lab services and doctor visits.

Define a package of services to sustain support for other locations and populations

Country teams should develop a package of services provided at PEPFAR-supported facilities and service outlets in other locations and for populations not prioritized for scale-up. The components of this package should be based on the host country's minimum/standard package of services for PLHIV but focused on essential HIV-related services and commodities. The components of this package will not be the same in every country and will depend on services provided by the host country

government and other stakeholders. Essential components to be considered for a minimum package of services for other locations and populations include:

- HIV testing and counseling on request by a presenting client or as indicated by clinical symptomology or identified risk behaviors.
- Care services for PLHIV, including provision of cotrimoxazole prophylaxis, screening for TB and other opportunistic infections, provision of fluconazole or INH prophylaxis, condoms, PHDP package, etc. depending on the country context.
- Treatment services including routine clinic visits, ARVs, and care package.
- Essential laboratory services for PLHIV – capacity for HIV testing, EID, viral load and CD4 testing.

Teams should consider how implementing a *sustained package* affects all parts of program support within a site where one or more program components would need to be transitioned to other stakeholders (e.g., MOH). Programs may transition at different rates, and there is expected to be a transition period for some program activities including OVC, VMMC, gender based violence, routine testing for pregnant women, key population outreach etcetera, and some above site-level support.

While PEPFAR programs phase out of active counseling and testing and new ART enrolment, PEPFAR service or technical support for other programs must be done as well through careful transition planning to ensure that harmful consequences are avoided. For OVC programs in central support and sustained SNUs, countries should use evidence-based models to set benchmarks for phased graduation and transition planning. PEPFAR teams should communicate early and comprehensively with other USG health programs, the Global Fund and government to identify a clear transition plan that may include: uptake of services by the government or referral of clients to service delivery points in prioritized locations.

The sustained package of services and transition activities will have an impact on the resources required to support programs in areas outside of those selected for prioritization in COP 2016. This package should be taken into account in estimating the budget needed to continue support in other locations and populations (see planning Step 6 below). As concisely as possible, PEPFAR teams should describe the package of sustained services provided outside of priority areas in the narrative of Section 5.1 in the SDS.

Outline plans for sites and programs that will receive central support

After teams successfully complete the site yield and volume analyses, define a core package of services, and interagency decisions are made about which sites will be supported with the core package in the coming cycle, plans for sites or other PEPFAR supported programs to transition to central support should be documented in Appendix A, Table A.3 of the SDS. Additionally, teams are requested to concisely describe these transition plans in the narrative of Section 5.2 in the SDS.

Determine expected volume of beneficiaries

Teams must specify in Standard Table 5.1.1 of the SDS the volume of beneficiaries expected to be reached with the core package of services outside of priority locations. In calculating these figures, teams should consider the following:

- Expected sites that will be supported *after* site yield and volume analysis (see Section 3.3.3)
- Impact of transition plans on volume of beneficiaries supported by PEPFAR.
- Differences in HTS yield in areas not prioritized for epidemic control compared with scale-up (priority) areas.
- Differences in HIV testing positivity yield associated with passive testing (i.e., PITC) versus yield associated with all HTS activities.
- Differences in retention and LTFU in sustained sites compared with scale-up sites.

Column definitions and instructions:

1. Sustained volume by group – Five activity groups, each representing one row in the table, are required:
    - HIV testing in PMTCT sites
    - HTS (only sustained ART sites in FY 17)
    - Current on care (not yet initiated on ART)
    - Current on ART
    - OVC

    In the SDS template, the MER indicator code is listed next to each group.

2. Expected result APR 16 – Enter the expected result as of APR 2016 (September 30, 2016) *only for areas not prioritized in COP 2016.*

3. <u>Expected result APR 17</u> – Enter the expected volume for each group in the implementation cycle. This should correspond to the expected APR result in 2017 (September 30, 2017) *only for areas not prioritized in COP 2016.*

4. <u>Percent increase (decrease)</u> – Enter the percentage increase or decrease in volume of beneficiaries for each group *only for areas not prioritized in COP 2016.* This can be calculated with the following formula:

(Expected APR 17 result – Expected APR 16 result) ÷ Expected APR 16 result

---

TTFs: The ***Data Pack*** has been provided to assist teams with calculating the expected volume of beneficiaries in each of the groups listed in Standard Table 5.1.1.

TA/TC Consideration

TA/TC programs where there has not been any historical PEPFAR direct service delivery investments outside of priority geographic areas or key populations are not required to complete Standard Table 5.1.1; however, they will be expected to discuss transition plans for activities no longer prioritized in COP 2016 in the narrative of Section 5.2 in the SDS.

Milestone: Complete Sections 5.1 and 5.2 of the SDS, including table 5.1.1.

PEPFAR teams are expected to determine the cost to PEPFAR of activities planned for COP 2016. This "resource projection" should be based on the actual cost of services and support provided in the past with necessary adjustments for how activities and costs will change in the future. *The actual cost is not the same as the amount budgeted.* Teams should use cost and/or expenditure data to determine the resources required to achieve desired targets and program deliverables in the next fiscal year and verify this amount *does not exceed the planned funding level for COP 2016.* Resource projections should also be used to guide program decisions regarding priority locations and populations chosen for scale-up; core, near-core, and non-core activities; selection of core and sustained packages for service delivery; and proposed targets. Generally, there is paucity of cost data at the field level that can be utilized to better inform program decisions and feed into budget projections. In response to this critical data gap, PEPFAR institutionalized the Expenditure Analysis (EA) Initiative in 2012 and expanded to all PEPFAR OUs in 2014. Through EA, PEPFAR teams have data on the unit expenditure (UE) observed for achieving program results in the last fiscal year. PEPFAR teams should use this information along with key resource projection data points from the COP 2015 review as a starting point for calculating the expected cost to PEPFAR of the program in the future.

A strategic approach to empirically-based budgeting is described in detail in the methods portion of this section (3.3.6). When implementing this approach during COP planning, there are several guiding principles teams should consider:

1. Carrying costs to PEPFAR of current program activities should be calculated first.

> As described in the section on sustained support above, PEPFAR will continue to support current PLHIV receiving clinical care and ART services in all sites until referral, consolidation or transition of site support to other stakeholders can be accomplished without compromising patients' health. For sustained sites (i.e., in areas not prioritized for epidemic control), PEPFAR teams should allocate sufficient funds to support the current cohort of patients enrolled in care and treatment, consistent with the sustained package of clinical services defined. For low-volume and central support sites, the expected volume of beneficiaries should be adjusted to account for transition of patients to support by other stakeholders. In addition, teams should determine the expected number of new patients that will be enrolled in

the implementation year in sustaining sites as a result of PITC and diagnosis. Calculating this carrying cost provides a sense of how much of the COP 2016 budget should be set aside prior to planning for any other activities or scale-up to meet PEPFAR obligations and maintain clinical standards of care.

2. Length of time enrolled should be taken into account when setting targets and projecting resources for care and treatment.

With the required congressional directive of 50% across the entire bilateral program care and treatment expenditures are not insignificant. Minor adjustments can have a large impact on the total cost of the clinical program and the number of patients that can be supported. One essential adjustment in any resource projection is the length of time a patient is receiving care over the implementation year—i.e., the cost-per-patient of a person initiated on ART in January will be different than the cost-per-patient of a person initiated on ART in July. Using the USG fiscal year as the discreet time period, the first patient would receive nine months of ART, whereas the second patient would receive three months, resulting in very different annual costs for each. When this principle is applied to the aggregate program, the enrollment rate matters and has an impact on the total estimated cost. Budgeting by multiplying the annual, average cost of ART by the total current on ART at APR 17 will substantially *overstate* the required resources needed to support the cohort since not all will be on treatment for a full year.

To correct for this time component, teams should use simple patient year calculations to determine the *equivalent number of patient-years* that would be expected given the number of patients enrolled at the start of the period, scale-up rate during the cycle, and the expected LTFU. This applies to both clinical services and commodities. This method is described in detail in section 3.3.6 below. EA results for pre-ART and ART unit expenditures are already adjusted using patient-year calculations.

3. Available data on unit costs to PEPFAR used for resource projections need to be adjusted to reflect program activities and expected costs in the future.

At minimum, there are two adjustments that all teams should make prior to calculating resource projections:

- *Adjustments for program focus*

Based on the results of the site yield and volume analysis and selection of scale-up, sustained and central support sites, teams should adjust the expected future UE based on the implementing mechanisms and sites that will be responsible for achieving targets in the implementation year. Costs vary across geographic areas and implementing partners, which will impact the total cost of the program in the next cycle as the program shifts focus to higher-burden locations and populations. Data on the historical UEs for implementing partners at the SNU-level can be used to make these adjustments.

- *Adjustments for expected changes to program components or costs*

  The UE from the last fiscal year may include expenditures that will not be expected in the coming fiscal year (e.g., purchase of a fleet of vehicles). Conversely, the UE may not include investments that are expected in the coming fiscal year (e.g., improvements to retention through enhanced provider training programs). These differences can be quantified and should be used to adjust inputs to resource projections. The same principle applies to adjustments based on expected changes in contribution of other sources of support (e.g., Global Fund).

- *Adjustments for expected changes to commodities procurement plan*

  Commodities including ARVs, non-ARV drugs and reagents, lab supplies, etc. are supported by PEPFAR in a number of operating units and are reflected in the relevant UEs. The commodities procurement plan for a given implementation cycle may vary by operating unit. PEPFAR teams can opt for making adjustments by excluding commodities from the UEs and budgeting them separately and then adding them back to the total projected required resources.

TTFs: The *PEPFAR Budget Allocation Calculator (PBAC)* is a resource projection tool that PEPFAR teams are required to use to estimate and document the required resources to fund program activities based on historical expenditure or cost data. PEPFAR teams must provide clear documentation and the data on which they made their adjustments. The final version of the PBAC should be saved with COP documents on pepfar.net for reference.

TA/TC Considerations

TA/TC programs may have limited unit expenditure data available for budgeting purposes. TA/TC programs should consider any UEs for any available program areas (e.g. HTS, Key Populations, etc.) and adjust per the guidance above. In addition, TA/TC programs can use EA data to examine site and above-site level expenditures and use this information to make an informed estimate of required resources to fund future program activities. Final, adjusted UE data (if available) and budget summary (including lump sums) should be saved in PBAC.

3.1.7 Planning Step 7:
Set Site, Geographic and Mechanism Targets

COP 16 will include five types of targets, all of which will be set for FY 17 results. FY 16 targets will not be restated in COP 16.

1. **Site Level Targets** – Site level target setting allows for implementing partners to clearly articulate and set expectations for achievements at each PEPFAR-supported site based on supported activities and in alignment with geographic, population, and intervention-based prioritization efforts for scale-up or sustained support.

2. **Sub-national (i.e., District) Level Targets** – Sub-national level target setting strategically demonstrates geographic prioritization of efforts towards the 90:90:90 by 2020 UNAIDS target in alignment with the distribution of the burden of disease in a country.

3. **Implementing Mechanism Level Targets** – Implementing Mechanism (IM) targets represent expected accomplishments for the implementing partner based on available funding and agreed upon activities. Target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements.

4. **Technical Area Summary Level Targets** – The PEPFAR Technical Area Summary Targets are an aggregated reflection of total expected achievements in a country based on the collective work of all PEPFAR partners, and should represent PEPFAR's contributions to the national program. These targets should reflect scale up for epidemic control in high disease burden areas and sustain support of programs in other areas.

5. **National Targets** – National data represent the collective achievements of all contributors to a program area, including PEPFAR (i.e., partner country government, donors, or civil society organizations).

Target Setting Overview
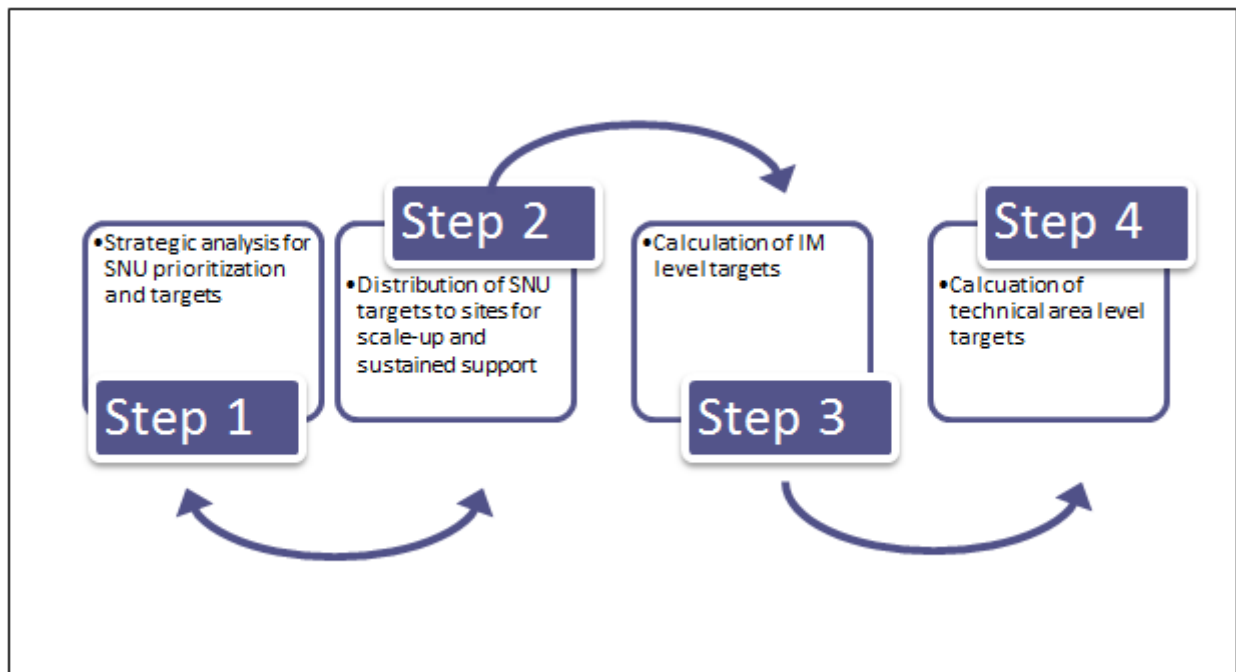
Recommended Process for Establishing and Entering Targets

- Country teams notify partners of priority areas and targets by SNU and work with partners to set relevant site-level targets
- Partners enter site-level targets into DATIM or other identified format
- Activity managers and project officers review and approve partner targets at the agency-level and confirm budgets
- Interagency PEPFAR team reviews and approves site, mechanism, and geographic targets

After teams have completed the geographic and efficiency analysis and set programmatic targets for priority areas and populations, these will need to be distributed to sites (facility and community). The strategic analysis conducted in Steps 1 - 6 now need to be operationalized by assigning site-level targets, and calculating mechanism level targets and budgets.

Distribution of SNU targets to sites for scale-up and sustained support

In Step 3, scale-up and sustained support targets by SNU for all indicators were determined. These targets need to be distributed to sites.

Distribution of scale-up targets by SNU to sites

1. Distribution of SNU targets across sites need to take into account the following considerations:

   - New ART treatment slots should be prioritized for sites within SNUs identified as Scale-Up to Saturation districts and *then* should be assigned to sites in Aggressive Scale-Up districts

   - Past performance of partners at sites and capacity to expand site volume (including changing the monitoring time intervals)
   - Site yield for testing and volume for other services
   - The need to establish additional sites in catchment areas within a geographic region to meet the target
2. If additional sites are needed, then look at current partner's capacity to expand to additional sites.
3. Relevant site support should be determined by assessing site needs for commodities, human resources, or relevant technical support for expansion of services. This will determine the appropriate categorization of targets by DSD or TA-SDI support to the site.
4. If several partners are working across the continuum at facility and community sites, it is imperative that the partners coordinate to ensure no patients are lost across the continuum.

Distribution of sustained support targets by SNU to sites

1. Resources need to be allocated to sites to maintain patients on ART, taking into consideration other critical programmatic areas of support such as OVC.

2. As described in Step 6, PEPFAR will continue to support current PLHIV receiving clinical care and ART services in all sites until referral or transition of site support to other stakeholders can be accomplished without compromising patients' health. For sustained sites (i.e., in areas not prioritized for epidemic control), PEPFAR teams should allocate

sufficient funds to support the current cohort of patients enrolled in care and treatment, consistent with the sustained package of clinical services defined. For low-volume and transition sites, the expected volume of beneficiaries should be adjusted to account for transition of patients to support by other stakeholders. In addition, teams should determine the expected number of new patients will be enrolled in the implementation year in sustained sites as a result of passive HIV testing and diagnosis.

3. Relevant site support should be determined by assessing site needs for commodities, human resources, or relevant technical support for expansion of services. This will determine the appropriate categorization of targets by DSD or TA-SDI support to the site.

Implementing Mechanism Level Targets

Implementing mechanism targets are the sum of the site-level targets. Where more than one partner may reach the same individuals at a given site, country teams should take the opportunity to rationalize partners for increased efficiency. Implementing mechanism targets should not be determined prior to conducting Steps 1- 6.

Technical Area Summary Targets

Technical area summary targets are a de-duplicated sum of the Implementing Mechanism targets. Cascade analysis of targets will need to occur at a subnational level as opposed to the technical area level, to verify or update COP 2016 planning targets.

Milestone: As an Interagency team, you should be able to determine technical area, mechanism, geographic and site-level targets. Targets should be entered in DATIM and mechanism budgets and other required details should be entered into FACTS Info.

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3.1.8 Planning Step 8:
Determine monitoring strategy for planned activities in accordance with requirements and assess staff capacity

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PEPFAR must continue to enhance oversight of and accountability for programs and ensure that PEPFAR-supported beneficiaries are receiving quality services and accounting for US tax payer dollars. Teams should consider how information from all data streams available to country teams will be used routinely throughout the year to monitor progress, ensure compliance with strategic plans outlined in the SDS, and course-correct where needed. PEPFAR teams should assess the current skills and time commitments of program staff to ensure sufficient capacity is available to meet monitoring requirements. Methods and tools to assess current staff time allocation and cost of doing business (CODB) can be found in section 8.1 of this guidance. In addition, site monitoring requirements for all PEPFAR OUs need to be specifically addressed in COP 2016 development.

PEPFAR's standards-based quality assurance Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of PEPFAR-supported services and technical assistance, (2) ensure accountability of USG investments, and (3) maximize impact on the HIV epidemic.

Consistent with these goals, SIMS promotes compliance with global and national service delivery standards by facilitating program improvement. SIMS data will be used to: (1) demonstrate the quality of services and TA at each site, (2) demonstrate accountability of USG investments by showing that quality is being monitored and improved where needed, and (3) prioritize quality improvement of core interventions where most important for epidemic control and impact.

SIMS assessment results confirm compliance to minimum PEPFAR quality assurance standards and identify areas where improvements in PEPFAR-supported programs can be made. These standards are assessed in PEPFAR-supported facilities, in communities, and above-site institutions that guide and support service delivery

In FY2016, teams made a clear demonstration of accountability of USG investment by systematically monitoring the quality of service delivery across all PEPFAR implementing agencies and partners. As of the issuance of this document, over 2,500 SIMS assessments have been conducted in facilities, communities and above-site entities by all PEPFAR-funded agencies across PEPFAR's 36 Operating Units. Additionally, use of SIMS data to facilitate program improvement is being embedded in

PEPFAR business processes beginning with the FY 15/Q3 PEPFAR Oversight and Accountability Review Team (POART) calls.

In FY 16, OU teams committed to SIMS site visit targets aligned with geographic and programmatic pivots made as part of COP 15. These commitments to scale up SIMS assessment coverage are critical to demonstrate USG investments toward standards of care to achieve HIV epidemic control. Access to PEPFAR resources for COP 2016 will be contingent upon approved plans for SIMS assessment visits for FY2017.

To align SIMS with programmatic pivots and geographic/population prioritization, the following requirements apply:

1. SIMS Assessments

All PEPFAR-supported sites (facility or community) or entities that guide and support service delivery (at the above-site level) must receive at least an initial SIMS assessment during the life of an Implementing Mechanism funding agreement. PEPFAR-supported high-volume sites (facility or community) must receive a SIMS assessment annually. An interagency agreed upon definition of high-volume facility and community sites should be established. This definition will be reviewed and approved by S/GAC at the DC Management Meeting. The high-volume definition for facility should be determined using MER indicators applicable to a given Implementing Mechanism (i.e., HTC_TST, TX_CURR, PMTCT_STAT, PMTCT_ARV, and VMMC_CIRC). The high-volume definition for community should be determined using MER indicators applicable to a given Implementing Mechanism (i.e., HTC_TST, OVC_SERV, and KP_PREV). Above-site entities at all levels must be visited annually. Specifically, all national-level above-site entities supported by a given IM should be assessed annually, and at least one entity at each sub-national level supported by a given IM should be assessed annually. SIMS assessments across all SIMS tools should be geographically prioritized (e.g., Scale-Up to Saturation and Aggressive Scale-Up districts) to focus on areas in which the majority of beneficiaries are receiving services supported by PEPFAR.

All newly-supported sites or entities must be visited in the first year of the agreement. A site or entity is considered "new" when it is supported through a new contract/agreement or a new Implementing Partner. A site or entity is not considered "new" if it was operational under a previous contract/agreement and is supported by the same partner/sub-partner.

2. Program Improvement

For all PEPFAR-funded CEEs that score yellow or red at an assessment, the IP is expected to have an action plan in place and have taken steps towards remediation within 3 months. Plans for improvement should be made between the IP and the USG activity manager, with monitoring of improvement tracked via routine partner management and oversight meetings with USG activity managers.

Any CEEs scoring yellow or red on an initial or annually required assessment trigger a rescore and, in certain cases, a re-visit. All CEEs scoring yellow or red should be re-scored by the IP within six (6) months of the assessment that triggered the rescore, with the rescore reported to the agency activity manager. IP-reported rescores should be entered into agency-specific data systems and sent to USG HQ by the next available reporting cycle.

For facility and community site assessments scoring red on 25% or more of all scored CEEs or both yellow or red on 50% or more of all scored CEEs, IPs will be required to address improvement in writing as described above within one (1) month of the assessment. For facility and community sites scoring red on 25% or more of all scored CEEs or both yellow or red on 50% or more of all scored CEEs, USG staff from the agency overseeing the IP must revisit and rescore the site within six (6) months following the assessment that triggered the rescore. For above-site assessments, USG staff from the agency overseeing the IP must revisit and rescore all CEEs scoring red or yellow within one (1) year following the assessment that triggered the rescore. For all sites and entities rescore assessments, USG-assessed rescores should be entered into the agency SIMS data systems and sent to S/GAC by the next available reporting cycle.

Figure 3.1.8:

Scenario	Timing	Who	What	Action
All Tools				
<25% CEEs Red <50% CEEs Red/Yellow	Within 3 months	IP	Corrective action for Red/Yellow CEEs	Action Plan
<25% CEEs Red <50% CEEs Red/Yellow	Within 6 months	IP	Rescore of Red/Yellow CEEs	Follow-Up Visit Rescore*
Facility and Community Tools				
≥50% CEEs Red/Yellow ≥25% CEEs Red	Within 1 month	IP	Corrective action for Red/Yellow CEEs	Written Response
≥50% CEEs Red/Yellow ≥25% CEEs Red	6 months	USG	Rescores of Red/Yellow CEEs	Follow-Up Visit Rescore
Above-Site				
Any Red/Yellow CEEs	Within 1 year	USG	Rescores of Red/Yellow CEEs	Follow-Up Visit Rescore

*Partner rescored CEEs reviewed, new scores entered by USG into agency-specific data systems

3. Quality Assurance

Quality Assurance of SIMS implementation will be conducted by PEPFAR Implementing Agencies and S/GAC. Implementing Agencies will be responsible for ensuring the quality and consistency of implementation and reporting of SIMS assessments to S/GAC using agency-specific standardized procedures. All PEPFAR Implementing Agencies must conduct SIMS Quality Assurance (QA) activities and report on their SIMS QA structures and process to S/GAC on an annual basis. S/GAC will conduct in-country reviews to determine OUs adherence to SIMS implementation standards outlined in the current SIMS Implementation Guide.

All site-, partner-, agency- and country-identified data will be exchanged into a secure location (DATIM). Data exchange and security attributes and guidance on reporting to S/GAC will be provided through DATIM deployment and its user guide

4. Agency-specific considerations

Results from DoD SIMS assessments conducted at military sites are reported at the national level by IM, not at the site level. Site-level data from military sites will not be publically available. Military site-level planning information related to SIMS will be reviewed internally at DoD and is not required for submission to S/GAC. Results from DoD civilian SIMS assessments conducted at civilian sites will be reported at the site level. Refer to agency-specific guidance for more detailed information

Peace Corps is not required to conduct SIMS assessments. However, given the importance of monitoring program quality, Peace Corps/Washington has designed a tool for use by Peace Corps Volunteers that is being piloted during FY 16 with select OUs. For Peace Corps posts implementing SIMS in FY 17, 25% to 50% of 1st-year volunteers who are conducting HIV activities are to be assessed during a scheduled site visit. Remediation is to occur at the time of the assessment. Refer to agency guidance for more detailed information.

5. <u>SIMS Planning</u>

In order to assist field teams with planning and budgeting for the SIMS assessments, **SIMS Action Planner (SAP)** templates will be made available on the COP 2016 page on pepfar.net. This SAP should serve as the basis to plan COP 2016 SIMS assessment visits and should be based on sites/entities at which PEPFAR partners will be active in the implementation cycle. For COP 2016, PEPFAR teams' are required to submit a SIMS Assessment visit plan that includes both agency-specific SIMS Action Planners and an interagency summary of total planned assessments.

As part of the development of the COP 2016 site visit plan, teams should carefully review the costs associated with conducting site visits, utilizing existing human resources and vehicles to conduct site visits. Should planning show that additional M&O needs are required, teams must rationalize (with data) any new SIMS related M&O requests.

3.2 Order of Planning Steps and Activities

The recommended planning steps described in section 3.1 are modular, meaning teams may complete each step in whatever order they choose depending on the PEPFAR program context and/or availability of staff time. Some steps can be done concurrently; other steps are dependent on the outcomes of prior activities and should be completed in sequence accordingly. Similarly, some steps may need to be revisited after further analysis and decision making. Finally, there are analyses/activities found in the methods section (3.3) that inform multiple steps and should be completed at specific points in the process to be most useful. PEPFAR field teams are encouraged to be innovative in their approach; however, some guiding principles are provided below. For ease of reference, the planning steps are as follows:

1. Understand the current program context
2. Assess alignment of current PEPFAR investments and program focus
3. Determine priority locations and populations for epidemic control and set targets
4. Determine program support and system-level interventions in which PEPFAR will invest to achieve epidemic control
5. Determine the package to sustain services and support in other locations and populations and expected volume
6. Project total PEPFAR resources required to implement strategic plan and reconcile with planned funding level
7. Set site, geographic and mechanism targets and budgets
8. Determine monitoring strategy for planned activities in accordance with requirements and assess staff capacity

<u>Guiding principles</u> for order of planning steps and key analyses/activities:

1. <u>The civil society engagement plan should be developed and implemented at the beginning of the planning process.</u>

    The intent of the civil society engagement plan is to engage early and often with organizations that offer valuable, on-the-ground information about the effectiveness of the current HIV response and viability of future plans. Teams should develop the plan and begin implementation concurrent to all initial planning steps and activities (see sections 2.3.3 and 3.3.2).

2. <u>Initiate strategic communication with external partners.</u>

PEPFAR teams should consult with host country governments and external partners to signal potential changes in direction to program implementation and work with key stakeholders to share critical data elements and jointly plan for program shifts in focus to achieve sustained epidemic control (see section 2.3). Effective engagement and joint planning should result in increased allocative and technical efficiency and program impact.

3. <u>Steps 1 and 2 should be completed prior to other planning steps and can be completed concurrently.</u>

Understanding the program context and assessing the alignment of program investments in requisite to informed decisions about how PEPFAR will fill critical gaps and design programs to maximize the impact of investments in the pursuit of sustained epidemic control. There is no dependency between Steps 1 and 2 and they may be completed concurrently to use time efficiently.

4. <u>Initial site yield and volume analyses should be completed prior to Steps 3-8.</u>

The results of the initial site yield and volume analyses (see Section 3.3.3) should inform decisions about geographic and population prioritization; targets at the site, mechanism, and SNU levels; establishment of sustained support package; transition plans; resource projections; and the monitoring plan and Management and Operations (M&O) activities, especially the implementation of SIMS. The site yield/volume analyses can be completed concurrent to Steps 1 and 2 to use time efficiently; however, it is likely the analyses will need to be revisited from time to time as other steps are completed and decisions made.

5. <u>Quantification of cost savings and productivity gains should always accompany site yield and volume analysis.</u>

As teams complete the site yield/volume analysis, it is recommended the results of each scenario are linked to resources to be freed up for redirection of PEPFAR resources or increases in productivity that result from enhanced program focus (see Section 3.3.4). Used in tandem, these analyses will inform program decisions made in completing future steps.

6. <u>Changes in core, near-core and non-core program activities are likely in COP 2016 and these classifications should be reviewed throughout the process.</u>

   As teams review their COP 2016 assumptions, progress and the results of Step 4, interagency decisions about which program activities will be classified as core, near-core, or non-core in the implementation period (see Section 3.3.1) should be reviewed. It is likely this activity will be iterative and decisions will need to be revisited as other target and budgets are finalized.

7. <u>Steps 3-5 are dependent and should be completed concurrently.</u>

   As teams make decisions regarding geographic and population focus (Step 3), set targets for epidemic control (Step 3), and determine activities that will fill critical program gaps (Step 4), they must also determine what the minimum package will look like in other areas and the expected volume of beneficiaries that will receive the minimum package (Step 5). Given a fixed funding level, trade-offs will need to be made that affect the ability of the program to scale and invest in laboratory strengthening, SI and HSS activities. These steps are dependent on each other and each will likely need to be revisited as different scenarios are considered.

8. <u>Steps 6 and 7 are dependent and should be completed concurrently.</u>

   Teams are required to project the required resources needed to implement the planned program and verify the program cost is within the planned spending envelope (Step 6). This will require estimating the total program cost, which will partially be determined by decisions made in Steps 3-5. Additionally, accurate resource projections will require adjustments to cost inputs resulting from shifts in program focus and partners selected to increase scale (see section 3.3.6). As such, teams should iteratively complete steps 6 and 7 and make adjustments to each as needed. Completion of Steps 6 and 7 may also require teams to revisit decisions made in Steps 3-5.

9. <u>Step 8 should be completed last.</u>
   Teams should wait to determine the monitoring plan and assess staff capacity after Steps 1-7 and all other required analyses and activities have been completed. This is particularly true for defining the SIMS implementation plan and the impact on cost of doing business.

Figure 3.2.1 below summarizes these guiding principles.

3.2.1 Recommended Order of Planning Steps and Key Activities/Analyses
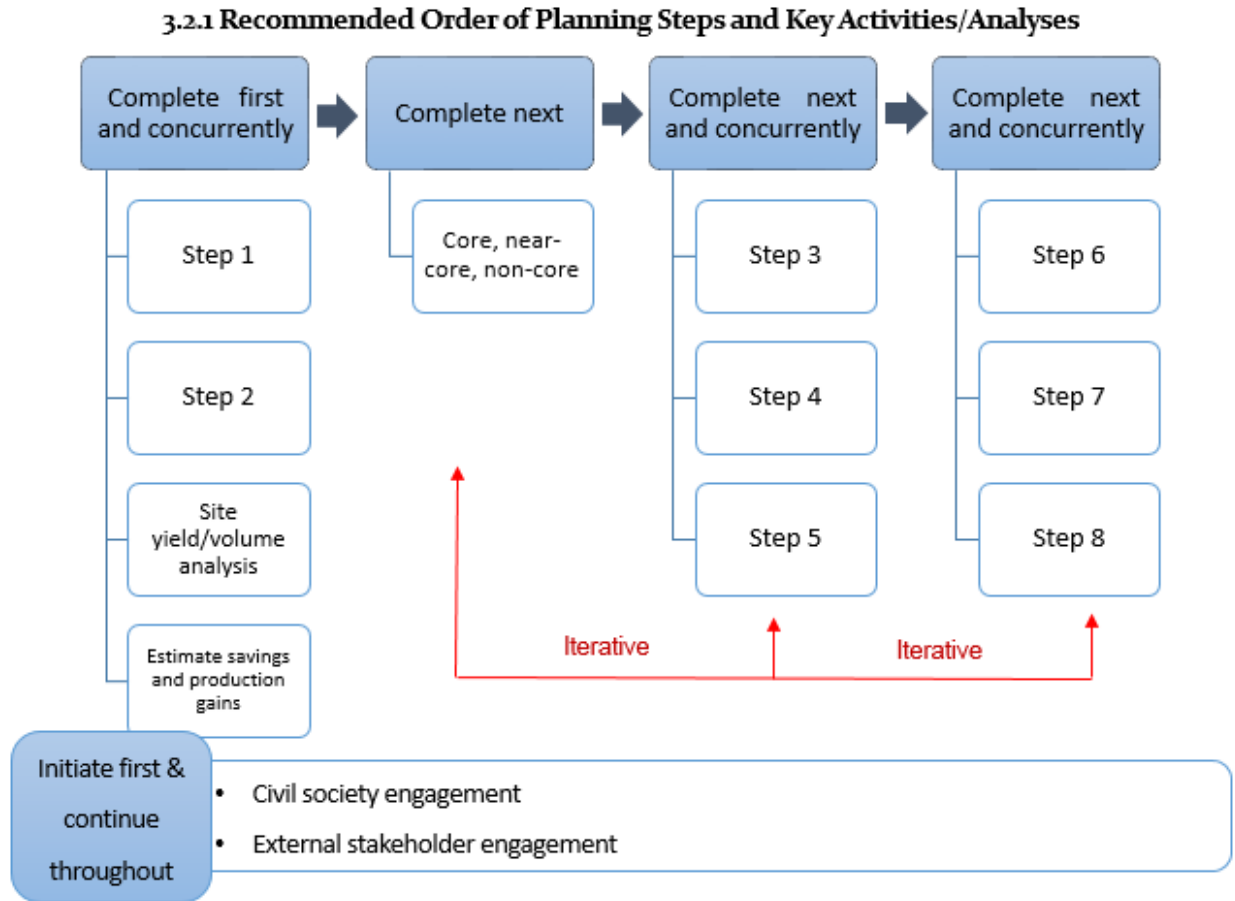
3.3 Methods

The sections below provide guidelines for completing activities and analyses necessary to successfully implement the modular planning steps in section 3.2 and generate a comprehensive SDS.

3.3.1 Core, Near-core, and Non-core Program Decisions

As in COP 2015, whether a PEPFAR country program is classified as long term strategy (LTS), targeted assistance (TA), technical collaboration (TC), co-finance (LTS/TA), or served from a regional platform, greater integrated data analysis and interpretation will underpin team decision-making in the third phase of PEPFAR. Moreover, programs will continue to take strategic action to focus resources geographically and programmatically to save lives and prevent the spread of HIV. This will require PEPFAR teams to continue to examine epidemic, programmatic, financial, and expenditure data in a more sophisticated and integrated manner. Teams will also be required to routinely assess where PEPFAR fits within a national response to accelerate scale-up of the highest impact interventions.

Based on scientific evidence in June 2014, Ambassador Deborah Birx described the following core activities for maximizing efforts to reach sustainable epidemic control:
- Combination Prevention (PMTCT, ART, Condoms, VMMC)
- Prevention (effective/targeted)
- OVC – services for families that have been specifically shown to impact children
- Neglected & Hard to Reach Populations
    - Pediatrics
    - Adolescent Girls & Young women (AGYW)
    - Key populations – MSM & transgender persons, sex workers, people who inject drugs
- Strengthening Health Systems as specifically required to support the core activities
    - Human resources for health, procurement & supply chain, laboratory, and strategic information

Defining a PEPFAR Country Team's Core, Near-Core, & Non-Core Activities:

In COP 2016, PEPFAR teams will need to review and update their core, near-core and non-core classifications. This update should be informed by the team's review of their COP 2015 assumptions and progress. It is critical that discussions about which program activities are classified as core, near-

core, or non-core be conducted as an interagency team and, ideally, with each programmatic area participating. It is likely that updating core, near-core and non-core activities will be an iterative discussion and that final decisions will need to be reflected once target and budgets are completed by the team. As in COP 2015, non-core activities should not be funded in COP 2016 and transition plans for these activities need to be reflected in Table A.3.

The purpose of this exercise is to ensure that the core activities described above are being scaled within the national response at a rate, coverage level and in a quality manner to achieve sustainable epidemic control. It is designed to ensure that PEPFAR country programs are supporting the scale-up, quality, and where appropriate, sustain support of these core activities within the national response. However, it does not mean that PEPFAR has to directly support or engage in all of these areas.

For a team to set and/or validate its role in the national response, each PEPFAR team needs to have a clear understanding of the progress of the national response in coverage and quality of the "right things"; any gaps and/or challenges that exist and/or are anticipated; and how other actors contribute in these areas. PEPFAR teams should examine the HIV clinical cascade for strengths and weaknesses as well as how PEPFAR-funded program support activities will help reach sustained HIV epidemic control. Also, PEPFAR teams will need to critically review their current portfolio to assess if there are activities or components of activities that can be transitioned away from PEPFAR funding for any of the following reasons: capacity has been built and can be transferred, including when the country is able to sustain activities with limited or no PEPFAR support; the activity is being addressed by another resource stream; the activity has matured and/or reached its intended outcome; and/or the activity is no longer central to an evidence-based, prioritized national HIV response. Teams may choose to define their core, near-core and non-core activities in a three-step process (reference Figure 3.3.1):

1. Review of PEPFAR's role at the national, sub-national, site level
2. Review of PEPFAR-funded activities by program area
3. Re-review of initial core, near-core and non-core findings (at national and program area(s) level) once program activities for scale-up/sustained locations and populations and finding from the SBOR have been determined

Because each national planning process is at a different stage, PEPFAR teams will design their approach to this exercise in a way that takes into account their national context and builds on and leverages national processes and information.

Finally, for this exercise, it is important to recognize that epidemic control is the primary goal of PEPFAR programs. To the extent that this goal is reached, PEPFAR teams will need to consider the sustainability of these gains in partnership with local governments, civil society, and other multilaterals including UNAIDS and the Global Fund.

Figure 3.3.1

Proposed Three Steps for Defining Core, Near-Core and Non-Core Activities
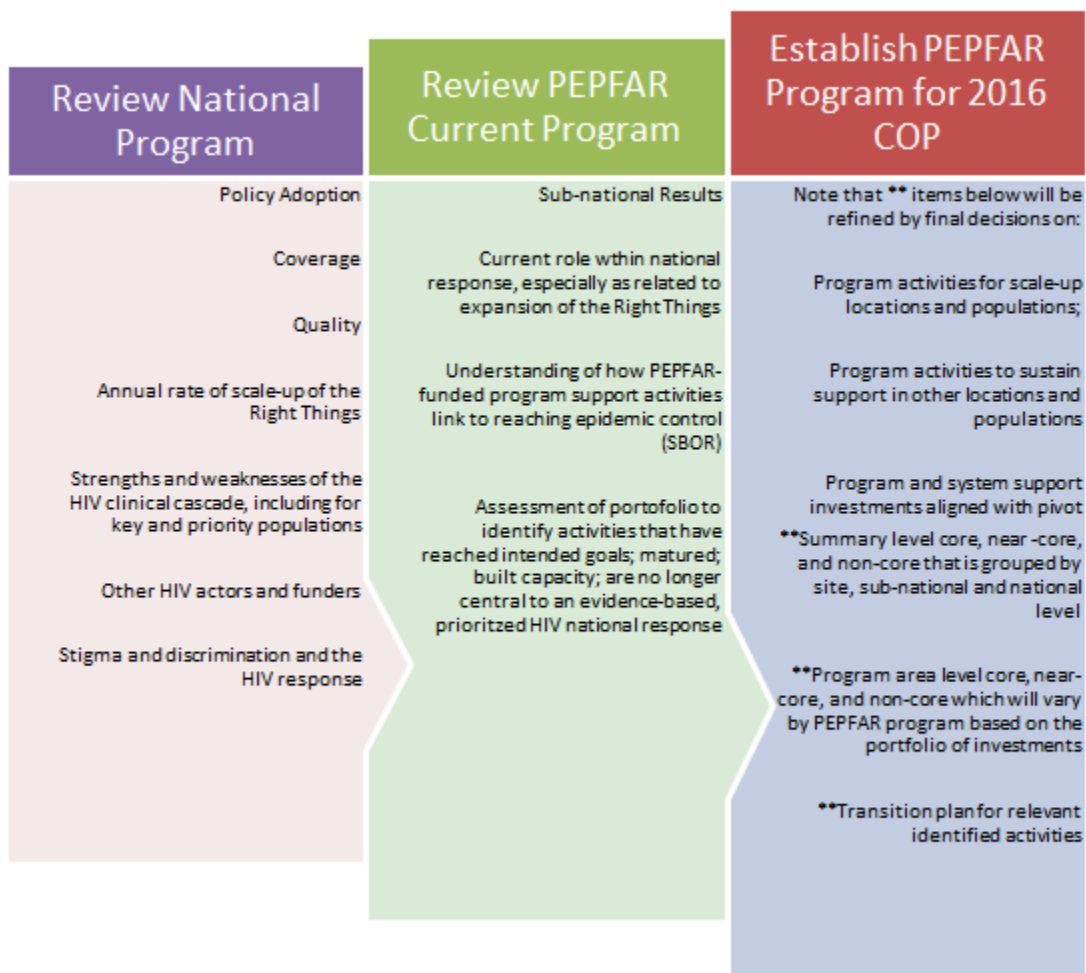
Previously released definitions for core, near-core and non-core activities apply in the development of the 2016 COP. They are listed below for your reference. Also, note for PEPFAR country-teams with existing COP commitments to the Pink Ribbon, Red Ribbon partnership, these will be classified as

near-core. <u>Expansion</u> of these commitments can be classified by relevant teams as core, near-core or non-core. Teams will reflect decisions in SDS Table A.1, A.2, and A.3.

Core, Near-Core, Non-Core Definitions:

<u>Long Term Strategy Countries</u>**:**   These are countries in need of external support for HIV/AIDS programs for the long term, based on prevalence, resource need, Global Fund financing, unmet service needs, capacity gaps, and U.S. geopolitical interest.

- **Core** - Activities critical to saving lives, preventing new infections, and those which PEPFAR is uniquely positioned to undertake.

- **Near-Core** - Activities that are critical to and/or directly support achieving core activities and that cannot yet be done well by other partners or the host country government.

- **Non-Core** - Activities that do not directly serve our HIV/AIDS goals and/or can be taken on by other partners.

<u>Targeted Assistance Countries and those supported through Regional Programs</u>**:**   These are countries receiving specific support for key populations or priority technical areas. USG activities largely support capacity building and technical assistance. May also provide direct services for key populations.

- **Core** - Activities critical to saving lives, preventing new infections - and which USG is uniquely qualified. *Primarily focused on key populations – MSM, TG, FSW, PWID – and stigma and discrimination.*

- **Near-Core** - Short term/time-limited investments/activities that are critical and/or directly support achieving core activities and cannot yet be done well by other partners or the host country government.

- **Non-Core** - Activities that do not directly serve our HIV/AIDS goals and/or can be taken on by other partners.

SDS Template Guidance:

PEPFAR teams should document interagency decisions on core, near-core, and non-core activities and support in Appendix A of the SDS, Standard Tables A.1 and A.2. In addition, teams should describe, as concisely as possible, major decisions in COP 2016 development regarding program focus by activity area in Section 2.0 of the SDS.

In Standard Table A.1, all major program activities should be recorded and assigned to the columns indicating core, near-core, or non-core. In addition, teams are asked to classify the activity by row as *primarily* implemented at the site-level, sub-national level, or national level. Regional programs may add a row marked "regional" to describe activities above country-level.

In Standard Table A.2, teams are asked to classify *components* of major activity areas as core, near-core, and non-core. The following rows are required in this table:

- HTS
- Care and treatment
- Prevention
- OVC

It is the expectation that those activities designated by a PEPFAR teams as non-core will be transitioned within in a 12-month timeframe and the transition plan summarized in SDS Table A.3. Note that as in COP 2015, PEPFAR teams should consider whether they need to use all the money that they previously allocated to the (non-core) activity. Discontinuation of a non-core activity could happen earlier than 12 months. Finally, funding for non-core activities will not be considered in COP 2016, and a zero should be reflected in the appropriate A.3 cell for each non-core activity.

Civil Society Engagement Checklist

Preparation

☐ Develop a strategy and timeline specific to the country for engaging civil society based on the principles put forth above in section 2.3.3 and in the Technical Considerations. A draft plan should be prepared in advance on the COP D.C. Management Meetings.

☐ Issue open invitations to scheduled consultations to current CSO contacts and ask that they share the invitations widely.

☐ On the PEPFAR page of the embassy website, post 1) a calendar of civil society consultation meetings and 2) a timeline that shows when background information or other relevant documents will be sent to civil society and the dates by which feedback is due (If applicable).

Engagement

☐ Schedule COP/ROP planning meetings with civil society representatives.

☐ Prepare background information for civil society representatives and disseminate it at least two weeks before the consultations to allow sufficient time for review and for clarifying questions to be asked and answered in advance. Depending on when the meetings, webinars, or calls are scheduled to occur, the data and documents making up the background information may include but are not limited to:

   ▪ A draft agenda for review and comment
   ▪ The current COP
   ▪ The draft Strategic Direction Summary for COP 16
   ▪ POART data (including draft data as appropriate)
   ▪ Summary of previously submitted civil society feedback and responses thereto
   ▪ Overview of current priorities, planned shifts, considerations, etc.

☐ Conduct the engagement process and solicit written recommendations from civil society.

☐ Conduct an additional meeting to bring together representatives from civil society organizations, multilateral organizations, and partner governments.

☐ Provide written responses to civil society representatives that submit written feedback. Whenever possible, responses should be provided within two weeks. For feedback that cannot be addressed within two weeks (e.g., because the relevant data are outstanding),

responses should be provided within one week to acknowledge receipt, explain why the action cannot be taken or why the question cannot be answered at that time, commit to responding when circumstances allow, and, if possible, provide an estimate as to when that will be the case. Written responses regarding COP 2016-specific civil society feedback should indicate whether the input will be reflected in the COP; if it will not be, the response should include an explanation as to why that is the case.

Note: Other avenues of civil society engagement (technical working groups, community advisory boards) can follow the basic format of the COP process.

On COP Approval: Follow Up/Evaluation Survey

☐ Upon final COP approval, PEPFAR country teams should provide written updates to civil society representatives to highlight key takeaways, including the ways in which their input is reflected in the COP. If a representative's feedback was included in the draft COP but does not appear in the final version, a follow-up message should be sent to that representative to explain why it was struck from the final version. Additionally, the COP should be a topic of discussion at the next consultation meeting.

Follow Up/Evaluation Survey

☐ Send the civil society representatives a survey (to be provided by S/GAC) to document and assess how the civil society engagement process was conducted, what strategies were most effective in leveraging improvements in the COP planning decisions, and what can be improved the following year.

Documentation Requirements for COP 2016

A supplemental document (no more than two pages) is required to describe the process and results of the civil society engagement strategy. **The Civil Society Engagement Process Documentation should be uploaded to FACTS Info as a supplemental document at the time of COP submission.**

To complete this requirement, PEPFAR teams should respond to the following:

1. Describe the process used to fulfill the requirement to meaningfully consult civil society representatives, brief them on the approved 2016 COP/ROP, engage in the POART, and

incorporate their feedback into the draft COP submitted to S/GAC. Name the organizations or networks that were consulted and the constituencies each represented. If any key constituencies were not represented, detail the efforts made to engage them.

2. Answer Yes/No to the questions below, providing additional information if necessary:
    a. Was an overview of the COP process provided to ensure that civil society representatives understood the timeline and their roles and responsibilities with regard to PEPFAR processes?
    b. How many CSOs provided input and what portion of them were funded by PEPFAR? Please provide a list of the individuals and organizations that were directly invited to participate in the engagement process.
    c. Were networks of PLWH and Key Populations-led or –focused CSOs engaged?
    d. Were any capacity development services provided, including helping civil society members understand how to make use of available data on epidemiology and PEPFAR programming?
    e. Did the team work with the U.S. Embassy, UNAIDS, and other partners to expand the number of CSOs being engaged?
    f. On what date was the draft SDS shared?
    g. Were changes highlighted from prior year programs and their expected impact?
    h. Were SAPR/APR and other performance data shared?
    i. Was impact modeling utilized?
    j. Were changes in PEPFAR targets and strategies over time included?
    k. Was information shared about USG funding available to civil society?
    l. Were local civil society advocacy efforts discussed? Examples include:
        • Increasing government transparency and accountability
        • Increasing quality and uptake of services
        • Decreasing stigma and discrimination
        • Promoting sustainability of efforts to achieve epidemic control

Provide a brief written response to each question below:
3. What major issues did civil society representatives identify or suggestions did they make about specific COP goals and targets?

4. What was the impact of these conversations and/or how were comments provided by local civil society incorporated into the COP?

5. What method was used to provide feedback to civil society groups regarding the impact of their participation, including explanations as to why suggestions were or were not incorporated into the final COP?

6. Please provide the following information from the COP planning budget process:

   a. What percentage of new FY 16 program funding (minus the M&O budget) will be received by Prime Partners who are local civil society organizations? *NB: This should be available as a MER auto-generated indicator.*

   b. If feasible, estimate the percentage of new FY 16 program funding received by local civil society organizations as sub-recipients.

7. What are the key engagement activities the PEPFAR team will conduct in FY 16?

8. With which CSOs will your team continue to engage throughout FY 16? Do the organizations represent the geographic and population focus?

As annexes to this supplemental report, please provide:

1. The Civil Society Engagement Plan
2. Written recommendations from civil society
3. Written responses from the PEPFAR team

3.3.3 Site Yield and Volume Analysis

While a site yield and volume analysis was done in COP15, this exercise should be conducted on the sites reporting results in APR15. Given a fixed resource envelope smaller than the resource gap, tough decisions will need to be made in most countries about where PEPFAR provides services or support. Sites with low-volume, and particularly, low-yield should be critically assessed to determine if operations resources could be directed towards other sites or interventions to get a higher net program output and/or epidemic impact. To answer this critical question, operational definitions must be established for 'low-volume' and 'low-yield.' There is not a single definition that can be applied across countries and PEPFAR program areas and the threshold used to define low volume and yield should be driven by historical data.

*All PEPFAR teams **with site-level results** are expected to complete a yield analysis for HTS sites, including testing for pregnant women through PMTCT sites and a volume analysis for ART sites.*

> **TA/TC Consideration**
>
> Given the types of support provided, TA/TC programs typically do not have the same volume of PEPFAR site-level results as LTS programs. TA/TC programs are required to complete site-level yield and volume analyses on any PEPFAR data available, but are also encouraged to access national site-level results, whenever possible, to complete a similar yield and volume analysis. This exercise will likely provide deeper insights into country program focus and resource alignment to assist with PEPFAR program planning and provides an additional tool for stakeholder engagement.

> **TTF:** The *Data Pack* is provided to field teams to assist with data organization and completing yield and volume analyses (see descriptions in text below).

HIV Testing and Counseling Yield Analysis (HTS and PMTCT sites)

The purpose of this exercise is to quantify the number and percentage of sites where the most HIV positive individuals are identified, and conversely, the number and percentage of sites where the fewest number of HIV positive individuals are identified relative to others. The results of this analysis should guide program decisions about where PEPFAR will invest to maximize program output. To effectively complete this analysis, the following three data elements are critical to review:

1. The absolute number of positives by site
2. The positivity rate by site (numerator and denominator)
3. The cumulative number and cumulative percent of positives at any specific point in the distribution

In the following graphs, figures 1, 2 and 3 are examples of HIV testing yield by site. The HIV testing yield is analyzed in two ways (1) HIV yield across all HIV counseling and testing sites and (2) HIV yield across sites testing pregnant women. In addition, figures 4, 5 and 6 show HIV testing yield among HIV pregnant women. Examples from countries in East Africa, Southern Africa and West Africa are included to show variability across the different epidemic types, HIV program coverage and HIV disease burden.

Figure 1

East African Country HIV Testing Example

HTC Yield by Site and Cumulative Number of Positives Identified
2014 Results

- **2,071** sites
- **63,129** positives
- **306** sites with 0 positives
- **448** sites with 1-4 positives

HTC HIV+ yield   Cumulative % Positives

Figure 2:

Southern Africa Country HIV Testing Example

HTC Yield by Site and Cumulative Number of Positives Identified
2014 Results

- **1,114** sites
- **282,230** positives
- **9** sites with 0 positives
- **30** sites with 1-4 positives

HTC HIV+ yield   Cumulative % Positives

Figure 3:

West African Country HIV Testing Example

HTC Yield by Site and Cumulative Number of Positives Identified
2014 Results

- **1,003** sites
- **64,208** positives
- **22** sites with 0 positives
- **58** sites with 1-4 positives

HTC HIV+ yield — Cumulative % Positives
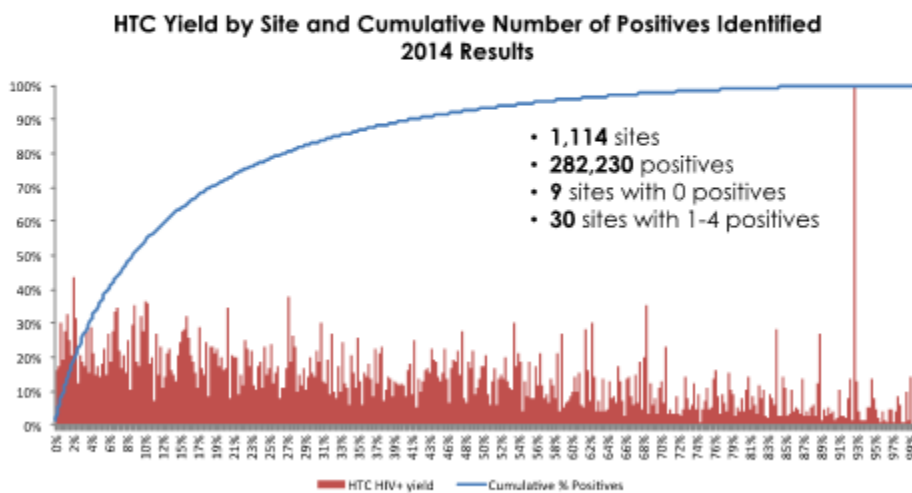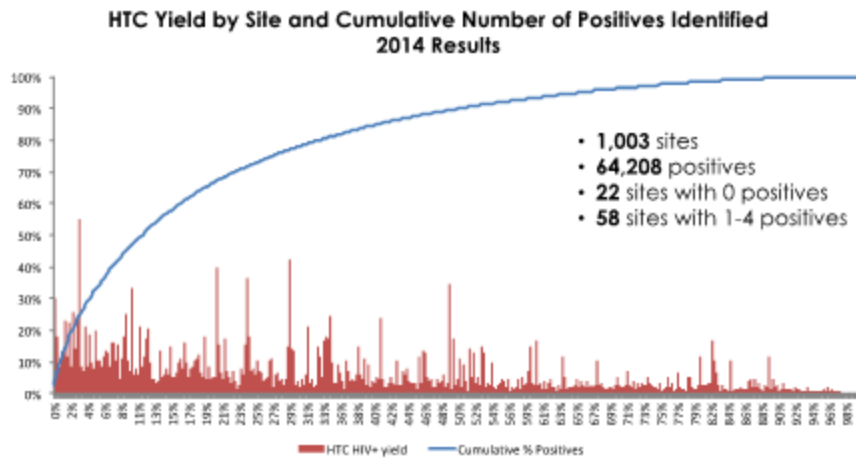
Figure 4:

East African Country PMTCT Example

PMTCT Yield by Site and Cumulative Number of Known HIV
Positive Pregnant Women 2014 Results

- **1,733** sites
- **22,811** positives
- **391** sites with 0 positives
- **558** sites with 1-4 positives

PMTCT Positivity — Cumulative % Positives
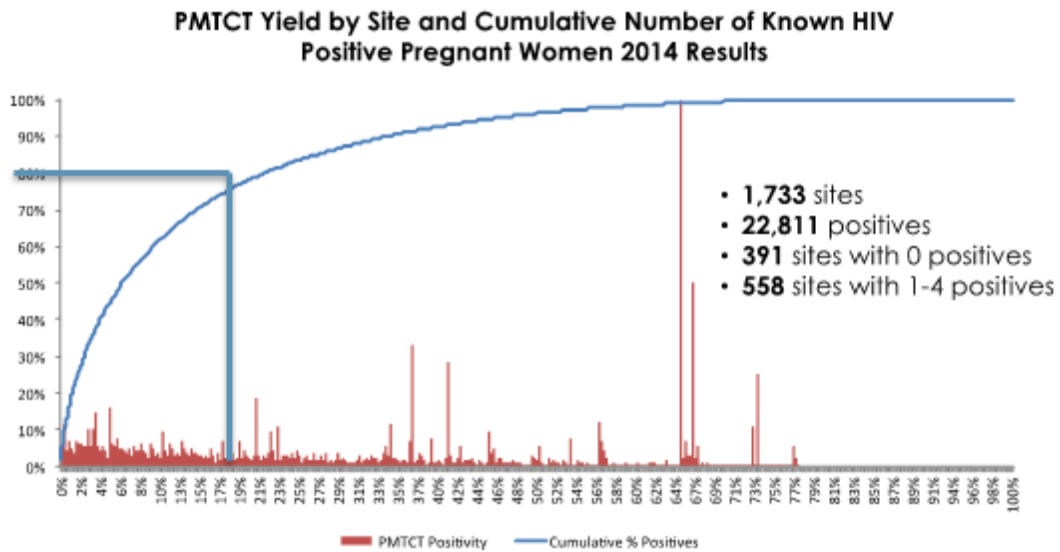
Figure 5:

Southern Africa Country PMTCT Example

PMTCT Yield by Site and Cumulative Number of Known HIV
Positive Pregnant Women 2014 Results

- **1,006** sites
  - **6** sites with no PMTCT results
- **93,931** positives
- **0** sites with 0 positives
- **35** sites with 1-4 positives

PMTCT Positivity — Cumulative % Positives
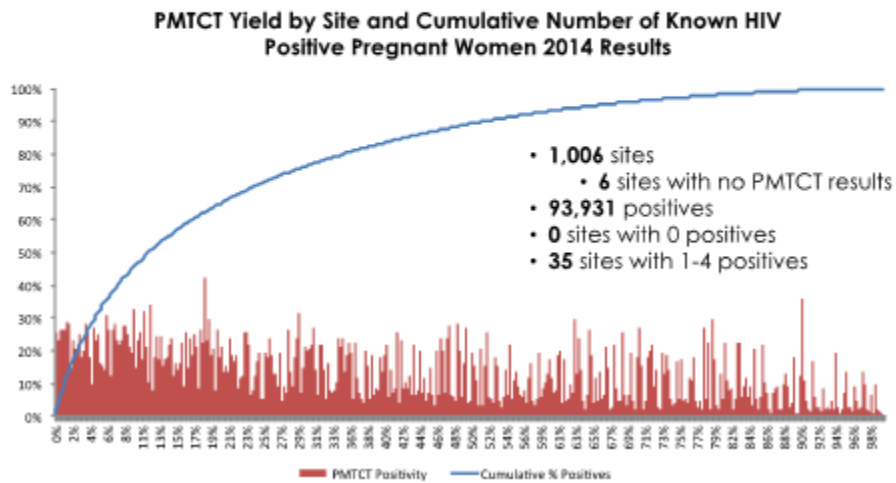
Figure 6:

West African Country PMTCT Example

PMTCT Yield by Site and Cumulative Number of Known HIV
Positive Pregnant Women 2014 Results

- **878** sites
- **17,193** positives
- **50** sites with 0 positives
- **226** sites with 1-4 positives

Legend: PMTCT Positivity — Cumulative % Positives

Note: 2 sites with 100% positivity: 1 site 2/2, 1 site 67/67
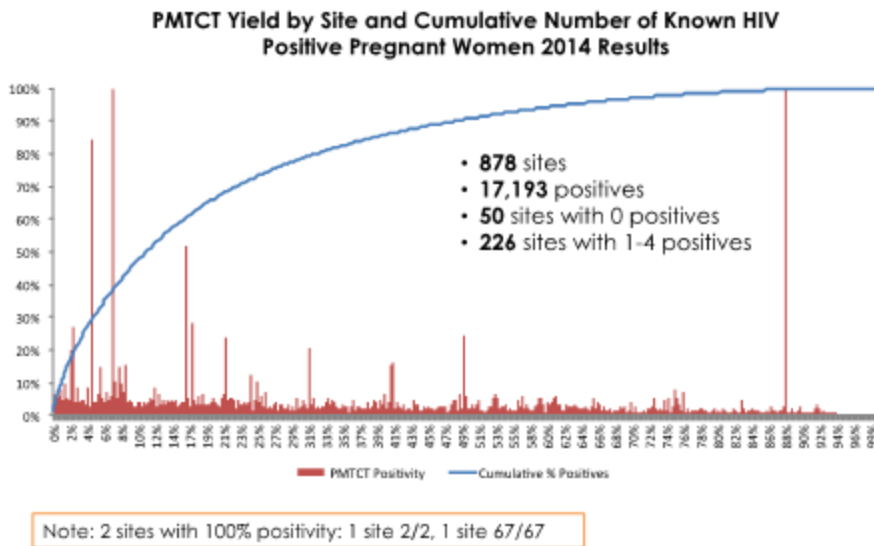
PEPFAR teams are expected to summarize their findings in the corresponding sections in the SDS—Section 4.5 (HTS) and Section 4.4 (PMTCT). In the ***Data Pack***, worksheets "HTS yield" and "PMTCT yield" are provided to assist field teams organize site-level data and summarize their results in standard figures that can be inserted directly into the SDS.

The organization of data in the ***Data Pack*** and the presentation of results in Standard Figures 4.4.1 and 4.5.1 in the SDS is the first step in conducting a site yield analysis. Field teams are also expected to summarize the results in terms of high and low yield classification. As stated above, 'high' and 'low' yield must be operationally defined by the PEPFAR team and the threshold used to classify sites should be reflective of the distribution. For example, identifying sites as 'low yield' where fewer than 10 HIV positive individuals are identified in the last year may not be reflective of the distribution if 95 percent of all supported sites identified more than 10 positive individuals. As a starting point for this investigation and identifying appropriate thresholds, teams may use one of the methods described below. This exercise will likely be iterative as the results are tied to resources (see section 3.3.4 below) and considered in decision making.

Method 1: "80/20 rule"

Country teams can use the **Data Pack** to classify sites as low-volume or low-yield using the "80/20 split test" to focus attention on sites with relatively lower performance (as measured by yield.) Specifically, the question to answer is: *What percentage of sites account for 80 percent of program yield?* Once the data are sorted largest to smallest by number of positive individuals identified at each site, the point in the distribution where the cumulative percentage of positive individuals equals 80 percent will indicate the percentage of sites that account for those positive individuals. This method will also allow users to identify the number of HIV positive individuals per year, per site that would establish the threshold for being classified 'low yield.'

Method 2: "(X) times greater UE"

The EA results can be a useful resource in identifying sites with relatively low performance and may help identify a threshold number of positives per year, per site used to classify sites as 'low' and 'high' yield. Though site-specific data are not currently available, unit expenditures (UEs) have been calculated for each partner working in each SNU (one level below national). Often "outliers"—those observations with higher than expected UEs—are driven by lower relative volume or yield or less efficient models of service delivery. To focus attention on sites with relatively lower performance (as measured by UE), country teams can set an acceptable range for UE and review outliers using the **EA Data Navigation Tool** (see Outlier Analysis in section 3.3.5 below). The outer bound of this range would be defined as (X) times greater than the average across all partner and SNUs for a specific UE. This allows teams to focus on partners, SNUs or sites where resources may not be utilized as efficiently as possible, resulting in lower relative yield and impact than could otherwise be achieved.

Other methods may be considered, but teams should complete an analysis that identifies low-yield sites using objective criteria. Identifying a site as low-yield does not necessarily result in discontinuation of services/support, especially if the site operates in a geographical focus area; however, the analysis will highlight areas where a performance improvement plan may be needed and help determine if additional investments in the site are sensible.

ART Site Volume Analysis

In addition to the yield analysis described above, PEPFAR teams with site-level ART data are expected to conduct a site volume analysis for ART. Two data elements are critical to effectively complete this analysis:

1. The absolute number of current on ART by site
2. The cumulative number and cumulative percent of current on ART at any specific point in the distribution

The following graphs are examples of ART volume analysis by site. Examples from countries in East Africa, Southern Africa and West Africa are included to show variability across the different epidemic types, HIV program coverage and HIV disease burden.

Figure 1:

East African Country HIV Treatment Example

ART Volume by Site and Cumulative Number of Patients on ART
2014 Results

- **1,422** sites
- **356,389** on treatment
- **80%** of patients at **18%** of sites

Total # on ART — Cumulative % Patients

Figure 2:

Southern Africa Country HIV Treatment Example

ART Volume by Site and Cumulative Number of Patients on ART
2014 Results

- **691** sites
- **509,331** on treatment
- **80%** of patients at **25%** of sites

Figure 3:

West African Country HIV Treatment Example

ART Volume by Site and Cumulative Number of Patients on ART
2014 Results

- **637** sites
- **129,993** on treatment
- **80%** of patients at **23%** of sites
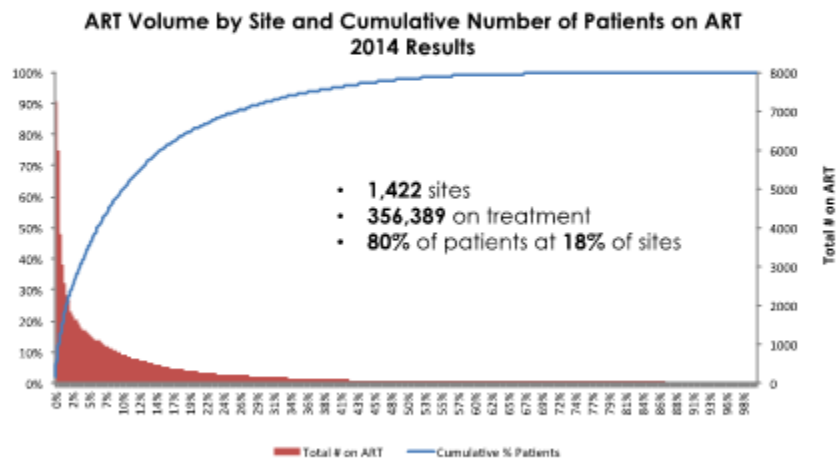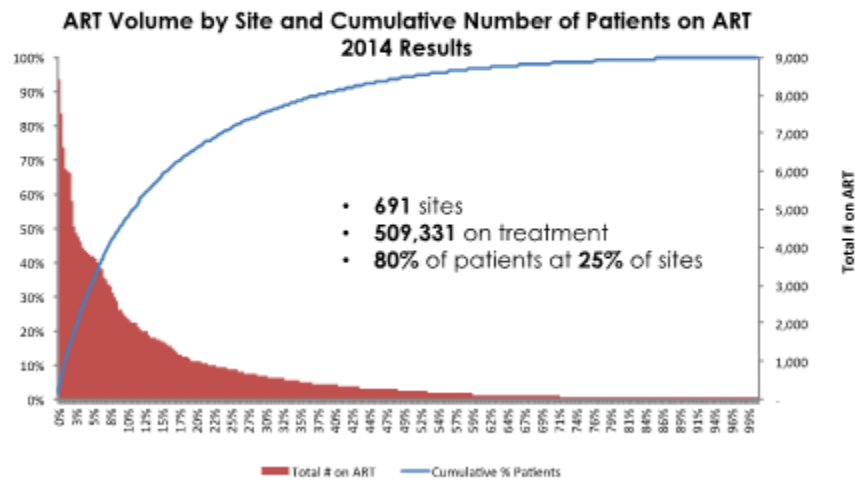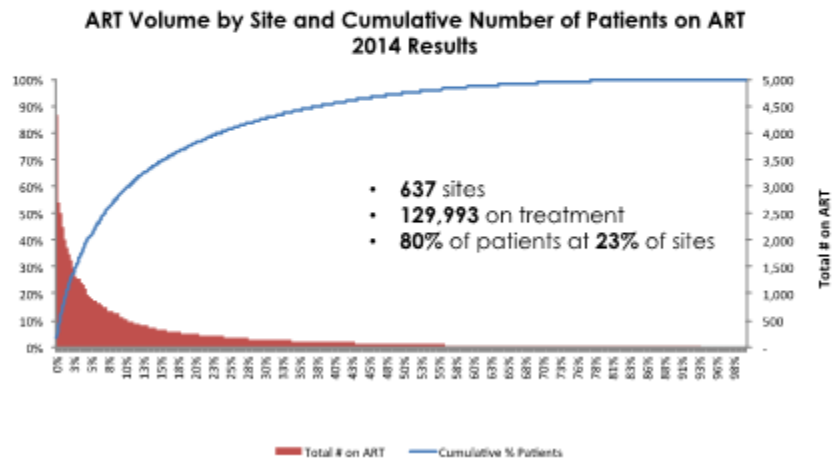
PEPFAR teams are expected to summarize their findings in the corresponding section in the SDS—Section 4.8 (Adult ART). In the **Data Pack**, worksheets "HTS yield" and "PMTCT yield" are provided to assist field teams organize site-level data and summarize their results in standard figures that can be inserted directly into the SDS. In addition to this analysis, teams are expected to classify sites as 'low' and 'high' volume as described in the yield section above. Both the *80/20 split* method and *(X) times greater* method are useful as starting points for the site volume analysis.

Using the Results of Yield and Volume Analysis

The HIV testing site yield analysis and ART site volume analysis should be used in conjunction with the efficiency analysis results; geographic and population prioritization; and core, near-core, and non-core determination to make decisions about which PEPFAR-supported sites will be prioritized for scale-up and which sites will be maintained or transitioned in the implementation year. *These decisions should be succinctly described in the SDS in the corresponding sections for HTS, PMTCT and ART.*

Teams are also required to include in the Goal Statement *narrative of the SDS the* **total number of sites that are assigned to each of the following categories:**

1. **Scale-Up Sites** are sites most often located in a Scale-up District (i.e., Scale-Up to Saturation or Aggressive Scale-Up.). However, Scale-Up sites can also be located in Sustained Districts if they are located in a "hot spot" and/or are targeting a key/priority population in order to leave no one behind.
2. **Sustained S**ites can be in Scale-Up or Sustained Districts and are characterized by ongoing PEPFAR-supported passive enrollment services and activities.
3. **Centrally Supported Sites** can be in Scale-Up, Sustained, or Central Support Districts, and represent sites that either transition to government or other support.

Sites prioritized for scale-up should generally be 'high' yield/volume per the operational definitions assigned by the country team. Additionally, sites defined as 'low' yield should generally be classified as 'sustained' or 'centrally supported' and not prioritized for scale-up. Further, analysis results across HTS, PMTCT and ART sites should be triangulated prior to making decisions about site classification. There is no step by step guide to how to accomplish this task, and the process will be iterative, likely requiring multiple rounds of data review and interpretation. Additionally, this information will need to be considered within the local context; for example, epidemiologic data describing the size, location and

HIV burden in key and priority populations, roll out of test and start, the current status of the national B+ implementation plan and the current HRH and HSS challenges will all be important to consider.

For each program area, (ART, HTS, and PMTCT) there are three broad categories of information that should be used to decide which group to place a PEPFAR supported site within:

1. Estimate of unmet need within the sub-national unit should be used to inform programs where additional support is needed and be consistent with geographic and population prioritization decisions

2. Location of sites in relation to each other (i.e., are ART, HTS and/or PMTCT sites co-located in the same facility and/or located in the same sub-national unit) should be used to ensure that prioritization decisions are consistent and integrated across all program areas.

3. Location and size of key and priority populations and the services targeted to these populations should be used to ensure hot spots are prioritized.

Further, there are a number of guiding principles teams should consider prior to making decisions about which sites will be prioritized for increased resources and program scale-up:

1. PEPFAR should no longer support sites where four or fewer HIV positives have been identified in the last 12 months.

   PEPFAR programs should stop supporting HIV testing at HTS and PMTCT sites that have identified two or fewer HIV-positive individuals during the last six-month SAPR period or four or fewer HIV-positives during the last 12-month APR reporting period. For PMTCT, teams should also consider if these sites provide Option B+ ART to pregnant women. If so, the results of the volume analysis of ART sites should be triangulated prior to making decisions regarding discontinuation of PEPFAR support.

2. Analysis should be completed first on the entire data set, and then adjusted for geographic focus.

   Teams should conduct the site yield and volume analyses described above on the full data set—i.e., including all sites with data over the last reporting cycle—and present/describe summary results for HTS, PMTCT, and ART using the total sites reporting in APR 2014 as the denominator. Once the yield/volume in each of these program areas has been characterized

for the existing program, the team should determine how the sites classified as 'low' and 'high' yield align with geographic and population prioritization decisions.

3. <u>Analysis should be based on empirical data, not what is "expected."</u>

   Consistent with guiding principle two above, actual results should be used to conduct site yield and volume analyses. Teams should not impute what the expected positivity rate would be in the future as a basis for decision making, unless there is strong empirical evidence that suggests otherwise. If any data are imputed, it must be clearly stated in the SDS in the relevant sub-sections of Section 4.0 (HTS, PMTCT, and Adult ART).

4. <u>Low-yield sites in focus areas require additional scrutiny.</u>

   Sites classified as 'low' yield that operate in areas prioritized for scale-up should be highly scrutinized to determine if support to these sites can be discontinued without interrupting services for priority populations, and/or if quality issues are impeding the ability of the sites to scale at a pace required for attaining the stated goal for epidemic control.

5. <u>The number of sustained or centrally supported sites should be de-duplicated when counting PEPFAR sites.</u>

   It is likely the site yield and volume analysis across HTS, PMTCT and ART programs will produce overlapping results—i.e., the same sites will be identified as 'low' yield in each program area analysis. Teams should look across platforms to consider co-location of services and how this impacts the total number of sites the team is reporting that will enter a sustained state, and the total number of sites PEPFAR will no longer support and will be centrally supported in the implementation period. In reporting the total number of sites classified as scale-up, sustained or centrally supported in the Goal Statement, teams should not count the same sites more than once.

Milestones:

-Complete yield analysis for HIV testing in HTS and PMTCT sites and volume analysis for ART sites.

-Insert yield and volume analysis graphics from the Data Pack directly into the relevant sections in the SDS—HTS (Section 4.5), PMTCT (Section 4.4) and Adult ART (Section 4.8)—and succinctly describe findings in the narratives.

-For each program area, classify sites as prioritized for scale-up, sustained, or centrally supported; de-duplicate sites repeated more than once in each category; calculate the total number of sites for each category and report in the Goal Statement of the SDS.

3.3.4 Quantifying Cost Savings and Productivity Gains from Site Analysis

For countries undergoing further geographic prioritization and/or enhanced program focus, if may be beneficial to examine potential cost savings and/or increases in productivity that result from enhanced program focus. For example, cost savings may result from discontinuation of support to sites classified as 'low' yield and 'central support' as the resources that would be consumed by supporting these sites in the coming year would be available to use in sites prioritized for scale-up or in other program interventions. Productivity gains, in this context, refer to increases in program output that would result from re-investment of cost savings in higher-yield or higher-volume sites. For HIV testing in HTS and PMTCT sites, productivity gains would be represented by increases to the yield—i.e., percent of HIV positives identified—with the same total resources allocated to these programs. For ART, productivity increases would be characterized by the percentage increase in the number of PLHIV served with care and treatment given the same total resources allocated to these programs.

TA/TC Consideration

TA/TC programs that are able to access and use national data to complete site yield and volume analysis will likely not have the necessary cost data to complete an efficiency analysis as described above and will not be expected to quantify cost savings and productivity gains from site focus. TA/TC programs should, however, think about how the results of these analyses would impact shifts in program support and what the expected difference in cost to PEPFAR might be.

There are a number of ways that analyzing outliers can assist with COP development, including identifying key cost-drivers and highlighting areas to focus attention for maximizing efficiency gains and program output. For the purposes of EA, an "outlier" is used to describe a unit expenditure (UE) that is a certain amount above or below the average UE for all observations in a distribution. An "observation" is a UE representing a combination of mechanism and location or the national UE for a mechanism. For example, if 10 PEPFAR implementing partners provide ART to adults in two provinces each, and have reported *both* expenditures and indicators for the same time period, there would be 20 (10X2) unique unit expenditure observations in the distribution for adult ART.

Note: *The average mechanism UE will be different (lower) than the PEPFAR national UE for the same indicator. This is expected and due to the restriction in the analysis to only partners reporting both indicators and expenditures.*

The threshold for identifying an outlier is not prescribed and should be tailored to the indicator and program context. In the ***EA Data Navigation*** tool provided, the threshold for analyzing outliers can be set to any desired level and evaluated across years. While the threshold for identifying an outlier should be tailored to the indicator and program context, a recommended cutoff is 5 or 10 times the average mechanism UE. PEPFAR teams should identify and pay close attention to EA 2015 outliers that were also outliers in 2014 and 2013.

While variation in the mechanism UEs is expected, PEPFAR teams should include in the SDS, at a minimum, an analysis investigating any "high" outliers and 1.) Determining why the unit expenditure is high (contextual factors, potential inefficiencies, or data quality concerns, 2.) Addressing any concerns identified and/or look for efficiency gains across partners and SNUs where similar expenditures and outputs are expected, and 3.) Determining whether or not the IM or IM-SNU combination will be funded for the same activities in COP16 with rationale as to why.

The Data Navigation Tool includes an Outlier Analysis Documentation table which can help country teams to document investigation of outliers. This section of the Data Navigation Tool includes space for country teams to indicate whether the IM-SNU will be funded in COP16 for the same activities, why the UE is an outlier, and the rationale for continued investment.

We recognize that partners have different models of service delivery, reach different populations, or may be providing different types of support even though they count the same indicator. It is also

important to remember that the calculated UE is a combination of expenditure and result data. Often outliers are identified because the volume is disproportionate to the expenditure (i.e., incredibly low or high). In this respect, the outlier analysis can identify low performing or high cost SNUs and quantify efficiency gains from enhanced program focus.

TTFs: The *EA Data Navigation* tool has been provided to assist country easily analyze outliers and assist in filling out the Outlier Analysis Documentation table

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In the context of COP refinement, we recommend country teams use the *EA Data Navigation* tool to address the following questions:

- What's an acceptable outlier threshold for each distribution?

- Which program areas have the greatest number of outliers?

- Which SNUs have the greatest number of outliers?

- Which partners/mechanisms have the greatest number of outliers?

- For extreme outliers (very top and bottom of distribution), does the volume or expenditure appear to be driving the UE? Is there reason to believe these data aren't accurate, and is it worth getting clarification from the reporting IP?

- What percentage of total expenditures for a specific intervention do the outliers account for? What percentage of total volume of beneficiaries do the outliers account for? Is this acceptable when compared?

- Given your knowledge of the program context and partner activities, can the outlier be explained *using quantitative data*? For example, if it's thought a partner has a higher UE due to serving a hard to reach population, can you demonstrate the partner spends more on travel/transport, vehicles, etc. than the average across all partners? Is this acceptable and in alignment with program prioritization?

This type of investigation may help teams identify common themes that will have broader implications for program output and efficiency, such as specific models of service delivery or geographic areas that are clear cost drivers and may need adjustment. It is important to note that UEs do not consider quality of the support provided. Other data, such as retention and linkage information and SIMS results, should be considered in tandem to assessing acceptability of outliers based on program quality considerations.

3.3.6 Resource Projections to Estimate the Cost of Program

Using empirical cost data[14] is a critical element in determining the expected cost to PEPFAR of the planned program. Some unit costs may be available and widely understood (e.g., cost/expenditure per person receiving HIV testing and counseling), whereas some unit costs may need to be outlined at the country level (e.g., cost of training one health worker on minimum package of voluntary medical male circumcision services). There are some activities where assigning a "unit" may be more difficult or less clear. For example, supportive supervision for clinical services is typically thought of as technical assistance, and traditional units of output – in terms of number of individuals reached – may not be an appropriate metric. These types of activities may be more difficult to accommodate in the budget; however, assigning some unit of output is still a useful method to determine how many resources will be needed to support the intended program in the next year. In the case above, a potential solution might be to use EA and other program data to determine, on average, how much was spent to provide supportive supervision to each site. Using the site as the unit allows for some standardization of costs to PEPFAR. Budgeting for such activities per site would then provide a proxy to ensure the program is adequately resourced in next year's budget. The above example is only one possible metric and country teams will need to explore all options that make sense for their program context and activities. Further, some activities may not need to be assigned a unit, but will still need to be included in the budget (e.g. a special study intended to be completed in the next fiscal year.)

The following flow diagram provides a conceptual framework for systematic use of empirical cost data to develop a COP budget. Each step is described below.

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[14] PEPFAR Unit Expenditures are not the full unit cost of delivering a program; however, it is the unit cost *to PEPFAR*. Unless the level of PEPFAR support or the intervention is expected to change dramatically, it is appropriate to use the unit expenditure from the Expenditure Analysis results to apply during the PEPFAR budgeting process.

Basic Premise:

COP Budget Envelope	=	Calculated Cost of Program
↓		↓
New Funding Request + **Applied Pipeline**		**Empirical Unit Expenditure/Unit Cost Data** x **Targets** + **Lump Sum Amounts**
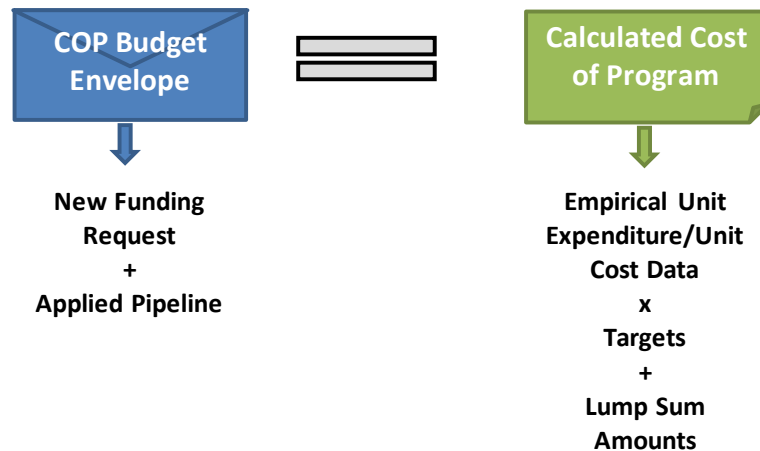
There are costs to PEPFAR of implementing a program ("calculated cost of program") and a total "COP budget envelope," which defines the financial ceiling (planning level) that constrains program output. Once a budget is completed, these two major elements need to be reconciled. The financial ceiling, or budget envelope, is the total available resources that can be applied to the next fiscal year. In theory, this envelope will consist of money in the pipeline that will be applied to next year's program, plus new money provided by PEPFAR. The calculated cost of the program should be where EA and other cost/expenditure information are applied.

As discussed above, the cost of the program to PEPFAR should be determined by multiplying unit cost/expenditure information by proposed targets and adding in any additional lump sum amounts to cover activities without clear output metrics. The following steps describe how to use available data to calculate the cost of the program.

Step 1: Outline all indicators for the program

Ex:
- No. Pregnant Women Tested and Received Results
- Percent of pregnant women who know their status
- No. of HIV-positive pregnant women receiving ARVs

The first step is to outline all output/outcome metrics used to measure program performance. These will include those indicators that are essential, required, and reported to S/GAC, as well as any indicators used for monitoring at the country level.

Step 2: Identify which indicators will carry cost to PEPFAR

Ex:
- No. Pregnant Women Tested and Received Results → YES
- Percent of pregnant women who know their status → NO
- No. of HIV-positive pregnant women receiving ARVs → YES

Next, teams should identify which of the indicators identified in Step 1 will incur a cost to PEPFAR. In the above example, the first indicator (number of pregnant women tested) will result in a cost to the program. The second indicator listed, however, will not incur a cost, because the costs of this activity (determining the percent of pregnant women who know their status) will be carried by the first indicator since it is a subset of testing (or caring for) pregnant women through PMTCT. Therefore, there is no need to assign a unit cost/expenditure to this metric. Representatives of the Finance and Economics Work Group (FEWG) are available to assist country teams with identifying indicators that carry costs and need to be included in budget projections.

Step 3: Map indicators to empirical cost data (where available)

Sources:

PEPFAR EA

Cost Studies

Data gathering

After determining which indicators will carry a cost to PEPFAR, teams should locate sources of empirical cost data that can be used to assign a unit cost/expenditure to these outputs. In many countries, EA results will be the only source of information for specific indicators. In some cases, there will be other sources of data, such as published cost studies or grey literature. In the absence of EA results or other cost data, teams should use their prior knowledge of activities and/or interact with implementing partners and service providers to derive an informed estimate. Teams are encouraged to determine which sources are most appropriate and relevant. EA Advisors are available to assist upon request.

Step 4: Adjust empirical cost data to reflect program in coming year

Exs: Remove contruction and renovation from EA unit expenditure estimate

Adjust ART cost per patient from external study to account for PEPFAR-only share

Next, teams should adjust empirical cost data to reflect the program's actual costs in the coming year. For example, some teams will need to adjust EA UE to account for one time investments made in the previous fiscal year. In this scenario, assume the UE for one patient year of adult ART was $200 (USD) using EA from FY 2015 in country X. The country team knows the $200 per patient includes the renovation of several health clinics. This cost will not need to be incurred in the next year, so budgeting $200 per patient for adult ART is not necessary. The team reviews the EA data with their EA Advisor and determines $20 per patient of the $200 accounts for the renovation cost. The team elects to reduce the unit expenditure from $200 to $180 to more accurately estimate what the program will cost PEPFAR next year.

Adjustments may also be required when using external cost data. If in country X there was a cost study on ART last year that concluded the yearly cost per patient-year of adult ART was $400 (USD), the country team could use this information to calculate the budget; however, the figure would need to be adjusted. Most HIV cost studies focus on total cost of service delivery without discerning the

source of funding. If the team knows that PEPFAR does not pay for ARVs in country X, the $400 would need to be adjusted downward to account for only the portion of the total cost per patient-year that PEPFAR will support.

Adjusting unit cost estimates can be very detailed and challenging. S/GAC and agency headquarters encourage country teams to work with their EA Advisors to think through these adaptations and impact on the budget.

Step 5: Add lump sum amounts, required for program but not carried by indicators

Exs: Agency management and operations
Resources needed for special studies/operations research to be implemented in coming year
Resources needed for program activities that rarely have unit cost/expenditure associated with them (e.g., infection control)

Next, teams should list all activities that are slated for the next fiscal year where no unit cost data are applicable due to the nature of the activity (e.g., policy guideline development, strengthen waste management activities). These activities require imputing a "lump sum" amount (e.g., renovations for a health clinic to improve ventilation and reduce opportunistic infections). It is at the country team's discretion how these lump sum amounts are determined. As in the supportive supervision example at the beginning of this section, the country team may elect to assign their own unit to an activity (e.g., sites supported). Some activities, however, will not have a natural unit for which to budget. For these, the country team should use their best judgment to determine cost to PEPFAR and evaluate if the investment aligns with program priorities.

Step 6: Calculate total resource needed by program areas

Ex:

✖	Unit Expenditure for VMMC:	$ 100
	Proposed target for VMMC	10,000
➕	Resources needed for targets	$ 1,000,000
	Additional fixed (lump sum)	$ 200,000
➖	Total resources needed for VMMC	$ 1,200,000

Next, teams should use the information assembled in Steps 1 – 5 to calculate the total program cost to PEPFAR. To do so, teams should multiply the unit cost/expenditure estimates used for each program area by the intended targets for that area and add any lump sum amounts. The total will represent the best estimate for what resources will be required to support the proposed program in the next fiscal

year. Summing across program areas and activities will yield the total cost of the PEPFAR program for a given country.

Note: *For most program areas, targets can simply be multiplied by UEs to estimate the total resource need. However, for ART, pre-ART, and Option B+ (PMTCT) targets, an additional step is necessary. Because the volume of patients receiving ARVs for treatment or PMTCT varies considerably over the course of the year, UEs for these program areas are calculated based on the average number of* ***patient years*** *over the given reporting period, as opposed to using the number of beneficiaries at the end of the fiscal year. In order to accurately estimate resource needs for these activities, year-end targets must first be converted into patient years. For example, if country teams were calculating the target number of patient years for FY16/17, the formula would be[15:]*

$$\text{Target FY16/17 Patient Years} = (APR16\ target + APR17\ target) \div 2$$

For ART and pre-ART activities, this measure provides a more accurate indication of the service volume provided over the course of the fiscal year. Once country teams have calculated the target number of patient years for the given fiscal year, the total resource need can then be estimated by multiplying the unit cost/expenditure by the intended targets for that area and adding in any lump sum amounts, as described above. Note that for countries implementing Option B+ (lifelong ART), patient years will also need to be calculated for PMTCT targets.

1.) Calculate Patient Years

FY16 COP target	10,000
FY17 COP target	15,000
Sum	25,000
FY17 Patient Year (sum / 2)	12,500

2.) Multiply Patient Year by UE

Unit expenditure for adult ART	$200
✕	
Adult treatment target (in patient years)	12,500
=	
Resources needed for targets	$2,500,000
+	
Additional fixed (lump sum)	$200,000
=	
Total resources needed for Adult ART	$2,700,000

Step 7: Map program area (indicator) totals to PEPFAR budget codes

	VMMC	**OR**	**Males circumcised**	Other program areas/indicators….
Ex: MTCT				
HVAB				
HVOP				
IDUP				
HMBL				
HMIN				
CIRC	**84%**		**84%**	
HVCT				
HBHC				
PDCS				
HKID				
HTXS				
HTXD				
PDTX				
HVTB				
HLAB				
HVSI				
OHSS	**16%**		**16%**	
HVMS				

Once the total cost of the program has been calculated, teams should map the cost data to the standard PEPFAR budget codes to determine how resources will be requested and verify that earmarks are met. This can be accomplished in one of two ways:

1) For a given **program area**, determine as a percentage how much of the total calculated cost of the program would be paid for by each PEPFAR budget code

2) For **each indicator** assigned a unit cost, determine as a percentage how much of the total calculated cost of the program would be paid for by each PEPFAR budget code

Note: *If electing method two lump sum amounts will also need to be mapped and are not rolled into unit cost estimates.*

The total dollar value required in each budget code to support the program can be determined by multiplying the percentage across each program area/indicator by the calculated cost of the program for that area/indicator.

Step 8: Reconcile with budget envelope and adjust targets if needed

Finally, country teams should ensure the total calculated cost of the program does not exceed the pre-determined COP budget envelope. If the cost is higher than the budget envelope, targets or lump sum amounts must be reduced to meet the financial ceiling. If the cost is lower than the budget envelope, the country team can identify additional program requirements or notify S/GAC that they will be able to execute planned COP activities with a smaller budget. The goal is to have the calculated cost of the program be less than or equal to the budget envelope.

TTFs: The ***PEPFAR Budget Allocation Calculator (PBAC)*** has been provided to assist country teams with completing the steps associated with calculating estimated program costs. Each country receives a unique copy of the PBAC, pre-populated with EA results (unit expenditures) from the most recent data collection cycle. Unit expenditure estimates can be adjusted to accommodate expected changes to program activities and/or costs as described in Step 3 above.

All countries should use PBAC to estimate program costs and document final, adjusted UE data (if available) and budget summary (including lump sums). The final version of the PBAC should be saved with COP documents on pepfar.net for reference.

4.0 TEMPLATES, TOOLS, AND SUPPORT FOR

COP 2016

4.1 Tools and Templates

Data Pack: The Data Pack has been provided to country teams in Microsoft Excel format and is intended to be a template and analysis tool to assist PEPFAR field teams meet the requirements for successful preparation of the SDS. The workbook is also intended to assist reviewers to understand the data analysis completed by the country teams and limit the need for extensive verbal or written clarification. The workbook is submitted in FACTS Info as a supplemental document.

The Data Pack may be downloaded on the pepfar.net COP 16 website.

Sustainability Index and Dashboard (SID): The SID is an excel-based tool that measures the current state of sustainability of the national HIV/AIDS response and tracks progress over time in PEPFAR countries among four key domains and fifteen elements essential for a sustainable HIV/AIDS response. All PEPFAR teams submitting a COP are required to complete the SID in advance of COP development to inform program planning and decision-making including through the Systems and Budget Optimization Review and Template outlined below. The SID results are intended to be used annually to inform PEPFAR investments and steadily advance sustainability across critical areas.

Systems and Budget Optimization Review and Template (SBOR): To determine COP/ROP 2016 program support and systems level interventions in which PEPFAR will invest to achieve epidemic control, PEPFAR teams will utilize the Systems and Budget Optimization Review (SBOR) and Template. The SBOR will assist PEPFAR teams to strategically align program and system support portfolio of activities for COP/ROP 2016 development, with greater clarity on government-to-government and non-government partners, both local and international, in all PEPFAR supported systems areas (including laboratory strengthening, SI, and HRH support at all levels) as well as the expected deliverables.

PEPFAR Budget Allocation Calculator (PBAC): There was considerable feedback from the phased institutionalization of EA on the difficulty of translating EA results into the PEPFAR budget codes. The PBAC tool will assist country teams with estimating expected program costs using empirical data from EA and other sources. Teams can enter or import key EA/cost data and targets into the tool and it will generate budget allocations that correspond to the traditional PEPFAR budget codes. Note that this budget tool provides an index value to assist teams and provides an objective basis for allocations, but

does not provide rigid benchmarks. Budgets should be guided by fiscal data and determined in overall program context. PBAC comes with an additional users' manual posted on pepfar.net.

EA Data Navigation Tool: This tool was designed to assist country teams and HQ support teams review EA data during the COP/ROP planning process. This Excel tool features multiple sheets with dropdown menus that allow users to customize and summarize EA results by program area, sub-national unit, and cost category over multiple fiscal years. The tool also contains information on national UEs and mechanism specific UEs, as well as mechanism specific information by program area, cost category and SNU. Pre-populated *EA Data Navigation Tools* for 2015 have been posted on each PEPFAR OU page on pepfar.net.

EA-Epi Comparison Tool: This tool is designed to align expenditures with Epidemiologic data at the sub-national level. Epidemiologic data may include prevalence, incidence, ANC prevalence, ART need, testing volume, and testing yield. Expenditures may be presented in total by sub-national unit, or disaggregated by the appropriate program area. Pre-populated *EA-Epi Comparison Tools* for 2015 have been posted on each PEPFAR OU page on pepfar.net.

Facts Info Staffing Data Module: The Staffing Data (in Facts Info) collects demographic and program time data for each position partially or fully funded by PEPFAR or those funded by other accounts who dedicate at least 30% of their time to PEPFAR. The staffing data should be used to analyze the size and composition of staff within and across agencies to manage intra-agency and interagency tasks. For COP/ROP 16, the Level of Effort (LOE) fields introduced in a separate Excel workbook in 2015 have been integrated into the Facts Info Staffing Data module and expanded to capture more accurately the types of work positions do to support PEPFAR implementation. In addition, a new field captures estimated business travel time for SIMS each quarter, which should align with the SIMS Action Planner. Pre-populated Excel workbooks will be distributed to teams in December to enable OU teams to update COP/ROP 15 data, collect the new LOE and SIMS travel data, and analyze staff composition prior to Facts Info being open for data entry. See section 8.2 for more information.

SIMS Action Planner (SAP): Each country must submit agency-specific and interagency summary SAPs at COP/ROP submission. The SIMS Action Planner is designed to assist country teams to operationalize the SIMS Requirements for COP/ROP 2016. Using the post's existing DATIM site list, the tool calculates how many SIMS assessment visits each country is required to complete at a minimum in FY2016. As part of that calculation, the SAP distinguishes SIMS assessment visits by tool

(i.e., facility, community and above-site), high- or low-volume sites (for facility and community assessment visits), and type (initial, focused follow-up, comprehensive follow-up). For planning purposes, the number of focused follow-up assessment visits is projected to be 25 percent of required initial or comprehensive follow-up assessment visits. The information captured in the SAP allows teams to accurately project costs and resource implications associated with SIMS in FY2017. The SIMS Action Planner is to be routinely updated with the most recent DATIM site list throughout the fiscal year to continuously monitor progress on achieving the COP/ROP 2016 SIMS Requirements. The tool and instructions on how to use it can be found on the COP 2016 page on pepfar.net.

PEPFAR teams will have access to download country-specific versions of each of the tools above on the designated webpage for their OU in pepfar.net.

4.2 Technical Considerations

The Technical Considerations should be used to assist PEPFAR teams and implementing partners apply normative guidelines, as well as the most recent scientific evidence, when planning and implementing programs. The Technical Considerations have been restructured for the 2016 COP to provide key strategic direction and links to normative guidance and resources. Additionally, the SIMS Core Essential Elements have been mapped to the corresponding areas of the Technical Considerations to facilitate use of the Technical Considerations in supporting quality program improvement. It is essential that teams read all relevant sections of the Technical Considerations, as they include new information on pre-exposure prophylaxis (PrEP) and service delivery models.

4.3 Financial Supplement Worksheet

Each country or region must submit a *Financial Supplemental Worksheet* at COP/ROP submission, detailing the historic, current and projected financial performance of all mechanisms and CODB categories included within the COP/ROP. Each country or region must submit one document compiling the information for all agencies.

The *Financial Supplemental Worksheet* can be found on the pepfar.net COP 16 website.

5.0 COP ELEMENTS

5.1 Chief of Mission Submission Letter

As in past COP cycles, PEPFAR teams are encouraged to include a letter in their COP submission from the Chief of Mission (COM) to the Ambassador-At-Large and Coordinator of U.S. Government Activities to Combat HIV/AIDS and U.S. Special Representative for Global Health Diplomacy. The purpose of the letter is to articulate at a high-level major changes that are being proposed, assumptions that the team has made about factors required to successfully meet the 2016 COP goals, objectives and targets, and identified concerns or barriers. Recognizing that each operating environment is unique and that there are significant contextual factors that influence the PEPFAR program, the COM letter is a place to articulate these issues and their impact on the team's success and plans.

5.2 Strategic Direction Summary

The SDS outlines key data and analysis results concentrating on changes between COP 15 and COP 16, the strategic plan for the coming year, and the monitoring framework that will be used to measure progress. The SDS is submitted in FACTS Info as a supplemental document. Microsoft Word format is recommended and a template has been provided to assist country teams prepare a comprehensive SDS.

PEPFAR teams should use the guiding questions and adhere to the required tables and figures in the SDS template to successfully meet this COP 2016 requirement.

*The SDS should be **no more than 12,500 words**, excluding tables, figures, footnotes and appendices. Submissions with a word count greater than 12,500 will not be accepted without advanced authorization.*

For specific SDS guidance for central initiatives (e.g., ACT and DREAMS) and Public Private Partnerships (PPPs) please see APPENDIX C; Private Sector Engagement SDS Roadmap.

The SDS template may be downloaded on the pepfar.net COP 16 website.

Note: *All data tables, graphics, figures and language contained in the SDS will be reviewed collaboratively with HQ and field teams to identify any sensitivity prior to being distributed outside of*

PEPFAR implementing agencies/partners and released into public domain. Elements that may be useful for internal program planning, but not yet cleared by external owners (e.g., unpublished data provided by host country governments) will be redacted if approval is not granted. Data that are likely to put certain populations at risk if published (e.g., geographic data on key populations) will also be redacted.

5.4 Indicators and Targets

In COP 2016, all teams are expected to report on targets for required indicators that are applicable to the program's funded activities. These targets reflect expected accomplishments that are directly supported by PEPFAR. PEPFAR recognizes that 'direct support' in the form of 'direct service delivery' or 'technical assistance for service delivery improvement' support[16] is provided within the context of partner country national programs, as a contribution to or a share of those programs, which may also receive financial and other support from the host country and other donors such as the Global Fund. As such, these targets should feed into the national program goals set through a strategic planning process led by the partner government and supported by key stakeholders.

PEPFAR will consider five types of targets that serve different purposes when reviewed at different levels of aggregation.

1. **Site Level Targets** – Site level target setting allows for implementing partners to clearly articulate and set expectations for achievements at each PEPFAR-supported site based on supported activities and in alignment with geographic, population, and intervention-based prioritization efforts for scale-up or sustained support.

2. **Sub-national (i.e. District) Level Targets** – Sub-national level target setting strategically demonstrates geographic prioritization of efforts towards the 90:90:90 by 2020 UNAIDS target in alignment with the distribution of the burden of disease in a country.

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[16] Please refer to PEPFAR's *MER Indicator Reference Guide v2* for more guidance on required indicators and reporting, including detailed information on what constitutes PEPFAR direct service delivery and technical assistance for service delivery improvement.

3. **Implementing Mechanism Level Targets –** Implementing Mechanism (IM) targets represent expected accomplishments for the implementing partner based on available funding and agreed upon activities. Target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements.

4. **Technical Area Summary Level Targets** – The PEPFAR Technical Area Summary Targets are an aggregated reflection of total expected achievements in a country based on the collective work of all PEPFAR partners, and should represent PEPFAR's contributions to the national program. These targets should reflect scale up for epidemic control in high disease burden areas and sustained support programs in other areas.

5. **National Targets** – National data represent the collective achievements of all contributors to a program area, including PEPFAR (i.e., host country government, donors, or civil society organizations).

Each type of target, starting at the site-level, builds upon the other. In other words, site-level targets should aggregate into sub-national level targets. Together, these should inform implementing mechanism target totals which feed into aggregate technical area summary level totals for each operating unit. Appropriate deduplication of the targets need to be taken into account at each level of aggregation.

PEPFAR teams are required to provide FY 17 targets (October 1st to September 30th of each fiscal year). FY 17 targets represent expected accomplishments with COP 16 funds by September 30, 2017.

5.4.1 Site and Sub-national Level Targets

Please reference Section 3 of the COP Guidance for information on the strategic approach for targeting.

5.4.2 Implementing Mechanism Level Indicators and Targets: Required for all IMs

Implementing Mechanism (IM) target setting is important for in-country partner management as well as routine planning and monitoring, and is aligned with agency-specific requirements.   Each

Implementing Mechanism's indicator set should represent a comprehensive set of measurements that provide the information needed by the partner and the PEPFAR team to manage the program activities. Minimally, partners will be expected (by the country team) to set targets for all required indicators that are applicable to the work they are doing (reference the MER Guidance for reporting requirements). If there are no applicable indicators, and none otherwise identified by the OU (such as a custom indicator), no IM target submission is necessary.

Target Justification Narratives (2250 characters) should follow the same guidance as provided below (as applicable) for the technical area indicator narratives.

5.4.3 PEPFAR Technical Area Summary Indicators and Targets

The PEPFAR Technical Area Summary Targets are based on the collective work of all PEPFAR partners, and should represent PEPFAR's contributions to the national program. These targets should reflect scale up for epidemic control in high disease burden areas and sustaining programs in other areas.

The FY 17 targets should reflect geographic and population-based prioritization and targeting efforts. Technical area summary are a duplicated sum of site/implementing mechanism level targets.

Target Justification Narratives (2250 characters)

Target justification narratives should be specific to each indicator and should describe:

- the methods used to calculate the indicator

- the strategic focus for implementation in that area and what type of activities are supported by U.S. government

- any changes in the focus of the work and/or in the IP landscape

- related national policies that may influence expected achievements

- any successes or challenges to implementing or monitoring the program (i.e. in a way that the targets are higher/lower than might be expected for the fiscal year)

- any de-duplication methods that were utilized

All operating units (countries and regions) will report national level data on a small core subset of indicators, where applicable. National targets are the expected national achievements inclusive of all stakeholders in a country, and are based on a reporting timeframe defined by the partner national government. These are required for submission to headquarters for selected indicators. All Operating Unit teams must work with partner governments to set and review the annual targets for 2016 and 2017, at a minimum. As in previous COP cycles, PEPFAR teams should have already identified the timeframe for which the national targets are set (e.g., Jan – Dec or Oct – Sept).

In light of recent legislation extending the authorities of the PEPFAR authorization, national targets will continue as a requirement of all COP submissions for selected program areas. These requirements are consistent with PEPFAR practices throughout the recent phase of the initiative.   PEPFAR teams will report national targets for seven national output indicators. For the FY 17 COP, the required targets are in the areas of treatment, PMTCT, voluntary medical male circumcision, key populations, and country ownership. The MER Indicator Reference Sheets revised for FY 16 based on feedback from the last year of implementation, outline the specific indicators that should be used for target setting and the reference sheets that will inform the target setting process. Although these indicator labels and reference sheets primarily describe PEPFAR-supported programming, OUs are being asked to expand the utility of these indicators to the national context.

5.5 Implementing Mechanism Information

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

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

- A partner is funded by more than one agency; or

- A partner has multiple projects that are administered through separate procurement instruments. These will need to be entered as two separate partners and implementing mechanisms.

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

All costs associated with institutional contractors providing support to the country team should be entered in the M&O section.

5.5.1 Mechanism Details

The following information regarding an implementing mechanism will be submitted on the "Mechanism Details" tab of the Implementing Mechanisms section of the COP. In general, these implementing mechanism details should not change from one cycle to the next (i.e., the data remains static over time):

- Prime Partner Name
- G2G (and Managing Agency)
- Funding Agency
- Procurement Type
- Implementing Mechanism Name
- HQ Mechanism ID (system assigned)
- Legacy Mechanism ID
- Field Tracking Number (optional)
- Agreement Timeframe (may change if there are no-cost extensions)
- Benefitting Country(ies) (only required for Regional OU programs)

The following implementing mechanism details must be reviewed and if necessary updated by country teams for the current FY 16 COP. While some items may stay the same from cycle to cycle, others must be updated for the current submission in order to respond to revised guidance and/or reflect current data.

- TBD mechanism (a mechanism that was TBD in prior cycles may be named in COP 16)
- New Mechanism (A mechanism can only be listed as "new" during its first COP cycle)
- Global Fund/Multilateral Engagement

- Construction/Renovation Projects
- Motor Vehicle data

5.5.2 Prime Partner Name

The prime partner name for a mechanism, regardless of prime partner type, will be selected from a list of pre-existing partner names that currently exist within the FACTS Info – PEPFAR Module system. If the partner is new, and does not already appear as a prime partner within the FACTS Info system, you will select "New Partner" as the partner name. To request the addition of a new partner, country teams will need to submit a "New Partner Form" to your CL. The New Partner form is posted on the FY 16 COP Planning section of the pepfar.net site under HQ > Planning and Reporting Cycles.

Once the partner form is received, the new partner name is validated and loaded into FACTS Info. You will be notified that the "New Partner" prime partner entry can be changed in the system to the actual partner name (note, this update will not be possible via templates).

Global Health Supply Chain Program (GHSC)

The Global Health Supply Chain Program (GHSCP) is USAID's new flagship health commodity procurement and supply chain assistance program, which serves as the follow-on to SCMS. If you have programmed funds into SCMS in the past, you may know that all SCMS COP funds go through the Working Capital Fund (WCF) managed by GH/OHA/SCH. This process will remain the same under GHSCP. For planning purposes, in COP 16, do not program funds under PFSCM or SCMS. Instead, please choose GHSCP as the prime partner in FACTS Info from the drop-down, and enter Global Health Supply Chain Program as the mechanism. This will ensure that your funds are correctly routed to the WCF. The GHSC COR in Washington will work with you to ensure funds are disbursed from the WCF to the appropriate supply chain project, including GHSC-PSM, GHSC-QA, GHSC-RTK and GHSC-TA.

As in prior years, once funding is deposited to the WCF, it cannot be transferred out of this account and allocated back to USAID Missions. In addition, GHSC cannot accept PEPFAR funds that have been obligated but not sub-obligated by USAID Missions (i.e. field support), except in special circumstances. Therefore, it is important that teams carefully plan the amount budgeted for GHSC in COP 16. If you have questions, please contact Amanda Paust (apaust@usaid.gov) or Venera Barsaku (vbarsaku@usaid.gov).

5.5.3 Government to Government Partnerships

The Department of State cable released 05 September 2012 serves as the guidance document to be followed when establishing and executing new government-to-government (G2G) agreements in the FY 16 COP. The Common Language Protocols document provides guidance for the transfer of funding to the host government agency receiving funding. Both documents are posted on the FY 2014 COP Planning section of the pepfar.net site under HQ > Planning and Reporting Cycles.

G2G funding is defined as **"Funding which is transferred to a Host Government Ministry or Agency (including parastatal organizations and public health institutions) for the obligation and disbursement of those funds by that government entity".**

The tick box designating the mechanism as G2G must be checked in FACTS Info if the mechanism represents an intention to provide direct G2G assistance from the U.S. government to any entity as defined above. Teams should **not** check the box if fund transfers to the government will be through a non-governmental implementing partner.

Upon selecting the G2G tick box, you must also indicate the "Managing Agency" for this mechanism, i.e. which agency will be managing the relationship with the government and the project. This may be the same agency or a different agency from the one listed in the implementing agency box.

If you have any questions about whether a partner falls under the G2G definition (i.e. whether your partner is a parastatal), or regarding the managing agency for a mechanism, please contact your CL.

Upon submission of a G2G request, S/GAC will conduct a review process to approve all newly planned G2G agreements under PEPFAR. This includes activities using FY 16 PEPFAR planned funds, prior-year funds and anticipated out year funds for the life of the project. To fully evaluate the proposed G2G mechanism, country teams need to provide supporting documentation on the government entity that will hold the agreement and execute the activities, the agency-specific risk assessments conducted or planned, as well as the intended fund transfer mechanism (i.e. Fixed Amount Reimbursement Agreement (FARA), direct transfer, cooperative agreement, etc.…).

To initiate the G2G review process the following information is required:

- Proposed grantee name (e.g. specific ministry)
- Annual funding for project

- Life of project funding

- Fiscal year of funds to be used

- Anticipated start and end dates

- Type of risk assessment to be done or already done for each agency

The merit of a G2G request will be evaluated during the technical and programmatic FY 16 COP reviews. S/GAC will conduct a final review and approve which proposals can advance through a G2G agreement.

In COP 2016 an "Activity Table" must be submitted for all G2G mechanisms, new and continuing. See Section 5.5.19 for detailed guidance.

5.5.4 Funding Agency

It is critical that teams identify the correct USG agency in the Funding Agency field; the agency or Operating Division selected will receive the funding from S/GAC.

USG Funding Agencies

- **DoD (Department of Defense)**
- **DOL (Department of Labor)**
- **Department of State**
  - AF (African Affairs)
  - EAP (East Asian and Pacific Affairs)
  - EUR (European and Eurasian Affairs)
  - INR (Intelligence and Research)
  - NEA (Near Eastern Affairs)
  - S/GAC (Office of the U.S. Global AIDS Coordinator)
  - PM (Political-Military Affairs)
  - PRM (Population, Refugees, and Migration)
  - SCA (South and Central Asian Affairs)
  - WHA (Western Hemisphere Affairs)

- **HHS (Health and Human Services)**
  - CDC (Centers for Disease Control and Prevention)
  - HRSA (Health Resources and Services Administration)
  - NIH (National Institutes of Health)
  - OGA (Office of Global Affairs)
  - SAMHSA (Substance Abuse and Mental Health Services Administration)
- **Peace Corps**
- **USAID (United States Agency for International Development)**
- **U.S. Treasury**

- **HHS/NIH:** Field teams should ensure that they are familiar with the scope of HIV-related clinical or other research that NIH (and potentially other U.S. government agencies) currently fund in country to determine whether or not there are non-research activities appropriate for

inclusion in the COP that may be logically "appended" to these research efforts. If there are opportunities to provide country/regional PEPFAR funding to add a service component to an NIH study, country funding for the additional service component *only* would be put into the COP. The NIH study would NOT be included. You can also include support for training through NIH via Fogarty International Center (FIC) research training grants that support the strengthening of human capacity in strategic information: surveillance, HIS, targeted and public health evaluations, program monitoring and evaluation, modeling, and bioethics. Operating Unit teams should be in contact with the FIC research training program officer or directly with the grantee and their in-country collaborators to discuss capacity building needs (see research training websites at www.fic.nih.gov for contact info for AIDS International Training and Research Program, International Clinical, Operations and Health Services Research Training Award for AIDS and TB, and International Research Ethics Education And Curriculum Development Award). As with all agencies, NIH should be listed as the Funding Agency, and the Prime Partner who will eventually receive the funding should be listed as the Prime   Partner.

- Please identify HRSA for all mechanisms where HRSA is the Funding Agency. Current mechanisms/prime partners include ITECH/University of Washington, the Twinning Center/American International Health Alliance (AIHA), Quality Improvement Capacity Project for Impact/New York AIDS Institute (HIVQUAL) and Columbia University (ICAP) and the Global Nurse Capacity Building Program/Columbia University (ICAP).

- **Peace Corps:** Funding going to the Peace Corps should be identified with Peace Corps as the Funding Agency. Peace Corps should never appear as another USG Agency's prime partner. The Implementing Mechanism section of the COP should only be used to capture Peace Corps programming outside of Peace Corps Volunteer costs.

- **Department of Labor:** Funding going to the Department of Labor should be identified with Department of Labor as the Funding Agency. Department of Labor should never appear as another U.S. government Agency's prime partner.

- **State:** Please identify the State Department Bureau for all mechanisms where the Department of State is the Funding Agency. Any project using State's Regional Procurement Support

Offices (RPSO) for construction or renovation, must list the relevant State regional bureau as the Funding Agency. For more information on construction or renovation as an implementing mechanism, see Section 5.5.11.

- **Treasury:** Treasury's Office of Technical Assistance (OTA), which provides advisors with expertise in public financial management to government ministries, was included in PEPFAR's most recent authorization. Depending on country context, Operating Unit teams may wish to incorporate this element into their broader health systems strengthening portfolio. For these mechanisms, please identify Treasury as the Funding Agency and as the Prime Partner.

5.5.5 Procurement Type

PEPFAR utilizes the following types of procurement:

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

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

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

- Umbrella Award – An umbrella award is a grant or cooperative agreement in which the prime partner does not focus on direct implementation of program activities, but rather acts as a

grants-management partner to identify and mentor sub-recipients, which in turn carry out the assistance programs.

- Inter-agency Agreement (IAA) - An Inter-Agency Agreement is a mechanism to transfer funding between agencies. This mechanism should only be used in **very rare** occasions and is never permitted for use with GHP-State funding. If the USG team decides that one agency has a comparative advantage and is better placed to implement an activity with either GHP-USAID or CDC GAP funding, the USG team has the option of requesting to transfer money from one agency to another through an IAA. This is not the most efficient way of providing funds from one agency to another. However, one example of an appropriate use of an IAA is agency buy-in for census bureau (BUCEN) services.

5.5.6 Implementing Mechanism Name

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

- Partner Acronym: AIHA; CHAZ

- Project Name: Support to RDF; Sun Hotel PPP; GHAIN, If this is a HQ buy-in implementing mechanism then you must put the name of the HQ project in the implementing mechanism name field. For example, if you are using the CTRU Project or UTAP, you should use these names in the implementing mechanism name field.

- Unique Agency Identifier: A grant/cooperative agreement or contract number.

Other than the HQ buy-in Implementing Mechanism requirement above, there are no limitations on mechanism name; we recommend that country teams choose unique values for the mechanism name.

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

Examples of Implementing Mechanism and Prime Partner names are below:

Implementing Mechanism Name	Prime Partner Name
Together We Can	American Red Cross
Twinning	American International Health Alliance
MEASURE/DHS	Macro International
Network RFP	To Be Determined
GH000642	Elizabeth Glaser Foundation

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

The **HQ Mechanism ID** will be assigned by the FACTS Info – PEPFAR Module system when the mechanism is saved in the system (either through a template upload or on-screen). New FY 16 mechanisms will be assigned HQ Mechanism IDs by the FACTS Info – PEPFAR Module system when they are saved to the system.

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

- For mechanisms that existed in the FY 2009 COP in the COPRS I system, Operating Unit teams should use the COPRS I "mechanism system ID."

- For mechanisms that were created in the FY 2010 or 2011 COP or using the "Plan B" system, country teams should use the mechanism ID from that system. For example, if the file name included "new017" in the name, the mechanism ID would be "17."

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

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

5.5.8 Agreement Timeframe

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

5.5.9 TBD Mechanisms

If the mechanism prime partner is TBD, the tick box "TBD Mechanism" must be checked and FACTS Info will automatically populate the Prime Partner field with "TBD." When using Implementing Mechanism templates, if you indicate that the mechanism is TBD, please ensure the Prime Partner is listed as "TBD" only.

Upon checking the TBD tick box, or when completing an IM template for a TBD, a new tab will appear in FACTS Info requesting the user to enter details regarding the status and history of the TBD, projected award date, and any other information that would be helpful for a reviewer.

5.5.10 New Mechanism

Upon the creation of a new mechanism in FACTS Info, the "New Mechanism" tick box will be checked automatically.

In COP 2016 an "Activity Table" must be submitted for all new mechanisms. See Section 5.5.19 for detailed guidance.

5.5.11 Construction/Renovation

This tick box in FACTS Info is used to identify mechanisms that contain funding for construction and/or renovation projects. Checking this box will then open a separate tab in the IM where country teams should complete required information on the projects.

A Construction/Renovation tab will appear requesting the user to enter each proposed project. All fields on the Construction/Renovation Project Plan form must be completed. There is no minimum or maximum limit on the amount of funds allocated to a construction/renovation project for it to be subject to inclusion in the COP submission i.e., all projects, regardless of amount, need to be submitted for approval. Attributions for construction and renovation for each IM should match the total of all IM project plans.

5.5.12 Motor Vehicles

This tick box is used to identify mechanisms that have purchased and/or leased motor vehicles over the timeframe of the IM/agreement. This tick box must be used in order to report on the FY 16 request for the purchase and/or lease of motor vehicles <u>as well as</u> to report on the number of previously PEPFAR purchased or leased that are in use at the time of COP submission. A Motor Vehicle tab is where country teams should enter the data on new FY 16 funding and provide the current size of the PEPFAR fleet under this mechanism.

- At the top of the tab, enter the total number of motor vehicles previously PEPFAR purchased or leased under this mechanism that are currently in use (i.e. from the start of the mechanism through COP submission).

- The main section of the tab requires OUs to provide specific information on each motor vehicle request. Upon clicking the "add" button, you will be required to provide:

    o The type of vehicle requested (boat, truck, car, ambulance, etc.)
    o The acquisition method for the requested vehicle (leased or purchased)
    o The total number/amount of this particular type of vehicle being requested
    o The new FY 16 funding being requested for the group of vehicles that are batched in this entry.
        ▪ NOTE: Any vehicles that are being funded out of the applied pipeline should be listed as zero-funded.

Only new FY 16 funding requested for motor vehicles should be entered in the appropriate attributions ("Motor Vehicle: Purchased" and "Motor Vehicle: Leased.") The totals for these attributions must equal the new funding requested in the motor vehicles tab. Teams are encouraged to utilize the Motor Vehicles IM Summary Report, found in the Budget Section of FACTS Info to check their planned allocations and requests to ensure accuracy.

Any USG related motor vehicle planned expense must be captured in the appropriate agency and cost category of CODB.

5.5.13 Prime Partners

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

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

As noted above, the prime partner name for a mechanism, regardless of prime partner type, will be selected from a list of pre-existing partner names that currently exist within the FACTS Info – PEPFAR Module system. If the partner is new, and does not already appear as a prime partner within the FACTS Info system, you will select "New Partner" as the partner name. In order to request the addition of a new partner, country teams will need to submit a "New Partner Form" to your CL. The New Partner form can be found on pepfar.net. Once the partner form is received, the new partner name validated, and the partner information loaded into FACTS Info, you will be notified that the "New Partner" prime partner entry can be changed in the system to the actual partner name (note, this update will not be possible via templates).

Maximizing Efficiencies:

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

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

- Different partners; different program area; different agency

- Partners working in multiple geographic areas on technical assistance only

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

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

For all direct programming to be implemented by a USG, the agency should have an implementing mechanism with itself named as the prime partner. Note that all of the costs associated with a USG agency's footprint in country, i.e., costs of doing PEPFAR business or "Management and Operations" costs (including staffing to support TA), will be entered in the M&O section. Technical staff salaries will be attributed to the applicable budget code through the M&O section, not through implementing mechanisms.

5.5.14 Definitions

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

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

5.5.17 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 MOH in your country, you should only list the district level health ministries as sub-partners if they are receiving funds directly from a prime partner without going first through a national level headquarters.

5.5.17 Funding Sources / Accounts

The funding sources tab is the space for OUs to indicate the total funding that will be used for the implementation of FY 16 COP, and provide details of the breakdown across funding accounts and new vs. prior FY year funds. Country teams are encouraged to think about new planned FY 16 resources and available pipeline funding as one funding envelope for the mechanism. A strong COP submission will reflect a strategic application of pipeline and allocation of new funds.

FY 16 Resources

For new FY 16 funds, there are as many as three accounts (GHP-State, GHP-USAID and GAP) available to country teams for programming. FACTS Info will be programmed with the available budgets for these three accounts, and not all OUs will have all accounts available to them.

 Please note: there are firm parameters as to how the three accounts can be allocated across agencies. The funding source choices for each agency are:

U.S. government Agency	FY 16 COP Funding Source Categories for New Planned Funding
USAID	GHP (State)
	GHP (USAID)*
HHS/CDC	GAP**
	GHP (State)
HHS/HRSA	GHP (State)
HHS/OGA	GHP (State)
DoD	GHP (State)
DoL	GHP (State)
State	GHP (State)
Peace Corps	GHP (State)
ALL OTHERS	GHP (State)

The GHP-USAID account is the account appropriated directly to USAID, formerly the Child Survival and Health (CSH) Account (FYs 2007 and prior), and the Global Health and Child Survival (GHCS) Account (FY 2008-FY 2011) and is applicable for USAID activities only.

*** The GAP account was formerly called "Base (GAP Account)," and is applicable for HHS/CDC activities only.*

As noted elsewhere, please ensure that you are coordinating as a USG Team in determining funding decisions and that **all** USG HIV/AIDS funding is being programmed as an interagency country team. Please also ensure that your programming is consistent with your budget controls in order to ensure a smooth submission.

At the top of the Funding Source tab, country teams have the opportunity to enter an amount of "**Applied Pipeline Funding**," which the system will auto-sum with the new FY 16 funding requested, by funding account. This applied pipeline data will reflect the amount of PEPFAR pipeline funding, from all accounts, that will be applied to the mechanism for the FY 16 COP implementation. The applied pipeline is the amount of money you project will not be expended by September 30th, 2016 and can be used in the FY 16 COP (i.e. FY 17).

5.5.18 Cross-Cutting Budget Attributions

For more information please see Appendix 2.

Overview

The importance of cross-cutting budget attributions cannot be over-emphasized. Each represents areas of PEPFAR programming with great potential to contribute to PEPFAR by more consciously seeking opportunities for integration and synergy across program areas. Cross-cutting attributions also reflect areas in which there is continuing stakeholder interest, including recommended ("soft") Congressional earmarks for water, and GBV activities. Similar to other earmarks and budgetary considerations, only new FY 16 planned funding can be reflected in cross-cutting attributions (i.e. applied pipeline does not get reflected).

Correct identification of cross-cutting attributions and key issues are **critical** to minimize data calls in the future.

All mechanisms that are applying new FY 16 planned funding for work in any of the cross-cutting attributions (HRH, Construction/Renovation, Motor Vehicles, Food and Nutrition, Economic Strengthening, Education, Water, Condoms, Gender-based Violence, or Gender Equality) **must** have the cross-cutting budget attributions identified and accurately quantified; if you need assistance in developing standard approaches to quantifying cross-cutting attributions, please contact your CL. It is critical that you estimate these attributions and submit with your COP; it is not acceptable to skip this process. For definitions of cross-cutting attributions, please see Appendix 2.

In FY 16, we will be capturing FY 16 funding information for sixteen system-level areas, which are listed below and defined in Appendix 2. Individual attributions should not total more than the FY 16 mechanism planned funding (new FY 16 funds only), but the sum of all system-level attributions may exceed the FY 16 mechanism total planned funding. For example, if a partner is being funded at $1,000,000 for Pediatric Treatment, the planned funding for each system-level attribution cannot be more than $1,000,000. A single activity can often have more than one system-level attribution (e.g., service training on safe water would be split between both HRH and Water), and together these attributions could exceed $1,000,000 in funding. System-level attributions should be identified for all relevant mechanisms, even in the case of TBD mechanisms. In these cases, country teams should estimate the amount of funding for each of the system-level budget categories. The system-level budget information can be updated during subsequent COP update cycles (OPU) if necessary.

System-level attribution categories are as follows:

1. Water
2. Gender: GBV
3. Gender: Gender Equality
4. Human Resources for Health
5. Construction
6. Renovation
7. Motor Vehicles: Purchased
8. Motor Vehicles: Leased
9. Key Populations: MSM and TG
10. Key Populations: FSW
11. Food and Nutrition: Policy, Tools, and Service Delivery
12. Food and Nutrition: Commodities
13. Economic Strengthening
14. Education
15. Condoms: Policy, Tools, and Services
16. Condoms: Commodities

5.5.19 Activity Table

In COP 2016, an **Activity Table** will be required for all new mechanisms and all G2G mechanisms (new or continuing). Narratives in FACTS Info are *not required.* The template for the **Activity Table** can be downloaded on the pepfar.net COP 2016 website. All **Activity Tables** should be uploaded to FACTS Info as a supplemental document. One supplemental upload is expected for each new and G2G mechanism identified in COP 2016.

In COP 2016, activity tables for continuing, non-G2G mechanisms are *not* required.

5.5.20 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. PEPFAR has three types of Public Private Partnerships (PPP), based on the origin of the funding for the PPP Program:

1. **Global:** Global PPPs are initiated and managed at the central (HQ) level. They are typically funded on the U.S. Government side by central funds, but they can also be jointly funded with combined central and country funds. These PPPs typically span multiple countries with multiple partners, and are reviewed by the Technical Working Group (TWG) and Deputy Principals (DPs).

2. **Country-Based:** Country-Based PPPs are initiated and managed at the country level. They are funded on the U.S. Government side by the country teams through the Country Operational Plan (COP) process. Countries are responsible for reporting on these programs in the COP and Annual Program Results (APR).

3. **Incentive Fund:** Incentive Fund PPPs are a combination of the two previous types of PPPs. They are initiated and managed by the country teams and reported on in the COP and APR. Incentive Fund PPPs are funded on the U.S. Government side solely through central (HQ) funds or through a combination of country funds and central (HQ) funds.

Country teams should incorporate country-based PPPs into the COP planning process. To strategically develop high-impact partnerships, country teams should prioritize alignment with core and near-core activities and geographic high yield/burden sub-national localities. New ideas and opportunities to scale and expand best practices should be regularly reviewed and discussed interactively with partners.

All PPPs should be considered when planning the COP and be part of the COP submission, in the same way as any other implementing mechanisms are planned for and reported;

- Country-based and Incentive Fund PPPs must be associated with an Implementing Mechanism and reported in FACTS Info.
- Global PPPs and Central Initiatives should also be fully aligned with the modular planning steps outlined within section 3.1.1 – 3.1.8 including geographic alignment and reported in FACTS Info.
- Please remember that a PPP can be a program by itself, but it may also be added to an existing program or can be designed as part of a larger program to fill gaps as necessary. For instance the Stronger Together PPP is supplementing the Rapid Testing Quality Improvement Initiative (RTQII) by offering the same proficiency testing and training of rapid HIV testers, but offering the program through innovative technology to scale-up the program to reach an increased number of people.

Key Programmatic areas and Implementation Focal Areas for PSE and PPP development include:

- Improving and strengthening program quality, efficiency and sustainability through private sector engagement aligned with the scale up of core interventions – ART, PMTCT, VMMC and condoms

- Focusing private sector engagement efforts on geographic areas at sub-national levels with the highest disease burden

- Engaging private sector to play a vital role in getting ahead of and ultimately controlling the HIV/AIDS epidemic

- Engaging private sector on commitments for prevention investments for DREAMS, Test & Start for men in DREAMS districts, and VMMC

- Supporting ACT initiative to double number of children on ART by December 2016

- Supporting private sector engagement on the investment to the Robert Carr Civil Society Networks Fund over the next three years to build the capacity of civil society

- Developing Innovation Challenge for new partners to contribute new resources and ideas to spark innovation into the DREAMS partnership

- Supporting investments and partnerships in the Global Partnership for Sustainable Development Data

- Developing new partnerships and central initiatives in line with other Front Office priority areas

In COP 2016, PPPs are entered in the mechanism information section of FACTS Info. All PPPs should be linked to an existing or planned mechanism. For additional instructions, see *FACTS Info PEPFAR Module Fiscal Year System Updates*, available for download on the pepfar.net COP 16 website.

6.0 SUBMITTING COP ELEMENTS

6.1 COP/ROP Submission

The COP is comprised of four primary elements, using DATIM and Facts Info.

The **Strategic Direction Summary (SDS)** outlines key data and analysis results, the strategic plan for the coming year, and the monitoring framework that will be used to measure progress. The SDS is submitted in FACTS Info as a supplemental document. Microsoft Word format is recommended and a template has been provided to assist country teams prepare a comprehensive SDS.

Supplemental documents as outlined in Section 9.0 are required and are to be submitted in FACTS Info.

This year, **targets** will be submitted through PEPFAR's data collection system DATIM. Targets are required at the site, geographic, mechanism and technical area levels.

The **budget**, **mechanism information** and **other required documentation** are submitted in FACTS Info by direct entry in the user interface.

Both DATIM and FACTS Info systems are accessible to field teams, and require users to set up accounts to access these systems. Please work with your CL to ensure your team has appropriate access.

6.1.1 FACTS Info Templates for Data Entry

COP/ROP submission may be done using PEPFAR Module templates that teams can upload directly into FACTS Info, or via direct data entry using the screens in the PEPFAR Module. **S/GAC intends to open the PEPFAR Module COP in February 2016. Prepopulated templates for existing IMs, and blank templates for new IMs will be available at this time.** When the COP module is launched teams can export templates and share them with their partners for data. Please note that **blank templates must be used for entering new mechanisms only, and <u>CANNOT</u> be used for existing mechanisms**. Teams are required to use prepopulated templates for existing mechanisms in order to maintain the mechanism ID number and history.

Template Name	Function of Template	Where to find the template
Blank Implementing Mechanism Template	For new IMs created in FY 16 COP/ROP, has all elements that will be asked for in FACTS Info and is organized in a way that corresponds to the FACTS Info Tabs for each IM. When the full COP Module is open you can upload this template to FACTS Info to create a new IM rather than entering data directly on the screen in FACTS.	FACTS Info only
Pre-populated Implementing Mechanism Template	Format is similar to the Blank IM template but this is specifically for continuing IMs. This template is exported from FACTS Info under the IM search screen. Use this template to update existing IMs created in previous FYs. You can import this template to FACTS Info to pull a continuing IM into the current year COP or ROP rather than entering data directly into the screen in FACTS Info.	FACTS Info only
Blank PPP Template	For new PPPs created in FY 16 COP/ROP, this template has all elements that will be asked for in the PPP tab in FACTS Info. You can export this template, populate it, and import in to FACTS Info, within the appropriate IM, to create a new PPP entry rather than entering data directly into the FACTS Info screen.	FACTS Info only
Pre-populated PPP Template	Format is similar to the Blank PPP template but this is specifically for continuing PPPs. This template is 'exported from FACTs Info in the PPP tab or the IM search screen. Use to update existing PPPs created in previous FYs. When COP is open in FACTS Info, you can export this template, populate it, and import it in to FACTS Info, within the appropriate IM, to update an existing PPP rather than entering data directly into the FACTS Info screen.	
New Partner Template	If you don't find a partner's name in the Partner List please fill out this form and submit to PEPFAR-Module-support@state.gov.	Pepfar.net >Planning and Reporting Cycles

6.1.2 Checking Your Work and Highlights of Key Reports

In addition to systems checks, the FACTS Info system offers multiple options for 'checking your work.' In many countries there are multiple U.S. government team members who enter data in FACTS Info and DATIM and even more that enter data into templates that are uploaded to FACTS Info that collectively become the COP or ROP. By utilizing key reports you can ensure the COP/ROP submission (i.e. what is in FACTS Info) is what the country team intended to submit. Checking your

work can also lessen the need for extensive clarifications between S/GAC, Agency Headquarters, and country teams after COP/ROP submission. We urge all teams to heavily utilize the reports available in both the Standard Reports section of the COP module and within the Budget section of FACTS Info in the 'ad-hoc' reports section where you can customize reports.

Highlights of Key Reports

- **Standard COP Matrix Report**- Shows all IMs along with Agency, Funding Source (including Applied Pipeline) and amounts, Budget Code Funding amounts, and crosscutting allocations. This report is the most useful snapshot of critical budget information entered into FACTS Info.

  o Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

- **Summary of Planned Funding by Agency**- Shows the allocations of the full programmed COP budget by funding account, applied pipeline and implementing agency.

  o Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

- **Summary of Planning Funding by Budget Code**- Shows the allocations of the full programmed COP budget by budget codes. This report can be filtered by implementing agency. Also, indicates the total budget code allocation "on hold" amount, if applicable.

  o Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

- **Agency Cost of Doing Business (CODB)** - Shows the agency-specific allocations across the 11 CODB cost categories by funding source.

  o Available in the Standard Reports section of the COP Section of the PEPFAR Module and also through the Budget section of FACTS Info.

7.0 BUDGETARY AND REPORTING

REQUIREMENTS

Countries or regions should fund their program based upon the COP 2016 planning level and earmark requirements as described in the official planning letter to be distributed by S/GAC in late 2015. **COP 2016 should be planned to the stated planning level in the letter, which equals the sum of requested new FY 16 resources and prior year available pipeline applied in support of COP 2016 activities (applied pipeline).** The distribution between new and applied pipeline should be determine based upon the amount of excessive pipeline available for implementation in COP 2016.

PEPFAR will continue to meet previously stipulated Congressional earmarks and fulfill the expectations around other key priority areas while S/GAC continues to communicate with Congress about their expectations and will make teams aware of any shifts for programmatic focus.

Please note: earmarks/budgetary considerations can only be satisfied via programming of current year (FY 16) funds. The application of pipeline cannot be counted towards a team's fulfillment of earmark requirements or other budgetary considerations.

7.1 COP Planning Levels, Applied Pipeline and Financial Supplemental Document

7.1.1 COP Planning Levels

The COP 2016 planning level represents the total resources (regardless of whether they are new FY 16 resources or prior year pipeline resources) that a country or region will outlay over a 12-month period in order to achieve the stated goals or targets of COP 2016.

The COP planning level is the sum of new FY 16 resources and pipeline applied to COP 2016 implementation (COP Planning Level = New Funding Request + Total Applied Pipeline). All outlays anticipated to occur during the COP 2016 implementation cycle must be included within the COP 2016 planning level.

As pipeline is applied to COP 2016 implementation, FY 16 new funds must be decreased in order to keep the entire COP request within the COP 2016 planning level.

Contact your Country Lead prior to final COP submission within FACTS Info in order to ensure FY 16 funding account control levels are updated within FACTS Info, and the completed COP/ROP balances. A COP/ROP cannot be submitted without these updates made at headquarters.

A COP/ROP may not include any "unallocated" funds within the COP Planning Level. If the total planning level exceeds the overall resource envelope required to achieve targets, or is determined to be greater than a country or region's actual ability to outlay within a 12-month period, teams are encouraged to submit a final COP requesting a lower COP 2016 planning level, rather than creating TBDs and/or overfunding mechanisms, or stating a higher spend-rate than is feasible. Some examples of instances in which this scenario may occur are as follows**:** transition, other available donor resources, etc**.**

Contact your Country Lead if this scenario seems likely during the COP planning process or for more information on expectations.

7.1.2 Applied Pipeline

Applied pipeline should reflect the pipeline resources that have been deemed as "excessive pipeline," and are therefore available for implementation within COP 2016. The applied pipeline field should include any prior year (non-FY 16) COP funding that will continue to be implemented and expended during the COP 2016 cycle (i.e. construction funding programmed in a previous year that continues to outlay during COP 2016).

It is expected that all agencies within all countries or regions will analyze their pipeline, ensuring that pipeline remains within an acceptable range, and adjust the new funding allocations as required to spend down excessive pipeline. A submitted COP that does not address excessive pipeline may be subject to delays in approval.

Every PEPFAR program requires a certain amount of pipeline to ensure there is no disruption to services due to possible funding delays or other unanticipated issues. An acceptable level of pipeline is expected to be reflective of an additional 3 months of outlays beyond the current implementation cycle, unless a country is designated as "Special Notification" within the FY 16 appropriations bill. Countries designated as "Special Notification" should consider a pipeline that is reflective of 9months of outlays as acceptable. Pipeline that is above this accepted level of 3 months (or 9 months for special notification) is considered "excessive." With the expectation that funds will arrive in the same fiscal year as the COP is approved, less excess pipeline is needed in reserve than previous years.

Only "excessive" pipeline should be included in the COP 2016 request as applied pipeline, as this excessive amount must be spent down in order to reduce pipeline and bring it into an acceptable range.

As stated in Section 8 below, funding for Peace Corps Volunteers (PCVs) must cover the full 27-month period of service and thus, countries with PEPFAR-funded volunteers are exempt from the 3-6 months of pipeline rule.

In most instances, the pipeline applied to a mechanism (or CODB category), "applied pipeline," will be less than the total pipeline available to the mechanism, as the acceptable pipeline level must be maintained and should not be considered as available for application to COP 2016.

The applied pipeline field within COP 2016 should be considered a type of COP 2016 funding source (in addition to the GHP-State, GHP-USAID, and GAP accounts). The sum of these funding sources (new FY 16 funds + applied pipeline) will equal the total resources expected to be outlayed by an individual mechanism (or CODB category) over the 12-month COP 2016 implementation period. When all mechanism funding sources (new FY 16 funds + applied pipeline) and all M&O funding sources (new FY 16 funds + applied pipeline) are added together, this total is equal to the outlay level for COP 2016, i.e. to the COP planning level.

Note: *It is understood that many agencies follow a "first-in, first-out" approach to budget execution, requiring the full utilization of expiring funds and older funds before any new FY 16 funds are obligated and expended. Due to this budget execution approach, the actual fiscal year of funds that are outlayed in support of an approved COP 2016 activity may not match the approved COP 2016 applied/new funding breakdown.*

7.1.3 Financial Supplemental Worksheet

Each country or region must submit a financial supplemental worksheet at COP/ROP submission, detailing the historic, current and projected financial performance of all mechanisms and CODB categories included within the COP/ROP. Each country or region must submit one document compiling the information for all agencies.

The *Financial Supplemental Worksheet* can be found on pepfar.net COP 16 website.

The *Financial Supplemental Worksheet* must be uploaded into the FACTS Info Document library upon submission. A COP/ROP submission will not be considered complete without the submission of

this supplemental document. The information entered into the supplemental document must match your COP submission in FACTS Info, and the current budget request information (new funds requested and applied pipeline) can be copied from a FACTS Info Standard COP Matrix Report.

The *Financial Supplemental Worksheet* includes three tabs:

<u>Tab 1: Mechanism Data</u>

All mechanisms included in the COP 2016 submission must be represented in this tab. The final submitted Financial Supplemental Worksheet must combine all agencies into one submission, and the totals must match with the data entered into FACTS Info.

The Standard COP Matrix Report should be used as a resource for completing this Tab. It is the best source for a complete listing of all implementing mechanisms and data within that report should be copied and pasted into the worksheet.

The remaining required elements should be completed with assistance from agency field and headquarters financial staff.

<u>Tab 2: CODB Data</u>
See M&O section 8.0 for further details.

<u>Tab 3: Totals (sum of Tabs 1 and 2)</u>
The totals reflected in this Tab must match with the total COP planning level and totals submitted within FACTS Info.

7.2 Budget Code Definitions

7.2.1 MTCT- Prevention of Mother to Child Transmission

MTCT – Includes activities aimed at preventing mother-to-child HIV transmission.

Activities that **should be** included in MTCT:

1. Services and support related to the initiation, adherence, retention, clinical monitoring (including labs), and Nutrition Assessment Counseling and Support (NACS) (including breastfeeding counseling) for HIV+ pregnant and breastfeeding women *newly initiating ARVs under option B+*.
2. HIV testing for all pregnant and breastfeeding women and their partner(s).
3. Salary support for CHWs that assist with PMTCT specific adherence and retention activities
4. Training for clinical and other personnel supporting PMTCT activities (i.e., lay counselors, mentor mother programs, data clerks)
5. Training for services for HIV-exposed infants (HEI)
6. Sample transport systems for specimens at the site level for clinical monitoring of PMTCT clients (CD4/VL)
7. Roll-out of B+ PMTCT program policy and implementation including:
   a. National/district level support for B+ roll-out
   b. Register revision/program reviews for B+ transition
   c. Evaluation of B+ implementation
8. Real-time PMTCT program monitoring and quality improvement
9. Activities on estimation of population transmission rates at national or subnational level
10. ARV prophylaxis for newborns

Activities that **should *NOT*** be included in MTCT (these costs should be accounted for in their respective budget codes):

1. Service delivery for B+ (HTXS)
2. ARV drugs (HTXD)
3. Male and female condoms and lubricant (HVOP)
4. Community based activities focused on family strengthening (HKID)
5. Household and economic food security (HKID)
6. Social welfare (HKID/HBHC)
7. Lab reagents for CD4/VL (care and treatment codes)
8. INH prophylaxis (HVTB)

9. TB screening and treatment for pregnant women (HVTB)

10. Women on their second pregnancy and are on ART from their previous pregnancy – service delivery (HTXS); ARVs (HTXD)

7.2.2 HVAB- Abstinence/Be Faithful

Activities that **should** be included in HVAB:

1. All prevention activities that promote abstinence or fidelity
   a. School-based prevention programs that promote delay of sexual debut
   b. Sexuality education
   c. Parenting programs
2. Life Skills Programs
3. Mass Communication and media campaigns
4. Behavior change programs

Activities that **should *NOT*** be included in HVAB:

1. Prevention aimed at Key Populations (HVOP)
2. Condom procurement, distribution or marketing (HVOP)

7.2.3 HVOP – Other Sexual Prevention

Activities that **should** be included in HVOP:

1. Services related to the procurement, distribution and marketing of male and female condoms and condom-compatible lubricant
   a. This can include condom procurement for key populations and for the general public
2. All sexual prevention programs targeted for key populations:
   a. Peer outreach
   b. Small group prevention activities
   c. Hotspot prevention activities
3. NGO Network building
4. PrEP demonstration projects (excluding procurement of ARVs)
5. Comprehensive care for survivors of sexual assault
6. Activities related to reducing alcohol related sexual disinhibition
7. Linkages to other services and platforms (i.e. VMMC, Care, Treatment)

8. Engagement with the government and civil society organizations to reduce criminalization of key populations
9. Training for providers for key populations considerations
10. Prevention targeting priority populations (i.e. military, adolescent girls)
    a. Adolescent friendly sexual and reproductive health services

Activities that **should *NOT*** in included in HVOP:
1. Activities for HIV+ key populations (These activities should be tracked using key populations budget attributions- KP : FSW or KP: MSM/TG- if possible):
    a. STI management for HIV+ in KP setting (HBHC)
    b. MAT/MMT for HIV+ PWIDs (HBHC)
    c. MAT/MMT for HIV- persons PWID (IDUP)
2. Community or facility clinical services for HIV+ KP clients (HTXS or HBHC)
3. All PwP or PHDP activities (HBHC)
4. Size estimation surveys or IBBS surveys (HVSI)
5. Procurement of drugs for Post-Exposure Prophylaxis (PEP) as part of care for survivors of sexual assault (HTXD)

7.2.4 HMBL- Blood Safety

Activities that **should** be included in HMBL:
1. Activities supporting a nationally-coordinated blood safety program to ensure accessible, safe and adequate blood supply
2. Infrastructure and policy
3. Donor-recruitment
4. Blood collection and blood testing (transfusion-transmissible infections)
5. Storage and distribution
6. Ensuring appropriate clinical use of blood
7. Transfusion procedures and hemovigilance
8. Training and human resource development
9. Monitoring and evaluation for blood safety

7.2.5 HMIN- Injection Safety

Activities that **should** be included in HMIN:

1. Programs, policies, training and advocacy to reduce medical transmission of HIV and other blood borne pathogens
2. Programs to reduce unnecessary injections and promote injection safety
3. Health care waste management programs
4. Management of needle sticks and occupational PEP
5. Safe phlebotomy
6. Infection prevention and control
   a. Single use syringes and needles
   b. Lancets and blood drawing equipment
   c. Safety boxes
   d. Gloves for safe phlebotomy

7.2.6 IDUP- Injecting and Non Injecting Drug Use

IDUP- Prevention among people who inject drugs (PWID)

Activities that **should** be included in IDUP:

1. Policy reform around PWIDs
2. Needle and syringe access programs
3. Training and capacity building for providers, including the host government and NGOs
4. Procurement of methadone and other medical-assisted therapies (MAT) should be included ONLY if it is for at HIV _negative_ PWIDs for prevention purposes (see HBHC for MMT/MAT for HIV _positive_ PWIDS)
5. Comprehensive programs for PWIDs included treatment of other drug addictions such as methamphetamine
6. Community mobilization and PWID Networks

Activities that **should _NOT_** be included in IDUP:

1. Prevention of sexually transmitted HIV infection among PWIDs (HVOP)
2. MMT/MAT for HIV _positive_ PWIDs (HBHC)
3. Continuum of care for HIV+ PWIDs (HBHC)
4. Non-injection drug prevention interventions (i.e., alcohol risk reduction) (HVOP)

7.2.7 CIRC- Voluntary Medical Male Circumcision

Activities that **should** be included in CIRC:

1. Support the implementation of VMMC - This includes the minimum package of clinical and prevention services which MUST be included at every VMMC delivery point
    a. Age-appropriate sexual risk reduction counseling
    b. Counseling on the need for abstinence during the healing process after the procedure
    c. Circumcision by a medical method recognized by WHO (device or surgery)
    d. Post-surgery follow-up, including adverse event assessment
    e. Distribution of condoms
    f. HIV testing prior to circumcision for all men and their partners
2. Circumcision supplies and commodities
    a. This includes emergency equipment such as tourniquet, IV and IV catheters, hydrocortisone, adrenaline, sphygmomanometer, stethoscope, and sodium chloride
    b. PrePex or other circumcision devises (only if they are WHO prequalified)
    c. Supplies for safety during the procedure: exam gloves, alcohol swabs, gauze, adhesive tape, syringes and needles
    d. Tetanus toxoid containing vaccine (TTCV) as needed to comply with MOH policy as part of tetanus mitigation.
    e.
3. Communication and demand creation
4. Training
    a. Adverse event and safety training
    b. In-service training for VMMC for either surgery or devices
    c. Curriculum creation
5. Linkages to treatment/ Care services for men who test HIV+

Activities that **should *NOT*** be included in CIRC:

1. Circumcisions for clients between 61 days old up to age 10 years
2. Circumcisions that require anesthesia or sedation

7.2.8 HVCT- HIV Testing Services

Activities that **should** be included in HVCT:

1. The provision of HIV testing services (HTS, formerly HTC) across the range of community and facility-based settings (including client and provider- initiated approaches)

   a. HVCT should include budgets for HIV testing for PHDP, key populations, adult treatment, care and support, pediatric treatment, and for orphans and vulnerable children

2. Supply, provision and distribution of HIV RTKs (Rapid Test Kits)

3. Mobilization to support HTC and testing demand creation

4. Linking HTS-users to the appropriate services (i.e. VMMC, Prevention, Treatment, Care) and tracking those linkages

5. Note that retesting (for confirmation prior to ART initiation) in persons testing HIV positive can be covered by HTS or by Adult Care and Support (HBHC)

Activities that **should _NOT_** be included in HVCT

1. Testing and counseling in the context of PMTCT (MTCT)

2. Early Infant Diagnosis (EID)(PDCS)

3. Testing and counseling in the context of TB (HVTB)

4. Testing and Counseling in the context of VMCC (CIRC)

7.2.9 HBHC- Adult Care and Support

Activities that **should** be included in HBHC:

1. All services provided under the HBHC budget code apply to HIV+ adult clients only. Care and support interventions (as defined in the Technical Considerations), including PHDP interventions, provided to HIV+ adult clients should be attributed to HBHC.

2. Procurement of cotrimoxazole and associated support (e.g. training, monitoring, oversight/mentoring, etc.)

3. Services related to prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications including malaria, diarrhea, and Cryptococcal disease (including provision of commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services) to all HIV+ adults,

4. Pain and symptom relief

5. Screening and treatment to prevent cervical cancer in HIV-infected women, specifically screening with visual inspection and treatment with cryotherapy or loop electrosurgical excision procedure (LEEP), including procurement of associated supplies and equipment

6. Nutritional assessment, counseling, and support (NACS) for HIV+ adults

7. Procurement of HIV+ monitoring commodities (CD4 and viral load)

8. Medication Assisted Treatment (MAT – methadone) can be proposed for inclusion in situations where country teams are able to track the portion of the MAT services provided to HIV positive individuals.

9. Support for community based ongoing adherence and retention interventions for PLHIV

10. For HIV+ individuals, all services related to the prevention of onward transmission of HIV as well as maintaining health of the patient (PHDP services):

    1. Assessment of sexual activity and provision of condoms (and lubricant) and risk reduction counseling (if indicated).

    2. Assessment for STIs and provision of or referral for STI treatment and partner treatment if indicated.

    3. Assessment of family planning needs and (if indicated) offering contraception or safer pregnancy counseling or referral for family planning services.

    4. Assessment of adherence and (if indicated) support or referral for adherence counseling; assessment of need and (if indicated) referral or enrollment of PLHIV in community-based programs such as home-based care, support groups, post-test-clubs, etc.

11. Retesting (for confirmation prior to ART initiation) in persons testing HIV positive can be covered by HTS or by Adult Care and Support (HBHC)

Activities that **should *NOT*** be included in HBHC:

1. ARVs (HTXD)

2. TB drugs and services, including TB screening and support for IPT (HVTB)

3. Costs associated with testing partners and family members of PLHIV (HVCT or MTCT)

4. STI drugs used for broader populations (e.g. KPs seen in a general STI clinic) (HVOP)

5. Services provided more broadly to key populations of unknown or negative serostatus (HVOP)

6. All care interventions for HIV+ children (PDCS).

7. With regard to cervical cancer, PEPFAR does not provide funding for primary prevention (HPV vaccine), cytologic screening (Pap smears), or treatment for invasive cervical cancer.

8. PEPFAR does not procure contraceptives, with the exception of male and female condoms.

7.2.10 HKID- Orphans and Vulnerable Children

Activities that **should** be included in the HKID budget code:

1. Support of vulnerable children and their households
    a. Promotion of Cash Transfers
    b. Household economic and food security
    c. Education subsidies
    d. Improve child and family relationships
    e. Protective services for children
    f. Keeping children in family structures
    g. Access to healthcare and health services
    h. Access to adolescent friendly services/ Reproductive health services
    i. Early Childhood Development programs
    j. Strengthen growth monitoring for young children and linkages to nutrition programming

2. Support of the community with OVC
    a. Mobilizing child protection committees
    b. Strengthening the capacity of local NGOs and CBOs who work on OVC issues
    c. Building of social welfare and service networks including the social workforce

3. Linkages to other HIV related services
    a. Linkage and referral to facility and community-based services like HTS, pediatric care and treatment

4. M&E for intervention evaluations of OVC programming

Activities that **should *NOT*** be funded under HKID:

1. Pediatric drugs, diagnostics and services (HTXD, HVCT, PDCS, PDTX)
2. Pediatric care and support (PDCS)
3. HTS in OVC settings (HVCT)
4. Prevention commodity procurements

Note: *Implementing Partners working to serve orphans and vulnerable children should be supported to offer comprehensive programs that include HTS and linkages to care and treatment from both community and facility sites; activities within these comprehensive programs must be coded to HTS and HKID accordingly as indicated in the budget code guidance as noted in sections 7.2.8 and 7.2.10.*

*Please refer to the 2012 PEPFAR OVC Guidance for more information on acceptable activities.

7.2.11 HVTB- TB/HIV

Activities that **should** be included in HVTB:

1. All TB screening, including for pregnant women, among PLHIV
2. INH prophylaxis for all HIV+ populations
3. Laboratory investments for TB/HIV, including GeneXpert equipment, test kits, and other consumables and other TB diagnostics (biosafety cabinets, AFB smear and culture)
4. Exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis (including isoniazid and drugs for treating active TB)
5. Testing of TB clinic clients for HIV (HIV testing), including fast-tracking/referral of PLHIV with TB for initiation of ART
6. Services that target TB/HIV activities in special populations such as pediatrics, prisons, and miners.
7. Human resources to accelerate planning and implementation of collaborative TB/HIV activities, including site-level integration of TB and HIV activities
8. Efforts to improve monitoring, evaluation and reporting of collaborative TB/HIV activities.

Activities that **should *NOT*** be included in HVTB:

1. Costs associated with ART treatment and monitoring of TB/HIV patients (HTXD, HTXS or PDTX)

7.2.12 PDCS- Pediatric Care and Support

Activities that **should** be included in PDCS:

1. All HIV-related care services provided for HIV-positive children and adolescents either in the community or in the facility

2. Facility based services for HIV-exposed infants (NACS, insecticide treated bed nets, safe water, clinical monitoring, pain and symptom relief, and nutritional assessment and support including food)

3. Early infant diagnosis (EID) services implemented at the site level

4. Cotrimoxazole (CTX) prophylaxis (commodities)

5. Sample transport and results return for pediatric specimens at the site level (CD4/VL/EID)

6. Activities to support the needs of adolescents with HIV (ALHIV) (PwP, support groups, support for transitioning into adult services, adherence support, reproductive health services, refer to the OVC program for educational support for in and out of school youth)

7. Activities promoting integration with routine pediatric care, nutrition services and maternal health services, malaria prevention and treatment.

8. Activities to ensure appropriate dispensation of CTX and Isoniazid (INH), prophylaxis in infants, children and adolescents.

9. Activities to address nutritional evaluation and care of malnutrition in HIV+ and exposed infants, children and youth.

10. Activities to address psychosocial support of children and adolescents, including disclosure, adherence counseling, and support groups. Where possible, countries should coordinate adherence and disclosure activities with the OVC program.

11. Activities that will increase direct linkages to the community to improve communication between facilities and community services for HIV+ children and youth.

12. Activities that support HTS to widen the access, utilization and uptake by families and adolescents

13. Activities that strengthen retention in care from infant to transition from adolescent to adult services

Activities that **should _NOT_** be included in PDCS:
1. Broader lab capacity, training and equipment, including activities to strengthen laboratory support and diagnostic services for pediatric patients (HLAB)

2. Services that target TB/HIV activities in pediatrics, including INH (HVTB)

3. Infrastructural and construction activities (OHSS)

4. Key prevention activities that address girls, Young MSM, LGBT, substance users and youth involved in sexual exploitation (HVOP)

7.2.13 HTXD- ARV Drugs

Activities that **should** be included in HTXD:

1. All ARVs, including ARVs for adult treatment, pediatric treatment, and PMTCT.
2. All antiretroviral Post-Exposure Prophylaxis procurement for rape victims and needle stick injuries

Activities that **should** *NOT* be included in HTXD:

1. Cost of distribution of ARVs to the site level - facility or community (HTXS)
2. Supply chain management advisors (OHSS)
3. Supply chain/logistics, pharmaceutical management and related systems strengthening inputs (OHSS)
4. Commodity storage costs or management of those storage costs related to distribution of ARVs (OHSS)
5. Rental costs or the tracking or equipment needed to move commodities inside a warehouse (OHSS)
6. Software or planning costs related to distribution of ARVs (OHSS)

7.2.14 HTXS- Adult Treatment

Activities that **should** be included in HTXS:

1. Direct service provision as well as direct technical support to the site, including:
   a. Direct services for HIV+ patients related to adherence, retention, and clinical monitoring both at the facility and community-level
   b. Procurement of CD4 and VL reagents (this can be coded in HBHC but costs cannot be double-counted)
2. Service delivery for option B+, including support for clinic personnel
3. In-service training for clinicians and other providers to provide adult care
4. Sample transport and results return for adult specimens at the site level (CD4/VL)

Cost of distribution of ARVs to the site level (facility or community)

Activities that **should** *NOT* be included in HTXS:

1. Procurement of RTKs (HVCT)
2. ARVs (HTXD)
3. Pre-service training (OHSS)

4. Laboratory services for counseling and testing (HLAB)

5. TB screening (HVTB)

6. Pediatric care and treatment (PDCS or PDTX)

7. HIV drug resistance surveillance activities (HVSI)

8. Services and support related to the initiation, adherence, retention, clinical monitoring (including labs), and NACS (including breastfeeding counseling) for HIV+ pregnant and breastfeeding women *newly initiating ARVs under option B.* (MTCT)

7.2.15 PDTX- Pediatric Treatment

Activities that **should** be included in PDTX:

1. Costs associated with providing clinical services to HIV+ children

2. Costs associated with community support to HIV+ children

3. Support to the government to roll out updated pediatric treatment guidelines

4. In-service training for clinicians and other providers to provide pediatric care

5. Clinical and laboratory monitoring of children and adolescents on treatment (CD4/VL reagents)

6. Activities building capacity to monitor, supervise and implement uninterrupted HIV treatment services from infancy to adolescents (including transition to adult services)

7. Activities supporting adherence in pediatric and adolescent populations, improve overall retention on treatment and establish functional linkages between programs and with the community to reduce loss to follow up and improve long-term outcomes

8. Activities promoting case finding and integration of pediatric HIV treatment services into MCH platforms

Activities that **should *NOT*** be included in PDTX:

1. Pediatric formulations of ARVs (HTXD).

2. Development of capacity to provide laboratory services that escalate case finding for children/adolescents and detect treatment failure (HLAB)

3. Infrastructural and construction activities (OHSS)

4. Promoting integrated approaches to improve outcomes HIV drug resistance surveillance activities (HVSI)

5. Activities related to specialized curriculum development and pre-service training (OHSS)

7.2.16 OHSS- Health Systems Strengthening

Activities that **should** be included in the OHSS budget code:

1. Activities that contribute to improvements in national-, regional- or district-level health systems (generally those that are implemented above the service delivery point (site) level and/or are not directly tied to patients, beneficiaries, facilities or communities)

2. Development and implementation of policy, advocacy, guidelines and tools (e.g., broad-based, such as development of Human Resources for Health Strategic Plan; related to specific technical areas, such as circular/guidelines/protocol development)

3. Technical assistance to improve system-level financial management systems

4. Pre-service training and curriculum development support for in-service trainings at regional training centers

5. An integrated package of activities focused on a range of health systems strengthening building blocks with a SI or lab component that does not constitute the majority of those activities

6. Support for supply chain at above-site level, including support to national and subnational levels for forecasting and warehousing of HIV-related commodities

7. Supporting supply chain systems through training and development of cadres with supply chain competencies

8. Capacity building of civil society organizations that interact with the health system, such as local non-governmental, faith-based, and community-based organizations

9. Support to Global Fund programs and activities, and donor coordination

Activities that **should *NOT*** be included in the OHSS budget code:

1. Laboratory and SI activities that fall under the HLAB and HVSI budget codes, respectively

2. In-service training for care and treatment and should be coded under the relevant care and/or treatment budget code (MTCT, HTXS, HBHC)

3. Cost of distribution of ARVs to the site level (facility or community) (HTXS)

7.2.17 HLAB- Laboratory Infrastructure

Activities that **should** be included in the HLAB budget code:

1. Development and strengthening of laboratory networks and facilities to support HIV/AIDS-related activities, including purchase of equipment (including Point-Of-Care) and commodities, quality assurance for HIV rapid testing, Lab staff training and other technical assistance
2. Lab training, QA/QI, mentoring/supervision
3. LMIS/forecasting systems
4. Lab commodities/consumables (except reagents for the support of CD4, EID and VL)
5. Lab equipment (except GeneXpert)

Activities that **should *NOT*** be included in the HLAB budget code:
1. An integrated package of activities focused on a range of health systems strengthening "building blocks" that has a lab component, but where laboratory activities does not constitute the majority of those activities (OHSS)
2. Lab reagents for the support of CD4, EID, and VL (adult and pediatric care and treatment codes)
3. GeneXpert (HVTB)
4. Service delivery costs, including costs associated with providing service to the patient such as phlebotomy or sample transport from the site (HTXS, HBHC)

7.2.18 HVSI- Strategic Information

Activities that **should** be included in the HVSI budget code:
1. Activities that build capacity for and ensure the implementation of the collection, analysis and dissemination of HIV/AIDS behavioral and biological surveillance and monitoring information; Supporting capacity building efforts and the implementation of facility and other surveys; Build the capacity for the development of national program monitoring systems; Support the development of country-led processes to establish standard data collection methods; and
2. Support for the national health information system planning and development.
3. HIV Drug Resistant (HIVDR) surveys
4. HIV Impact Assessments (HIA)
5. Lab Management Information Systems (LMIS)
6. Integrated Bio-Behavioral Survey (IBBS)
7. Country wide electronic medical records

Activities that **should *NOT*** be included in the HVSI budget code:

1. Activities directly supporting one specific program area (e.g., B+ M&E framework);

2. Activities that are integral components of a prevention, care, or treatment funding mechanism;

3. An integrated package of activities focused on a range of health systems strengthening "building blocks" that have a SI component that does not constitute the majority of those activities (OHSS).

7.3 Mandatory Earmarks

Planning for mandatory earmarks should be fully integrated into the COP planning process. This funding should complement and enhance the country program, reflect sound and effective allocations to partners with high outlay rates and associated results and ultimately allow for PEPFAR to continue meeting Congressional expectations.

7.3.1 Orphans and Vulnerable Children

PEPFAR's authorizing legislation directs that 10 percent of PEPFAR's bilateral funds be used for Orphans and Vulnerable Children programming. The OVC earmark focuses on socio economic interventions critical to mitigating the impact of HIV and AIDS on children ages 0-17, prioritizing those which contribute to epidemic control, in line with the 2012 OVC Guidance.

For FY 16, S/GAC will consult with Congress prior to determining the final OVC funding level. For the 2016 COP submissions, PEPFAR country teams will receive their HKID investment requirement in the COP 2016 planning level letter.

As described in the 2016 Technical Considerations, activities should focus on OVC core/near core interventions in close proximity to other PEPFAR supported HIV and AIDS services and interventions and within PEPFAR defined geographically prioritized areas to the extent possible. OVC programs provide socio-economic services that mitigate the impact of AIDS on children ages 0-17 by reducing vulnerability, contributing to prevention goals (especially for adolescent girls), and supporting access to and retention in treatment (especially pediatric treatment).

7.3.2 Care and Treatment Budgetary Requirements and Considerations

Globally, at least 50 percent of the total FY 16 bilateral resources must be dedicated to treatment and care for PLHIV. In order to reach this global requirement, each country or region submitting a 2016 COP or ROP will be notified of their specific care and treatment requirement within the country- or regional-specific planning level letter issued in late 2015.

The care and treatment earmark is calculated according to the following formula:

$$\frac{Care\ \&\ Treatment\ for\ PLHIV\ (HBHC + HTXS + HTXD + PDCS + PDTX + HVTB + \ 0.3 * MTCT)}{Total\ FY\ 2016\ Resources}$$

If upon submission of your COP/ROP, the above formula is not greater than or equal to the care and treatment requirement allocated to your team, your Country Lead will be in touch to discuss further how each COP/ROP can reach this mandatory earmark with FY 16 resources.

7.4 Other Budgetary Considerations

While it does not rise to the level of "hard" earmarks in legislation, our partners in Congress may use the annual appropriations process to emphasize priorities from their unique perspectives and to indicate levels of funding for those priorities which they expect the program to achieve, sometimes referred to as "soft" earmarks. It is vitally important that teams are responsive to these concerns. If any such provisions are enacted for FY 16 within the expected full year FY 16 appropriations bill, S/GAC and the implementing agencies will communicate any changing or new expectations for teams to incorporate such provisions in their planning processes.

7.4.1 Water and Gender-Based Violence (GBV)

It is anticipated that in the FY 16 appropriation bill, investments in GBV and WATER will be earmarks for all foreign assistance funding. PEPFAR has an obligation to meet its portion of the earmark by ensuring investments in these two areas are at the same level, or greater, than the FY 15 investments as captured by the cross-cutting allocations in COP 2015.

For FY 16 COP submissions, PEPFAR country/regional teams will use the final FY 15 COP allocations to the GBV and WATER cross-cutting allocations as the baseline planning level. The 2016 COP planning levels for GBV and WATER can be above the COP 2015 amounts, however, **cannot** fall below it. Exact required investment levels will be reflected in the COP 2016 planning level letter.

If, due to a pivotal change in COP 2016, you will be unable to reach these levels of investments, please contact your Country Lead to discuss further.

7.4.2 Tuberculosis

As tuberculosis (TB) remains the most common cause of death among people living with HIV in sub-Saharan Africa, implementation of the package of evidenced-based interventions is a very high-impact, life-saving smart investment of resources and is a priority for PEPFAR programming in areas with the greatest burden of co-infection.

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

However, progress has been slower than in other areas of clinical care. There remain important gaps is screening for TB and HIV and assuring effective linkages across TB and HIV services and programs. Rates of ART for co-infected TB patients are lagging behind in many countries. Efforts to overcome barriers to effective service-level integration need ongoing attention as do efforts to explore and adapt models of integration that are country context-specific.

Investment in TB/HIV should therefore be maintained PEPFAR-wide.

Please refer to FY 16 COP Technical Considerations for further programming guidance.

In Global Fund high-impact countries implementing joint TB/HIV grants, PEPFAR teams should also seek opportunities to support effective joint program implementation.

7.4.3 Food and Nutrition

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

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

7.4.4 Abstinence and Be Faithful Reporting Requirement

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

If AB programmed activities do not reach a 50 percent threshold of all sexual prevention funding in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the Epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

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

$$\frac{AB\,(HVAB)}{Sexual\,Prevention(HVAB+HVOP)} \leq 50\%$$

7.4.5 Strategic Information

Central Support for SI – HVSI Budget Code

An important consideration when determining the overall COP planned budget is how much to allocate towards Strategic Information (SI). International standards suggest approximately 5-10 percent of the total budget should be dedicated to SI. Some exceptions may include countries with very large planned budgets, which may have a lower percentage in SI, while some technical assistance countries may have SI budgets that far exceed 5 -10 percent. Activities supported by these resources have a more central or SI infrastructure focus, including for example, support to national or district health information systems, government monitoring and evaluation or statistical units, surveillance/survey implementation, university centers of excellence, etc.

Program Budget Allocated for M&E

In addition to the overall support for SI activities in the country plan mentioned above, further deliberations are necessary to determine what percentage of program-level funding should be set aside for basic program monitoring and evaluation. International standards suggest approximately 5-10 percent of a program budget should be dedicated to monitoring and evaluation of the program. Regardless of the exact percentage, routine monitoring and evaluation should be integral to all PEPFAR programs. It is important to note that an outcome or impact evaluation may be considered in conjunction with a program, and these studies often require a higher level of funding (note that any such planned studies must also be identified in section 6.2b). In these instances, additional resources above the 5-10 percent range may be necessary.

7.5 Single Partner Funding Limit

The single partner funding limit diversifies the PEPFAR partner portfolio, and expands partnerships with local partners, all with the goal of promoting the long-term sustainability of HIV/AIDS programs in our partner countries. For FY 16, the limit on funding to a single partner is no more than 8 percent of a country's PEPFAR budget, excluding U.S. Government country team management and operations costs.

7.5.1 Exceptions to the Single Partner Funding Limit

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

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

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

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

C. **Umbrella Agreements**[17]**:** The grants officer will determine, in consultation with the country team, whether an award is an umbrella for purposes of exception from the cap on an <u>award-by-award</u> basis. This determination may be made at the time the announcement is written based on the statement of work or at the time of award based on the applicant's work plan. The following criteria apply to decisions about umbrella status:

- Awards made with the intent that the organization make sub-awards with at least 75 percent of the grant (with the remainder of the grant used for administrative expenses and technical assistance to sub-awardees) are umbrellas and exempted from the cap.
- Awards that include sub-awards as an activity under the grant but do not meet the above criteria are <u>not</u> exempt, and the full award will count against the cap.

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

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

7.5.2 Umbrella Award Definition

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

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

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

The following are "best practices" for umbrella awards:

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

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

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

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

7.5.3 Single Partner Limit Justifications

You will be asked to submit a justification for any partner that exceeds the single-partner funding limit, after excluding organizations (host country government organizations, parastatals) and funding (umbrella awards, drug and commodity purchases) exempted under the exceptions noted above. No justification is required for partners that would exceed the 8 percent limit only if procured commodities were included; however, the dollar amount of funding the partner will use for commodity procurement should be included with the implementing mechanism information. Teams can utilize the Single Partner Funding Limit report in the Budget Module of FACTS Info to help determine if a justification is required for any partners. Justifications should be uploaded to the FACTS Info document library as 'Budgetary Requirements Justification'.

7.6 Justifications

All justifications should be uploaded into the FACTS Info document library as 'Budgetary Requirements Justification'. Again, the Budgetary Requirements Worksheet and the Single Partner Funding Limit report will help teams to determine if justifications are required for the FY 16 COP.

Justifications are required in the following instances:

- Generalized epidemic countries not allocating 50 percent or more of their sexual prevention budget to Abstinence and Be Faithful programming
- Any country allocating more than 8 percent of their program budget to more than one partner if this partner does not fall within one of the exceptions.

8.0 U.S. GOVERNMENT MANAGEMENT AND OPERATIONS (M&O)

8.1 Interagency M&O

For COP 2016, the data elements in the Staffing tool within Facts Info have been updated to be more functional for OU and HQ staffing analysis. The number of individuals field has been removed. For COP 2016, all staff fully or partially funded by PEPFAR should be included as individual entries. Other staff who work more than 30 percent on PEPFAR also should be included as individual entries. The Level of Effort (LOE) indicators that were introduced in a separate Excel workbook for COP 2015 have been expanded and integrated into the staffing data for enhanced analysis. In addition, a new field captures estimated SIMS business travel days in a quarter. The total aggregated travel days should correspond with the SIMS Action Planner outputs. In addition, the guidance has been updated to set expectations for the type of assessments OUs should conduct of their interagency footprints and organizational structures to facilitate successful implementation of PEPFAR 3.0 and their pivots. The SDS prompting questions have been updated accordingly as well. Finally, the Costs of Doing Business (CODB) USG Salaries and Benefits field has been split in two to capture Internationally Recruited and Locally Recruited Staff separately. Further, the budget code FTE inputs used to allocate CODB funding proportionally have been updated. Facts Info will now pull only FTE associated with fully or partially PEPFAR-funded staff. Hence, for the Internationally Recruited and Locally Recruited Staff Salaries and Benefits, the system will only pull the FTE of the partially and fully PEPFAR-funded staff who meet the respective Citizenship Status criteria.

PEPFAR's new business model focusing on regular data analysis and use for decision-making requires that teams revisit and update their staffing footprints and organizational structures to maximize effectiveness and efficiency. With consideration given to intra-agency and mission-wide demands, as well as space constraints at virtually all Embassies, teams should review how they are staffed and organized to meet regular and ad hoc tasks, perform core PEPFAR functions, oversee partner performance, and ensure achievement of goals and targets.

In COP 2016, interagency M&O includes a short narrative in the SDS to summarize the team's staffing and organizational analysis, itemization of the personnel implementing the OU program in the Facts Info staffing data, and allocation of the CODB that capture the costs inherit in running the program and having essential personnel. The CODB proposed funding levels are captured in Facts Info and the Financial Supplemental Workbook (see Section 4.3).

COP 2016 M&O Submission List:

- SDS Narrative (questions updated for 2016)

- Staffing Data (some data fields updated for 2016)

- Functional Staff Chart (as previously required but updated to reflect any footprint or organizational changes)

- Agency Management Charts (one per agency)

- *Financial Supplemental Workbook* – Cost of Doing Business Worksheet (updated for 2016)

8.1.1 PEPFAR Staffing Footprint and Organizational Structure Analysis, Expectations and Recommendations

OU teams should ensure that all management, operations, and staffing decisions are based on meeting PEPFAR programmatic goals, given legislative and budget constraints, rather than non-PEPFAR needs driving organization decisions. Teams must be able to accomplish interagency tasks and processes while simultaneously ensuring agency oversight and accountability over implementing partners. OU teams should be working in a complementary, non-redundant fashion (e.g. all technical staff working as a team, shared team responsibility for the entire U.S. government program rather than just one agency's portfolio, new technical staffing needs considered by the team rather than just one agency).

Expectations

For 2016, the minimum expectations for all OUs are that they complete an analysis of the existing staffing footprint and interagency organizational structure <u>prior</u> to the COP DC Management Meetings and identify any adjustments that need to be implemented to successfully manage business process. Teams should have made recommendations on any adjustments to their staffing footprints and CODB ahead of the D.C. Management Meetings as these decisions have an impact on the amount of funding available for program implementation and earmarks.

The focus of reviewing the OU's footprint and organizational structure for COP 2016 should be on how staff are organized and funded to meet key tasks and core functions and deliver results. While OU footprints should follow rightsizing and good position management principles, the emphasis is not simply on the number of staff or vacancies vis a vis overall footprint. The focus should be on ensuring a balance of staff across interagency business process and coordination demands, agency partners' management and accountability, and external engagement. Further, the expectation is that staff

funded partially or fully by PEPFAR are available and assigned to meet key interagency and intra-agency tasks throughout various PEPFAR business cycles (e.g. POART, COP, S/APR).

First, teams should consider the core competencies and functions needed to meet pivots. A first step will be to outline various PEPFAR-required (interagency and intra-agency) and agency-required (intra-agency) processes (e.g. COP, POART, SAPR, APR) then use the staffing data to measure and ensure coverage of tasks and functions. Updated Level of Effort Workload Management Indicators (Section 8.2.3) have been incorporated into the staffing data for COP 2016 to facilitate teams' assessments. Organizational structures may need to be shifted e.g. creating new teams to manage each step of the COP process or collapsing TWGs to streamline. Key questions include: how will the OU team handle key tasks during the year? Who is the lead? Who are the alternate and/or team members? OUs should consider how to de-duplicate current activities across the team to maximize efficiency.

Second, the OU should analyze the staffing data and review the staffing footprint to determine whether there is alignment with the core competencies and functions. What does the data tell you about how the OU is managing the program and essential tasks? Are there missing skills identified during COP 16 development or post-pivot for which training is needed or new/revised positions might be required? Is there a need to repurpose or update existing positions (whether filled or vacant) to meet key competencies and accomplish tasks? If space is available, is there a need for new positions? In lieu of new positions, is there a plan to bring in TDY, WAE, or temporary hire assistance at certain times of the year? Teams should consider the trajectory, including funding, of the program in reviewing the staffing footprint and organizational strategy.

Best Practices

For 2016, teams should consider the following best practices:

- Consult with Embassy and agency management support offices for help with finding balance across the OU footprint.

- Create or update its interagency charter, SOPs, and/or manual to codify decisions made around core tasks and assignment of individuals and groups. As examples, OUs could consider including:

  o SOPs for each working group or task team

- o Principles for regularly scheduled in-person and phone meetings and ad hoc meetings and processes, for example:

    - General schedule

    - process for scheduling ad hoc discussions

    - principles for meeting minutes and action item follow-up

  - o General communication principles

    - How information is shared, when

    - Who is addressed and/or copied on certain messages

  - o How to handle conflict, seek consensus, and come to decision

  - o External engagement leads, principles

- Review all PEPFAR-related Position Descriptions (vacant and encumbered) to ensure they are updated for PEPFAR 3.0, e.g. include data analysis, interagency work, and SIMS site visits.

- Itemize training or other skill development needed across the team to achieve pivots and creating a training schedule in partnership with S/GAC and Agency headquarters.

- Identify for the Working Group on Issues Affecting LE Staff (LE Staff WG) any positions that would benefit from a Framework Job Description (standardized PD for mid- and senior-level common positions that can be used by any agency or OU). See pepfar.net for the currently available FJDs that can be used as is or as guides.

- Identify any additional HQ assistance needed to facilitate a staffing or organizational analysis, implement organizational changes, or provide training.

An addendum with helpful tips on how to utilize the staffing data and conduct a staffing and organizational assessment will be shared separately. In addition, the pepfar.net LE Staff WG page houses a repository of helpful guides, tips, and templates to assist teams.

8.1.2 SDS Requirements

The SDS M&O narrative will:

1) Summarize the analysis conducted of its staffing footprint and interagency organizational structure in the SDS. The following key questions will help teams evaluate appropriate staffing and CODB levels:

- What changes did the team make to its USG staffing footprint and interagency organizational structure to maximize effectiveness and efficiency to achieve program pivots? How did you assess baseline Level of Effort of current staff in order to determine changes in staffing needs?
  - How has the team ensured balance between interagency business process coverage and intra-agency partner management and technical roles?
  - How will staff be utilized to meet SIMS requirements?
  - What additional action does the team want to take that has a timeline beyond COP submission?
- Were there missing skill sets or competencies identified? What steps are the team taking to fill these (e.g. training, repurposing vacancies/encumbered positions)?
  - Did the team alter existing, unfilled positions to better align with the new PEPFAR business model and program priorities in Country/Region X?

For TA/TC countries in which a large portion of staff time is dedicated to providing technical assistance, explain in the SDS how a balance has been achieved within the team between site monitoring and TA. What TA goals will be delivered through USG staff, rather than through external partners?

2) Explain Vacant Positions

In the SDS, OUs should summarize the steps it is taking to fill vacancies of more than 6 months and what action it has taken to alter the scope of the position to balance interagency and intra-agency needs.

For each approved but vacant (as of March 1, 2016) position, the OU must explain the reason(s) it is vacant and describe the plan and timeline for filling the vacant position in the Facts Info staffing data. If the position has been previously encumbered, please provide the date that the position became vacant and whether the position has been recruited yet. If recruitment has occurred but the team has been unable to fill it, please indicate why (e.g. lack of candidates, salary too low). Vacant position narratives should be no more than 500 characters and entered directly into the Comments field within the Staffing section of the Facts Info PEPFAR module. There should be one explanation for each staffing record marked as vacant.

Submitting this information will help identify program-wide recruitment and retention issues and skill and knowledge gaps.

3) Justify Proposed New Positions

In the SDS, OUs should summarize the interagency analysis and decision making that culminated in the agreement to request funding for a new position, including whether space for the position has been validated with the Embassy Management Officer and Chief of Mission. Teams should strongly justify why they are proposing new positions instead of repurposing an existing filled or vacant position. For positions that the team plans to fill with a U.S. citizen direct hire or PSC, indicate why this position cannot be hired locally. In addition, teams are encouraged to use term-limited appointments versus permanent mechanisms.

In the Comments field within the Staffing section of the Facts Info PEPFAR module, OUs must describe how each proposed new position fits into the interagency and individual agency staffing footprints (e.g. meets changes in the program, addresses gaps, and complements the existing staff composition). New position narratives should be no more than 500 characters. All proposed positions (not previously approved in a COP) should be marked as planned in the staffing data.

In the COP 2016 review process, all proposed new positions will be rigorously evaluated for relevance to new business process needs and alignment with programmatic priorities. Because the approval threshold for new positions will be high, wherever possible, country teams are advised to repurpose existing vacancies to fill new staffing priorities (particularly long-standing vacancies, i.e. having been vacant for 2 or more COP cycles). Note that any proposed new positions should spend at least 50 percent of their time on PEPFAR activities.

4) Explain major changes to CODB

In the SDS, OUs should summarize any factors that may increase or decrease CODB in COP 16. Identify whether there are any trade-offs that will be required if the CODB request is not fully approved.

8.2 Staffing and Level of Effort Data

OUs must update their staffing data annually within the FACTS Info PEPFAR Module (pre-populated with COP 2015 staffing data). For COP 2016, there have been several changes made to make the data more useful to OU teams and HQ review.

The purpose of the staffing data is to assist each OU with strategic staffing assessments and decisions – during the COP planning process and throughout the year – by transparently organizing and managing the demographic information and staff time/LOE. The information should assist each team in assessing their current and proposed PEPFAR staff, from interagency and intra-agency functional perspectives, for the purposes of effective and efficient program design and oversight. Helpful tips on how to utilize the staffing data to assess staffing and functional balance will be disseminated separately.

The annual revision of staffing data should support each U.S. government agency in ensuring that sufficient staff are in place for effective fiscal management, partner oversight, SIMS implementation, and interagency collaboration. Staffing data should be integral to COP planning and reporting, staff planning, and position and program management. In both management and technical areas, review of staffing data may help to identify gaps (e.g. skill sets or functional area/business process coverage) and areas of overlap, as well as support Chiefs of Mission in managing the PEPFAR team while engaging in agency headquarters-driven management exercises such as "rightsizing" and "managing to budget."

To assist teams in best aligning their staff to operationalize the pivot and new targets, as well as continue to implement SIMS and quarterly data reviews, the Facts Info staffing data has been updated for COP 2016, e.g. integrating aspects of the COP 2015 LOE staffing tool. Changed fields are noted with ***asterisks.

8.2.1 Who to Include in the Database

- All fully or partially PEPFAR-funded (i.e. GHP, GAP, or other PEPFAR fund accounts) current, vacant (as of March 1, 2016), and proposed positions working on PEPFAR planning, management, procurement, administrative support, technical, and/or programmatic oversight activities. Note that **all** PEPFAR-funded staff must be included in the staffing data. This is a change from previous years when there was a 10 percent threshold.

- Any non-PEPFAR funded current, vacant (as of March 1, 2016), and proposed positions that are involved in decision making for PEPFAR planning, management, procurement, and/or programmatic oversight activities. (new requirement for 2016)
- Any non-PEPFAR funded current, vacant (as of March 1, 2016), and proposed positions that will spend at least 30 percent of their time working on PEPFAR planning, management, procurement, administrative support, technical, and/or programmatic oversight activities.

Include all:

- U.S. Direct Hire (USDH) (includes CDC appointed staff, military, and public health commissioned corps),
- Internationally recruited Personal Services Contractors (PSCs),
- Personal Services Agreements (PSAs) (includes locally-recruited Eligible Family Members and Foreign Service Nationals),
- LE Staff (locally hired PSC or PSA host country nationals, Americans, and TCNs),
- Internationally recruited TCNs,
- Non-Personal Services Contractors (also known as commercial, third party, or institutional contractors)/Fellows, and
- Other employment mechanisms (for which there should be very few entries).

Any non-PSC/institutional contractor who is employed by an outside organization (e.g. CAMRIS, GH Pro, ITOPPS) who provides full-time, permanent support to field operations and sits imbedded with USG staff should be included in the staffing data if they are partially or fully paid for by PEPFAR and/or otherwise meet the inclusion criteria above. Do not temporary or short-term staff. However, if the position slot is permanent and the incumbent rotates, please include the position and state "rotating" in the last and first name fields. The costs of these staff should be captured in the Institutional Contractor CODB field.

Temporary or seasonal hires should not be included but should be considered in overall footprints/organizational structures to achieve various business processes.

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

Notes

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

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

Aggregate Entries: **New for 2016** Country teams no longer have the option of including in the database an aggregate entry for program staff who individually contribute less than 30 percent of their average time on PEPFAR. Please create individual entries for all positions that meet the overall criteria for inclusion.

Inclusion of non-PEPFAR-funded and non-program staff: While optional, you may also elect to include in the database non-PEPFAR funded staff who work less than 30 percent of their average time on PEPFAR. However, do not include any staff that work on a temporary or seasonal basis, such as during the COP season. Do not include those working in ICASS-funded offices (e.g. motor pool, GSO, FMO, EX, HR, etc.); staff working in ICASS offices and paid by ICASS contributions should be removed from the staffing data.

Inclusion of Global Fund Liaisons: As in past years, Global Fund Liaison positions (whether centrally funded or cost-shared) should be included in Staff Information. For centrally funded Liaisons, enter the record into the staffing database as "Non-PEPFAR Funded" (i.e., centrally or non-COP funded). As Missions pick up the funding of the Liaison position (full or cost share), enter the record as "PEPFAR Funded" or "Partially PEPFAR Funded" as relevant. Please contact your CL with any questions about funding stream for this position.

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

OUs should update the staff demographic information in the following fields (data field definitions are included below) pre-populated from COP 2015. Please note that there are new fields required in COP 2016 that are labeled with ** and their titles italicized.

Operating Unit: The appropriate OU will be pre-populated by the system to facilitate analysis across countries.

Time Devoted to PEPFAR: Refers to the annual staff time the person in the position spends on PEPFAR. This is one of the key fields in determining the position's PEPFAR-related FTE. Enter the average percentage (10-100 percent) in the data field.

Staffing Status: Refers to whether a position is currently staffed or not. Select whether the position is Filled, Vacant (previously approved in COP 2015 or prior), or Planned (new request for COP 2016):

- Filled refers to currently encumbered positions;
- Vacant refers to positions that have been previously approved in a COP, but are currently empty; or
- Planned (new requests) refers to positions that are new for COP 2016 and have not been approved in previous COPs. A justification narrative must be entered into the Comments section per 8.1.2.

Last Name: If desired and the position is filled, enter the staff member's last name.

First Name: If desired and the position is filled, enter the staff member's first name.

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

Agency Position Title: Country teams should use a detailed functional title appropriate for each position or use official titles. Choices are pre-populated. For example, "Senior Technical Advisor for PMTCT" or "M&E Advisor," or "Management and Program Analyst" and "Public Health Advisor." For LE Staff positions for which a Framework Job Description has been used, please use the associated official title.

Type of Position: Select the type of position from the following list. Please note for positions within categories (a) and (b), part or all of the staff time/funding will likely be attributed to technical budget

codes; whereas for positions within categories (c), (d), and (e), all of the staff time/funding will likely be attributed to the M&O budget code (HVMS).

a. Technical Leadership/Management includes positions that lead the health/HIV team within the agency, e.g. the head of the agency (e.g. CDC Country Director), someone who oversees all U.S. government health activities and spends only part of the time on PEPFAR (e.g. USAID health office head), and a U.S. Direct Hire Foreign Service officer filling an HIV/AIDS advisor position and thereby leading an HIV/AIDS team. The PEPFAR Country Coordinator and Deputy Coordinator should be included in this category.

b. Technical and Programmatic Oversight and Support includes the technical staff within the health/HIV team who spend most of their time developing, implementing, or managing programs in technical areas, including Agreement Officer Technical Representatives (AOTRs), Project Officers (POs), and Public Health Advisors. Please also include here any entry and mid-level staff providing direct public health programmatic activities in this category (this is most relevant for CDC staff) and any programmatic support positions within the health/HIV team or non-health/non-HIV staff who provide support to the health/HIV team (e.g. Education, Reproductive Health, TB, Food & Nutrition). Contracting/Financial/Legal includes acquisition (contracts) and assistance (grants and cooperative agreements) officers and specialists and their support staff. A contracting officer represents the U.S. government through the exercise of his/her delegated authority to enter into, administer, and/or terminate contracts, grants, and cooperative agreements, and make related determinations and findings. Contracting officers and specialists usually support an entire agency in country or will support an entire regional portfolio. If an agency utilizes the contracting officer services of another agency, include the position only in the contractor's home agency. This category also includes the financial management officer or specialist for the agency who support financial and budget analysis and financial operations functions. Legal includes staff who provide legal advice and support to PEPFAR. Do not include ICASS-supported positions.

c. Administrative and Logistics Support includes any secretarial, administrative, drivers, and other support positions.

d. U.S. Mission Leadership and Public Affairs/Public Diplomacy (PA/PD) include any non-health/HIV staff who provide management, leadership, and/or communications

support to PEPFAR, such as the Ambassador, Deputy Chief of Mission, USAID Mission Director, Political or Economic Officers, and any PA/PD staff.

Employee Citizenship: Select the citizenship of the staff member:

a. U.S.-based American citizen: Direct hire (including military and public health commissioned corps), appointees (CDC), or PSCs hired in the U.S. for service overseas, often on rotational tours. They are paid on the U.S. Foreign Service or Civil Service pay scale or compensated in accordance with either scale. The U.S. government has a legal obligation to repatriate them at the end of their employment to either their country of citizenship or to the country from which they were recruited.

b. Locally Resident American Citizen: Ordinarily resident U.S. citizens who are legal residents of a host country with work permits or Eligible Family Member positions authorized to work in country and hired locally. U.S. government agencies recruit and employ them as LE Staff under Chief of Mission (COM) authority at Foreign Service (FS) posts abroad often as PSAs. They are compensated in accordance with the employing post's Local Compensation Plan (LCP).

c. Host Country National (or legal permanent resident): Citizens of the host country or ordinarily resident foreign nationals who are legal residents of the host country and hold work permits. They are employed as LE Staff at FS posts abroad and compensated in accordance with the LCP of the employing post.

d. Locally Hired Third Country Citizen: Foreign Service Nationals (FSNs) who are not citizens or permanent residents of either the host country or the United States and are hired locally in the country in which they are employed. They are compensated in accordance with the employing post's LCP.

e. Internationally Recruited Third Country Citizen: FSNs who are recruited from a foreign country other than where they are employed with whom the U.S. government has a legal obligation to repatriate them at the end of their employment to either their country of citizenship or to the country from which they were recruited.

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

a. Direct Hire: A U.S. government position (AKA billet, slot, ceiling, etc.) authorized for filling by a Federal employee appointed under U.S. government personnel employment authority. A civilian direct-hire position generally requires the controlling

agency to allocate an FTE resource. NOTE: Host country nationals that are appointed by a U.S. government agency should be listed as a Direct Hire.

    b. Personal Services Contractor (PSC): An individual hired through U.S. government contracting authority that generally establishes an employer/employee relationship. Both USAID and Peace Corps use PSCs to obtain services from individuals.

    c. Personal Services Agreement (PSA): An individual hired through specialized Department of State contracting authority that establishes an employer/employee relationship.

    d. Non-Personal Services Contractor (non-PSC/PSA): An individual engaged through another contracting mechanism (e.g. institutional contractor) by a non-U.S. government organization (e.g. CAMRIS, GH Pro, ITOPPS) that does not establish an employer/employee relationship with the U.S. Government.

Funding Type: Select the appropriate choice for the position:

    a. PEPFAR Funded: Any position fully funded by GHP-State, GHP-USAID, GAP, or other PEPFAR fund accounts.

    b. Partially PEPFAR Funded: Any position partially funded by GHP State, GHP-USAID, GAP, or other PEPFAR fund accounts.

    c. Non-PEPFAR Funded: Any position funded by agency core (State, Defense, and Peace Corps positions). CDC and USAID positions should be partially or fully PEPFAR funded).

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

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

Note: *The overall full time equivalent (FTE) box and budget code FTE boxes will auto-calculate based on the percentage of time entries. The position's overall PEPFAR-related FTE is calculated by multiple the Schedule entry by the Percent Time Devoted to PEPFAR:*

- Full-time (= 1) vs. Part-time (= .5),
- Percent Time Devoted to PEPFAR by Each Individual (40% = 0.4; 100% = 1).

Other Roles: Identifies additional responsibilities of staff engagement in the following categories:

      a. Education

      b. ES: Economic Strengthening

      c. Food (and Nutrition)

      d. HCD: Human Capacity Development

      e. Water

      f. Gender

      g. CTO: CTO (Cognizant Technical Officer)/CTOR (Cognizant Technical Officer Representative)/Project Officer or Agency Equivalent

      h. PPP: Public Private Partnership

      i. Supervisor: Has official supervisory duties per position description

      j. Financial Manager: Has official management duties per position description

**Note that PHE: Public Health Evaluations and NPI: New Partners Initiative have been eliminated as options.

Gender: If a staff member works on gender, indicate 'Yes' and include a numeric value of 25-100 indicating the percent of time the staff member spends on gender activities. The amount of time spent on gender will not impact the allocations made to the Program Areas or total percent of time spent on PEPFAR.

For example, an OVC Senior Technical Advisor may spend 30 percent of his/her time on gender issues. In the Staff Information tab, time spent on gender will be indicated with 'Yes' and a value of 30. In the Program Area tab, the budget code distribution will follow the division of time associated with the established budget codes (e.g., 80 percent OVC and 20 percent HVMS) with no reference to gender.

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

8.2.3 Capturing Staff Time Instructions

There are two ways in which the staffing data assist teams in measuring a PEPFAR's contribution to PEPFAR and whether there is appropriate balance of workload for various business processes.

First, as it has since its introduction, the staffing data captures the amount of time (out of total 100 percent PEPFAR-related time – irrespective of total time dedicated to PEPFAR) the position spends working on different technical areas (i.e. budget codes). OU teams are expected to reflect staff time across technical budget codes as appropriate. Technical area time allocation should be reserved for technical guidance, activity, in a particular area. Whereas general program management, leadership, grants administration, communications, external engagement (of a non-technical nature), should be captured under HVMS. For example:

- A PMTCT Senior Technical Advisor who is involved in technical direction of the eMTCT program but also provides technical advice regarding lab activities related to Option B+ implementation would be captured, for example, as 70 percent MTCT, 20 percent HLAB, and 10 percent HVMS. The 10 percent attributed to HVMS for this position reflects staff time spent on managerial responsibilities.
- A Finance Specialist's PEPFAR work would be captured wholly (100 percent) under HVMS. This position does not contribute to any technical areas and provides general administrative support.

The expanded LOE indicators, now incorporated directly into the Staffing tool in Facts Info, are being introduced to better capture and understand what positions are actually doing that contribute to intra-agency, interagency, mission-wide, and external engagement activities and goals. These indicators build upon the concept introduced in the COP 2015 LOE tool that accompanied the SIMS Action Plan, but have been expanded to cover a wider range of mutually exclusive activities. They can be used by OU teams to assess their staff balance across seven functional work streams.

OU teams should complete the following fields based on the average time spent by the position in an average quarter. The total should add up to 100 percent of the position's total PEPFAR-devoted time. While these fields are mutually exclusive from the technical area fields above, there should be harmony between the entries. The fields are:

- Intra-agency Administration, Training, Financial Management – this field captures time spent on agency-mandated or agency-focused activities, e.g. training requirements, administrative tasks. This field should not include any time spent directly managing or overseeing partners. The majority of admin staff will have 100% of their time captured in this field unless they are

providing direct support to interagency groups, in which case that percentage of time would be reflected in Interagency Other.

- Intra-agency Partner Management/CoAg Admin/Site Visits – this field captures all time spent in the management and oversight of implementing partners including time spent in FOA development and technical review, work plan development/oversight, COR/Activity Manager duties, and SIMS and non-SIMS site visits. Contracting Officers time should be reflected in this field.

- Interagency Leadership – this field captures time spent in the leadership role over an interagency team, such as member of an executive-level PEPFAR interagency committee, technical working group (TWG) chair, or head of a COP/APR planning task team.

- Interagency Other – this field captures all other interagency activity, e.g. TWG membership, participation in COP or other task teams, and participation in all hands meetings.

- Mission-wide Activities – this field captures participation in mission-wide activities, such as engagement with the Embassy Front Office, participation in Ambassadorial-led committees (e.g. senior staff, country team, interagency health team), or participation in subject-matter-focused mission-wide working groups (e.g. on human rights).

- External Engagement – Leadership – this field captures engagement with the host government, other donors, civil society, media, etc. at a senior- or policy-level. Activities reflected in this field include time spent in review of COP plans or APR results with senior Ministry of Health officials, participation on donor group committees or the Global Fund Country Coordinating Mechanism, or speeches to stakeholder groups. The engagement captured here reflects broader PEPFAR program goals vice a single technical area. This category is most appropriate for interagency PEPFAR leadership, Embassy/agency leadership, and communications staff.

- External Engagement Technical – this field captures technical advice and assistance given by the position to the host government or other stakeholders, participation in national TWGs. This category is most appropriate for technical and programmatic staff.

Please note that the FTE for each of the indicators will auto-calculate based on the position's overall PEPFAR-related FTE.

Coupled with an assessment of staff time needed to accomplish key interagency and intra-agency tasks, the updated LOE FTE can help teams understand whether they have well balanced staff time across the streams. For example, the team can look at the COP development step-by-step guide,

quantify the amount of estimated staff time needed to complete the tasks, and assign responsible staff. Then looking at the allocation of staff time in the LOE indicators, they can assess whether there is a match or mis-match between the amount of time estimated to complete the tasks and the staff assigned to do it. The outcomes of this analysis can also inform changes to interagency organizational structures needed to facilitate work, identify missing skills that can be addressed through training or Position Description updates, and provide a framework for interagency Standard Operating Procedures or an interagency manual.

In addition, the team can look at estimated SIMS travel and determine whether there is a good balance between a position's intra-agency and interagency responsibilities and the amount of time expected to be out of the office on SIMS visits. The new SIMS field captures the average number of business days each quarter a position is expected to be out of the office on SIMS visits. It does not capture days spent in the office on SIMS visit planning or data analysis. This field should align with the percentage of time allocated to Intra-agency Partner Management/CoAg Admin/Site Visits as well as to the SIMS Action Planner. Teams can use the aggregated data from an agency or interagency perspective to evaluate whether adequate time has been allocated to achieve the desired site visits itemized in the SIMS Action Planner.

A LOE tool populated with the new fields will be disseminated to teams after COP guidance dissemination to enable teams to enter and use the new data ahead of Facts Info being open for COP 2016 entry.

8.2.4 Attribution of Staffing-Related CODB to Technical Areas

Each position's entry should reflect the amount of time spent working on PEPFAR and whether the position is partially or fully PEPFAR-funded or non-PEPFAR-funded. The funded costs for all positions should be reflected in the U.S. government Salaries and Benefits CODB categories. New for 2016, there are separate CODB salary and benefit categories for:

- Internationally recruited staff, e.g. U.S. direct hire, U.S. PSC, and TCNs
- Locally recruited staff, e.g. host country national PSA staff, locally hired Americans and TCNs

Salary costs for Institutional Contractors should be entered in the appropriate CODB category for non-PSC/PSAs.

For U.S. government Staff Salaries and Benefits and Staff Program Travel, OU teams will update their staffing data and enter the top-line budget amount for each CODB category, by fund account (see CODB guidance below). Based on the calculated budget code FTE (for only those fully or partially funded PEPFAR positions) aggregated for each agency, a portion of the agency's top-line CODB budget amount will be attributed to relevant budget codes and to the M&O funding amounts. **New for COP 2016, only the budget code FTE for partially and fully PEPFAR-funded positions will be applied to the CODB categories.**

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

For Peace Corps staff in COP 2016, country teams should attribute all PCV funding to Management and Operations (budget code HVMS).

8.3 OU Functional and Agency Management Charts

OU teams are asked to submit charts reflecting their functional and management structures. The functional staff chart and agency management charts should be uploaded as required supplemental documents to COP 2016.

The interagency chart should reflect the leadership and decision-making structures for the OU as well as permanent working groups or task teams involved in interagency program management and oversight and/or external engagement. Only leadership position and TWG titles should be included; do not include names of persons. Teams should update the chart as appropriate to reflect any organizational changes made based on its review of the staffing footprint and organizational structures to facilitate achieving the pivots and targets. Examples of functional management charts will be available on the LE Staff WG pepfar.net page.

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

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

8.4 Cost of Doing Business Worksheet

U.S. government Cost of Doing Business (CODB) includes all costs inherent in having the U.S. government footprint in country, i.e. the cost to have personnel in-country providing technical assistance and collaboration, management oversight, administrative support, and other program support to implement PEPFAR and to meet PEPFAR goals.

There are a number of cost drivers in FY 16 that S/GAC anticipates may cause teams to increase their CODB, including global U.S. Department of State increases in Capital Security Cost Sharing (CSCS), ICASS costs, and Locally Employed (LE) Staff pay increases. In addition, as new PEPFAR business processes come on-line, teams must ensure that they are staffed and supported to successfully implement SIMS, POART, and enhanced routine program planning with civil society, governments, and the Global Fund.

Again for COP 2016, teams must submit a *Financial Supplemental Workbook* detailing the historic and projected financial performance of all CODB categories included within the 2016 COP/ROP. Each OU must submit one document compiling the information for all agencies, and the totals must match with the data entered into FACTS Info. The CODB worksheet can be found in the second tab "CODB Data" of the *Financial Supplemental Workbook* located on the pepfar.net COP 2016 website.

- Teams should refer to the Agency CODB report to complete Tab 2. The data in this report should be copied and pasted into columns A-I of the worksheet.

- Column J requires information on CODB category pipeline as of 12/31/2015 and column K is a new requirement detailing the total funds spent per CODB category in FY 2014. These required elements should be completed with assistance from agency field and headquarters financial staff.

- Column L will auto-calculate the percent change in CODB, per cost category, from the FY 2014 actual expenditure to the FY 16 planned amount.

- Justifications for any increase or decrease from FY 16 COP CODB expenditures should be detailed in column M, the "Notes" section of the worksheet.

The completed Financial Supplemental Workbook must be uploaded into the FACTS Info Document Library. A COP/ROP submission will not be considered complete without submission of this supplemental document.

8.4.1 Cost of Doing Business Categories

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

If there is any funding requested for the following CODB categories, then you must complete the "Item Description" field associated with the category and planned amount.

- **Non-ICASS Administrative Costs:** Please provide a detailed cost breakout of the items included in this category and their associated planned funding (e.g. $1,000 for printing, $1,000 for supplies). The narrative should be no more than 500 characters.

- **Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) and will be used solely for that purpose, purchase or lease information needs to be justified and dollar amount specified. The narrative should be no more than 500 characters.

- **U.S. Government Renovation:** Describe and justify the requested project. Significant renovation of properties **not** owned by the U.S. government may be an ineffective use of PEPFAR resources, and costs for such projects will be closely scrutinized. The description should be no more than 1000 characters and include the following details:

    - The number of U.S. government PEPFAR personnel that will occupy the facility, the purpose for which the personnel will use the facility, and the duration of time the personnel are expected to occupy the facility.

- A description of the renovation project and breakout of associated costs. Include a description of why alternatives – facilities that could be leased and occupied without renovation – are unavailable or inadequate to meet personnel needs.

- The mechanism for carrying out the renovation project, e.g. Regional Procurement Support Office (RPSO).

- The owner of the property.

- The U.S. government agency which will implement the project, and to which the funds should be programmed upon approval. If the project will be implemented by DOS through RPSO, the funding agency should be the State Bureau (e.g., State/AF).

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

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

There are eleven U.S. government CODB categories. The following list of CODB categories provides definitions and supporting guidance:

1. **U.S. Government Staff Salaries and Benefits:** The required costs of having a person in country, including housing costs not covered by ICASS, rest and relaxation (R&R) travel, relocation travel, home leave, and shipping household goods. This category includes the costs associated with technical, administrative, and other staff.
   a. PEPFAR program funds should be used to support the percentage of a staff person's salary and benefits associated with the percentage of time they work on PEPFAR. The direct costs of PEPFAR, specifically the costs of staff time spent on PEPFAR, need to be paid for by PEPFAR funding (e.g. GHCS, GAP). For example, if a staff person works 70 percent on PEPFAR, PEPFAR program funds should fund 70 percent of that person's salary and benefits. If the percentage worked on PEPFAR is 10 percent, then PEPFAR funds should fund 10 percent of the person's salary and benefits.

b. For agencies that cannot split-fund staff with their agency appropriations (such as USAID's OE funds), multiple staff may be combined to form one FTE and one of the staff's full salary and benefits will be funded by PEPFAR. For example, if two staff each work 50 percent on PEPFAR, PEPFAR funds should be used to fund the salary and benefits of one of the positions. If three staff each work a third of their time on PEPFAR (33% + 33% + 33%), PEPFAR funds should be used to fund the salary and benefits of one of the positions. If multiple staff work on PEPFAR but not equally (such as 10% + 20% + 70% or 25% + 75%), the full salary and benefits of the person who works the most on PEPFAR (in the examples, either 70 percent or 75 percent) should be funded by PEPFAR. This split should be reflected in the staffing data.

c. If the agency is paying for host country citizen fellowships and is going to only train the fellows, then the funding can remain in an implementing mechanism. If the agency will receive a work product from the fellows, then this cost should be counted in M&O. Similarly, if agencies are paying for trainers who are U.S. government staff, then the costs associated with these staff should be reflected within M&O. If the mechanism is paying for the materials and costs of hosting training, then the funding should be reflected in an implementing mechanism.

New for 2016 – there are two categories of Salaries and Benefits:

d. Internationally Recruited Staff
e. Locally Recruited Staff

2. **Staff Program Support Travel:** The discretionary costs of staff travel to support PEPFAR implementation and management does NOT include required relocation and R&R travel (those are included in U.S. government Salaries and Benefits).

This category includes the costs associated with technical staff travel and travel costs associated with the provision of technical assistance. All costs associated with technical staff time should be reflected within M&O; other TA funding (e.g. materials) should be reflecteded in an implementing mechanism.

Teams should include SIMS related travel costs in this category. Refer to your country SIMS action plan and ensure that the following costs are properly captured: driver travel, driver overtime, gas, lodging, and M&IE (GSA rate).

In FY 16, technical assistance-related travel costs of HHS/CDC HQ staff for trips of less than 3 weeks will be included in the PEPFAR Headquarters Operational Plan (HOP) and funded centrally. Under this model, costs for short-duration technical assistance travel by HHS/CDC staff should not be included in COPs.

3. **ICASS (International Cooperative Administrative Support Services):**
   a. ICASS is the system used in Embassies to:
      i. Provide <u>shared common</u> administrative support services; and
      ii. <u>Equitably distribute</u> the cost of services to agencies.
   b. ICASS charges represent the cost to supply common administrative services such as human resources, financial management, general services, and other support, supplies, equipment, and vehicles. It is generally a required cost for all agencies operating in country.
   c. Each year, customer agencies and the service providers present in country update and sign the ICASS service "contract." The service contract reflects the projected workload burden of the customer agency on the service provision for the upcoming fiscal year. The workload assessment is generally done in April of each year. PEPFAR country teams should ensure that every agency's workload includes all approved PEPFAR positions.
      i. ICASS services are comprised of required cost centers and optional cost centers. Each agency must sign up for the required cost centers and has the option to sign up for any of the optional cost centers.
      ii. More information is available at http://www.state.gov/m/a/dir/regs/fah/c23257.htm.
   d. ICASS charges must be planned and funded within the country/regional budget (COP). However, ICASS costs are typically paid by agency headquarters on behalf of the country team from their budgeted funding. Each implementing agency, including State, should request funding for PEPFAR-related ICASS costs within its M&O budget.
      i. It is important to coordinate this budget request with the Embassy Financial Management Officer, who can estimate FY 16 anticipated ICASS costs. This FY 16 ICASS cost estimate, by agency, should then be included as the planned ICASS funding.

ii. It is important to request all funding for State ICASS costs in the original COP submission, as it is difficult to shift funds at a later date.

iii. The Peace Corps subscribes to minimal ICASS services at post. Most GSO and all financial management work (except FSC disbursing) are carried out by Peace Corps field and HQ staff. In order to capture the associated expenses, Peace Corps will capture these costs within the indirect cost rate.

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

In addition to completing the budget data field, teams are expected to explain the costs that compose the Non-ICASS Administrative costs request, including a dollar amount breakout by each cost category (e.g. $1,000 for printing, $1,000 for supplies) in the "Item Description" field.

5. **Non-ICASS Motor Vehicles:** If a vehicle is necessary to the implementation of the PEPFAR program (not for implementing mechanisms) and will be used solely for that purpose, purchase or lease information needs to be justified. For new requests in **FY 16** please explain the purpose of each vehicle(s) and associated cost(s) in the "Item Description" field. It is also a requirement that the total number of vehicles purchased and/or leased under Non-ICASS (Motor Vehicles) costs to date **(cumulative through COP 2016)** are provided in this category. Teams should include new vehicle requests related to the completion of SIMS in this category.

6. **CSCS (Capital Security Cost Sharing):** Non-State Department agencies should include funding for CSCS, except where this is paid by the headquarters agency (e.g. USAID).
   a. The CSCS program requires all agencies with personnel overseas subject to Chief of Mission authority to provide funding in advance for their share of the cost of providing new, safe, secure diplomatic facilities (1) on the basis of the total overseas presence of each agency and (2) as determined annually by the Secretary of State in consultation with such agency.
   b. The State Department uses a portion of the CSCS amount for the Major Rehabilitation Program (MRP).

c. It provides steady funding annually for multiple years to fund 150 secure New Embassy Compounds in the Capital Security Construction Program.

d. More information is available at http://www.state.gov/obo/c30683.htm.

e. Country teams should consult with agency headquarters for the appropriate amount to budget in the COP.

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

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

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

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

9. **U.S. Government Renovation:**

a. Country teams should budget for and include costs associated with renovation of buildings owned/occupied by U.S. government PEPFAR personnel.

b. Costs for projects built on behalf of or by the partner government or other partners should be budgeted for and described as Implementing Mechanisms (see Sections 5.5.11 of the COP Guidance).

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

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

b. All institutional contractors providing M&O support to the country team should be entered in M&O, not as an Implementing Mechanism template.

c. *In addition to the budget information, country teams must provide a narrative to describe institutional contractor activities in the "Item Description" field.*

    d. Costs associated with this category will be attributed to the appropriate technical program area within the FACTS Info PEPFAR Module.

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

    a. Includes costs associated with Peace Corps Volunteers (PCV), Volunteer Extensions, and Peace Corps Response Volunteers (PCRVs) arriving at post between **October 1, 2016** and **September 30, 2017**.

        i. The costs included in this category are direct PCV costs, pre-service training, **Volunteer-focused** in-service training, medical support and safety and security support.

        ii. The costs <u>excluded</u> from this category are: U.S. government staff salaries and benefits, staff travel, and other office costs such as non-ICASS administrative and computer costs, which are entered as separate CODB categories. Also excluded are activities that benefit the community directly, such as Volunteer Activities Support and Training (VAST) grants and **selected** training events where the number of host country nationals is greater than the number of PCVs participating. These types of activities should be entered directly into the appropriate program area budget code in an Implementing Mechanism template.

    b. Funding for PCVs must cover the full 27-month period of service. For example:

        iii. Volunteers arriving in June **2016** will have expenses in **2016, FY 17 and FY 2018**.

        iv. Volunteers arriving in September **2016** will have expenses in FY 16, **FY 17, FY 2018, and FY 2019**.

    c. PCV services are not contracted or outsourced. Costs are incurred before and throughout the Volunteer's 27-month period of service. Costs incurred by Peace Corps Washington and domestic offices, such as recruitment, placement and medical screening of Volunteers, are included in the Headquarters Operational Plan (HOP). Costs such as living allowance, training, and support will continue to be included in the COP.

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

PEPFAR funded should be reflected in the COP and allocated to the above CODB categories. Please contact your CL with any questions about funding stream for this position.

8.5 U.S. Government Office Space and Housing Renovation

Country teams may include support for U.S. government renovation in their CODB submission. All other construction and/or renovation should be included in the Implementing Mechanism section of the COP. The terms are defined as follows:

Construction – refers to projects that build new facilities, or expand the footprint of an already existing facility (i.e. adds on a new structure or expands the outside walls).

Renovation – refers to projects with existing facilities intended to accommodate a change in use, square footage, technical capacity, and or other infrastructure improvements.

All construction and renovation projects should be cleared by the Ambassador in country before submission to headquarters. The notes below outline how U.S. government renovation funds may be used.

PEPFAR Funding May Not Be Used for New Construction of U.S. Government Office Space or Living Quarters

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

PEPFAR Funding May Be Used to Lease U.S. Government-Use Facilities

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

PEPFAR Funding for Renovation of U.S. Government-Owned and Occupied Properties

Country teams may request the use of PEPFAR funds to renovate U.S. government-occupied facilities in exceptional circumstances. The justification for using PEPFAR funds to renovate U.S. government-occupied facilities must demonstrate that the renovation is a "necessary expense" that is essential to carrying out the foreign assistance purposes of the PEPFAR appropriation, and should show that the cost of renovation represents the best use of program funds. The justification should also explain why appropriate alternative sources of funding for renovation are not available. The country team must submit a comprehensive plan that includes an explanation of the unique circumstances around the request to renovate U.S. government-occupied facilities. The plan must have support from the Ambassador that justifies the renovation project. In addition to the "Item Description" narrative, country teams must provide the total costs associated with renovation of buildings owned/occupied by U.S. government PEPFAR personnel under the CODB section. Note, renovation of facilities owned by the U.S. government may require coordination with the State Department's Office of Overseas Buildings Operations (OBO) and other State Department bureaus, and may require the clearance of the State/Office of the Legal Advisor.

8.6 Peace Corps Volunteers

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

- Volunteers on board as of October 1, 2016;
- Volunteer Extensions on board as of October 1, 2016;
- Peace Corps Response Volunteers on board as of October 1, 2016;
- New Volunteers proposed in COP 2016;
- Volunteer Extensions proposed in
- COP 2016; and

- New Peace Corps Response Volunteers proposed in COP 2016.
- Peace Corps Washington will obtain this information from Peace Corps country programs.

9.0 SUPPLEMENTAL DOCUMENT CHECKLIST

9.1 Supplemental Document Checklist

Supplemental Document	Requirement	Standard Template Location	Instructions to complete
Strategic Direction Summary (SDS)	**All OUs**	Pepfar.net, COP 16	Sections 3.0 and 5.2
Data Pack	**All OUs**	Pepfar.net, COP 16	Section 3.0; in workbook
Chief of Mission Letter	**All OUs**	None	Section 5.1
Financial Supplement Worksheet	**All OUs**	Pepfar.net, COP 16	Sections 7.1.3 and 8.4; in workbook
Justification for Partner Funding	**Yes:** Single partner budget *exceeds* 8 percent of PEPFAR budget **No:** No partner exceeds 8 percent of PEPFAR budget	None	Section 7.5
Activity Table for New IMs and All G2Gs	**All OUs**	Pepfar.net, COP 16	Section 5.5.19
Laboratory Construction Supplement	**Yes:** PEPFAR funding proposed for laboratory construction in COP 2016 **No:** PEPFAR *not* funding laboratory construction in COP 2016	None	Appendix 4
Site Improvement through Monitoring System (SIMS) Action Plan (SAP)	**All OUs**	Pepfar.net, COP 16	Section 3.1.8; additional guidance on Pepfar.net, COP 16
Implementation Science and Impact Evaluations	**Yes:** PEPFAR funding proposed for impact evaluation or operations research in COP 2016 **No:** PEPFAR *not* funding impact evaluations or operations research	None	Appendix 8
Civil Society Engagement Documentation	**All OUs**	None	Sections 2.3.3 and 3.3.2
Sustainability Index and Dashboard (SID)	**All COP OUs; strongly recommended for 1-2 countries within ROP OUs**	Pepfar.net, Country Sustainability Index	3.1.1.; additional guidance on Pepfar.net (Sustainability Index page)
Functional and Agency Staff Charts	**All OUs**	None	Section 8.3
Human Rights Agenda Documentation	**All OUs**	Pepfar.net	Section 2.3.5
PEPFAR Budget Allocation Calduator (PBAC)	**All OUs**	Pepfar.net	Section 4.1

| Systems and Budget Optimization Review (SBOR) Template | **All OUs** | Pepfar.net | Section 3.1.4 |
| Evaluation Plan | **All OUs that fund evaluations** | Pepfar.net | Appendix 8; in workbook |

*All supplemental documents should be uploaded into the file library in FACTS Info.

APPENDICES

1. Acronyms and Abbreviations

A – Bureau of Administration (State Department Bureau)

A&A – Acquisition and Assistance

AB – abstinence and be faithful

ABC – abstain, be faithful, and, as appropriate, correct, and consistent use of condoms
 – African Affairs (State Department Bureau)

AFG – AIDS-free Generation

AIDS – Acquired Immune Deficiency Syndrome

ANC – antenatal clinic

APR – Annual Program Results

APS – Annual Program Statement

ART – antiretroviral therapy

ARV – antiretroviral

CBO – community-based organization

CCM – country coordinating mechanism

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

CN – Congressional Notification

CODB – Costs of Doing the U.S. government's PEPFAR Business

COP – Country Operational Plan

CoR – Continuum of Response

CP – Combination Prevention

CQI – Continuous Quality Improvement

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

CL – Country Lead (formerly CSTL)

CSW/SW – Commercial Sex Worker

DFID – Department for International Development (UK)

DOD – U.S. Department of Defense

DOL – U.S. Department of Labor

DOS – U.S. Department of State

EA – Expenditure Analysis

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

EID – early-infant diagnosis

EUM – End use monitoring

EUR – European and Eurasian Affairs (State Department Bureau)

F - The Office of U.S. Foreign Assistance Resources

FBO – faith-based organization

FDA – Food and Drug Administration (part of HHS)

FJD – Framework Job Description

FP – Family Planning

FSN – foreign service national

FSW – female sex workers

FTE – full-time equivalent

FY – fiscal year

GAP – Global AIDS Program (CDC)

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

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

GHCS – Global Health Child Survival funds (funding account)

GHI – Global Health Initiative

HCN – Host Country National

HCW – Health Care Workers

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

HIV – Human Immunodeficiency Virus

HMIS – Health Management Information System

HQ - headquarters

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

HRH – Human Resources for Health

HTS – HIV Testing Services (formerly HIV Testing and Counseling – HTC)

ICASS – International Cooperative Administrative Support Services

ICF – Intensified Case Finding

ICPI – Interagency Cooperative for Program Improvement

INH - Isoniazid

INR – Intelligence and Research (State Department Bureau)

IPT - isoniazid preventive therapy

IRM – information resources management

LE – Locally Employed (Staff)

LCI – Local Capacity Initiative

LOE – Level of effort

LTFU – Lost to follow up

M&E – monitoring and evaluation

MER – Monitoring, Evaluation and Reporting

M&O – Management and Operations

MC – Male Circumcision

MOA – Memorandum of Agreement

MOU – Memorandum of Understanding

NACS - Nutrition Assessment Counseling and Support

NEA – Near Eastern Affairs (State)

NIH – National Institutes of Health (part of HHS)

OE – operating expense

OGA – Office of Global Affairs (part of HHS)

OMB – Office of Management and Budget

OS – Office of the Secretary (part of HHS)

OU – Operating Unit

OVC – orphans and vulnerable children

PASA – Participating Agency Service Agreement

PEPFAR – President's Emergency Plan for AIDS Relief

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

PM – Political-Military Affairs (State Department Bureau)

PMTCT – prevention of mother-to-child HIV transmission

POART - PEPFAR Oversight and Accountability Response

PPP – Public-Private Partnership

PR – Principal Recipient

PRH – Population and Reproductive Health

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

PSC – Personal Services Contract

PSE – Private Sector Engagement

PWID – People who inject drugs

QA – quality assurance

RCNF – Robert Carr civil society Networks Fund

RFA – Request for Application

RFC – Request for Contracts

RFP – Request for Proposal

ROP – Regional Operational Plan

SAPR – Semi-Annual Program Results

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

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

SCMS –Supply Chain Management System

SDS – Strategic Direction Summary

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

SI – Strategic Information

SSDA—System Support Decision Algorithm
SIMS – Site Improvement through Monitoring System

TAN – Technical Area Narrative

TA/TC – Technical Assistance/Technical Collaboration

TB –Tuberculosis

TBD – To Be Determined

TCN – Third Country National

TTFs – Tools, Templates and Frameworks

TWG – Technical Working Group

UNAIDS – Joint United Nations Program on HIV/AIDS

UNDP – United Nations Development Program

UNICEF – United Nations Children's Fund

USAID – U.S. Agency for International Development

USDA – U.S. Department of Agriculture

USDH – U.S. direct hire

USPSC – U.S. personal services contractor

UTAP – University Technical Assistance Project

VCT – voluntary counseling and testing

VL – viral load

WHA - Western Hemisphere Affairs (State Department Bureau)

WHO – World Health Organization

2. Cross-cutting attributions

Definitions

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

Human Resources for Health (HRH)

This attribution includes the following:

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

Construction or Renovation (two separate attributions)

These attributions are meant to capture construction and renovation costs. Construction refers to projects to build new facilities, such as a health clinic, laboratory, or hospital annex or to expand an already existing facility (i.e. adds on a new structure or expands the outside walls). Renovation refers to projects with existing facilities intended to accommodate a change in use, technical capacity, or other infrastructure improvements. PEPFAR-funded construction projects should serve foreign assistance purposes, will involve facilities that are provided to the partner government (or potentially to another implementing partner) as a form of foreign assistance, and are considered necessary to the delivery of HIV/AIDS-related services. Note, any funding attributed to these codes must have a corresponding should be identified in a Construction/Renovation Project Plan completed directly in FACTS Info. For more information about project plans and details concerning the "bundling" of renovation requests, please consult Appendix 4 of the COP Guidance.

For U.S. government-occupied rented or owned properties, the cost of renovating should be captured in the Agency Cost of Doing Business (CODB). None of these costs should be captured in budget attributions within Implementing Mechanisms.

Motor Vehicles: Purchased or Leased (two separate attributions)

Countries need to provide the total amount of funding by Implementing Mechanism, which can be attributed to the purchase and/or lease of motor vehicle (s) under an implementing mechanism. The term Motor Vehicle refers to motorcycles, cars, trucks, vans, ambulances, mopeds, buses, boats, etc. that are used to support a PEPFAR Implementing Mechanism overseas.

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

This budget attribution is meant to capture activities that focus on gay men, other men who have sex with men including male sex workers, and those who do not conform to male gender norms and may identify as a third gender or transgender (TG). Broader definitions can be found in Section 3.1.1. These activities may include 1) implementation of core HIV prevention interventions for MSM/TG that are consistent with the current PEPFAR technical guidance; 2) training of health workers and community outreach workers; 3) collection and use of strategic information; 4) conducting Epidemiologic, social science, and operational research among MSM/TG and their sex partners; 5) monitoring and evaluation of MSM/TG programs; and 6) procurement of condoms, lubricants, and other commodities essential to core HIV services for MSM/TG.

Activities marked as Key Population: MSM/TG will now be required to provide additional information on activities. Teams should select all that apply and must select at least one tick-box if there is funding in this crosscutting attribution.

Please include the amount of the budget allocated to MSM and TG activities and check all of the following boxes that apply:

- ☐ Implementation of core HIV prevention interventions for MSM/TG that are consistent with the current PEPFAR technical guidance
- ☐ Training of health workers and community outreach workers
- ☐ Collection and use of strategic information
- ☐ Conducting Epidemiologic, social science, and operational research among MSM/TG and their sex partners
- ☐ Monitoring and evaluation of MSM/TG programs
- ☐ Procurement of condoms, lubricants, and other commodities essential to core HIV services for MSM/TG

Key Populations: Sex Workers (SW)

This budget attribution is meant to capture activities that focus on sex workers. Relevant activities include: 1) implementation of core HIV prevention interventions for SWs consistent with PEPFAR guidance on sexual prevention; 2) training of health workers and community outreach workers; 3) collection and use of SI on SWs and clients; 4) conducting Epidemiologic, social science, and operational research among SWs, their partners, and clients; 5) monitoring and evaluation of SW programs; and 6) procurement of condoms, lubricants, and other commodities essential to core HIV services for SWs.

Activities marked as Key Population: SW will now be required to provide additional information on activities. Teams should select all that apply and must select at least one tick-box if there is funding in this crosscutting attribution.

Please include the amount of the budget allocated to SW activities and check all of the following boxes that apply:

- ☐ Implementation of core HIV prevention interventions for SWs consistent with PEPFAR guidance on sexual prevention
- ☐ Training of health workers and community outreach workers
- ☐ Collection and use of SI on SWs and clients
- ☐ Conducting Epidemiologic, social science, and operational research among SWs, their partners, and clients
- ☐ Monitoring and evaluation of SW programs
- ☐ Procurement of condoms, lubricants, and other commodities essential to core HIV services for SWs

Key populations: People Who Inject Drugs (PWID)

Investments in programs for this key population are captured in the IDUP budget code.

Food and Nutrition: Policy, Tools, and Service Delivery

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

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

distribution of therapeutic and fortified foods for use in food and nutrition activities.

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

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

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

Food and Nutrition: Commodities

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

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

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

- Replacement Feeding and Support – The cost of antenatal, peri- and postpartum counseling and support to HIV-positive mothers concerning infant feeding options and vertical transmission; on-going nutritional and clinical assessment of exposed infants; replacement feeding support, including limited provision of infant formula where warranted; and associated counseling and program support through at least the first year of life, per national policies and guidelines.

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

Economic Strengthening

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

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

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

- Microenterprise - A very small-scale, informally organized business activity undertaken by poor people. Generally refers to enterprises with 10 or fewer workers, including the micro-entrepreneur 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 micro-entrepreneurs and poor households. Microcredit can take the form of individual or

group loans, and have varying terms, interest rates and degrees of formality. Microcredit is a *type* of microfinance.

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

Education

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

Condoms: Policy, Tools, and Service Delivery

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

- Development and/or Adaptation of National Condom Policies and Guidelines – The cost of developing or adapting national guidelines for condom procurement, distribution and promotion. This also includes activities that improve forecasting, procurement and distribution systems.
- Training and Curricula Development – The cost of training for health care workers, HIV prevention program staff, peer educators, and others to enhance their ability to promote and distribute condoms effectively and efficiently. This includes developing appropriate condom-related curricula for inclusion in pre- and post-service training programs and development of appropriate job aids.

- Condom promotion, distribution and provision – The cost of programs that promote, distribute and provide condoms (but not the cost of procuring condoms – this should be captured in the Condoms: Commodities cross-cutting budget attribution). This includes programs nested within existing clinical and community programs, such as programs for HIV-positive individuals or PMTCT programs, as well as costs for programs that focus exclusively on condom promotion. Condom social marketing programs should be attributed to this cross-cutting attribution.

- Equipment – The cost of procurement of any tools or equipment necessary to carry out condom programs, such as distribution boxes or dispensing machines, display stands, etc. This also includes more general procurement, logistics and inventory control costs.

Condoms: Commodities

This secondary cross-cutting budget attribution is meant to capture the cost condoms **procured using bilateral funds** including:

- Condoms for free distribution – The cost of condoms procured with bilateral funds for free distribution in clinical, community or other settings.
- Socially marketed condoms – The cost of condoms procured with bilateral funds for socially marketed condoms clinical, community or other settings.

Please note: most PEPFAR OUs order condoms through USAID's Commodity Fund (CF) and do NOT pay for condoms using bilateral funds. Only those few OUs that are not eligible to order condoms through the CF and are therefore purchasing condoms with bilateral funds should be reporting through this secondary cross-cutting budget attribution.

Gender: Preventing and Responding to Gender-based Violence (GBV)

This secondary cross-cutting attribution should capture all activities aimed at preventing and responding to GBV, For PEPFAR, GBV is defined as any form of violence that is directed at an individual based on his or her biological sex, gender identity or expression, or his or her perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political

inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age. It can affect women and girls, men and boys, and other gender identities. Women, girls, including men who have sex with men and transgendered individuals are often at increased risk for GBV. While GBV encompasses a wide range of behaviors, because of the links with HIV, PEPFAR is most likely to address physical and sexual intimate partner violence, including marital rape; sexual assault or rape; female genital cutting/mutilation; sexual violence against children and adolescents; and child marriage.

Examples of activities for "Preventing and Responding to Gender-Based Violence" include: Collection and Use of Gender-related Strategic Information: assess differences in power and gender norms that perpetuate GBV as well as gender and societal norms that may facilitate protective actions against GBV and changes in attitude and behaviors; analysis of existing data on different types of GBV disaggregated by sex, age and geography, and in relation the HIV epidemiology in order to identify priority interventions and focus in the context of PEPFAR programs; analysis of treatment, care and referral services data by sex and age to ensure the unique needs of actual and potential victims are being met; employ rapid assessment, situational analyses and other quantitative and qualitative methods to understand norms and inequalities perpetuating GBV

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

- Capacity building: capacity building for U.S. government staff and implementing partners on how to integrate GBV into HIV prevention, care and treatment programs; capacity building for Ministry of Women's Affairs, Ministry of Health or other in-line Ministries to strengthen

national GBV programs and guidelines; pre and in-service training on the identification, response to and referral for cases of intimate-partner violence, sexual violence and other types of GBV; assist in development and implementation of agency-, government-, or portfolio-wide GBV strategy

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

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

Activities marked as GBV will now be required to provide additional information on specific acuities supported. Upon ticking the GBV crosscutting attribution box a drop-down menu of activities will appear. Teams should select **all** that apply.

- GBV Prevention
  - Collection and Use of Gender-related Strategic Information
  - Implementation
  - Capacity building
  - Monitoring and Evaluation
  - Operation Research

- GBV Care
  - Collection and Use of Gender-related Strategic Information
  - Implementation
  - Capacity building
  - Monitoring and Evaluation
  - Operation Research

Gender: Gender Equality

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

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

- Changing harmful gender norms and promoting positive gender norms
- Promoting gender-related policies and laws that increase legal protection
- Increase gender-equitable access to income and productive resources, including education
- Equity in HIV prevention, care, treatment and support

Examples of these activities include:

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

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

female partners, mothers and other women in the community and incorporate messages around gender norms in pre and post counseling

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

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

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

Activities marked as GBV will now be required to provide additional information as part of a drop-down menu. Teams should select all that apply.

- Changing harmful gender norms and promoting positive gender norms
  - Collection and Use of Gender-related Strategic Information
  - Implementation
  - Capacity building
  - Monitoring and Evaluation
  - Operation Research

- Promoting gender-related policies and laws that increase legal protection
  - Collection and Use of Gender-related Strategic Information
  - Implementation

- o Capacity building
- o Monitoring and Evaluation
- o Operation Research

- Increase gender-equitable access to income and productive resources, including education
  - o Collection and Use of Gender-related Strategic Information
  - o Implementation
  - o Capacity building
  - o Monitoring and Evaluation
  - o Operation Research

- Equity in HIV prevention, care, treatment and support
  - o Collection and Use of Gender-related Strategic Information
  - o Implementation
  - o Capacity building
  - o Monitoring and Evaluation
  - o Operation Research

3. Small Grants Program

Beginning in FY 2005, program funds were made available for all PEPFAR countries and regional programs to support the development of small, local partners. The program is known as the PEPFAR Small Grants Program, and replaced the Ambassador's Self-Help Funds program for those activities addressing HIV/AIDS. These grants provide an opportunity for country teams to address diverse issues specific to each country context. In prior years, grants have supported a wide range of activities, including but not limited to:

- Training for local press to effectively cover HIV/AIDS,
- Building capacity within civil society organizations to combat LGBTQ stigma and discrimination,
- Developing education and cultural programs for HIV prevention and awareness, including for key populations (PLHIV, MSM, PWID and prisoners),
- Providing job skills training for women and girls living with HIV, and
- Developing networks of PLHIV to increase retention in care.

S/GAC will release additional guidance and best practices for use of PEPFAR Small Grants later this year.

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

Proposed Parameters and Application Process

Eligibility Criteria

- Any awardee must be an entirely local group.

- Awardees must reflect an emphasis on community-based groups, faith-based organizations and groups of persons living with HIV/AIDS.
- Small Grants Program funds should be allocated toward stigma and discrimination, democracy and governance (as related to the national HIV response), HIV prevention, care and support or capacity building. They should not be used for direct costs of treatment.
- When PEPFAR funds are allotted to Post for State to issue grant awards, the below clauses must be included in addition to the standard terms and conditions.

CONSCIENCE CLAUSE IMPLEMENTATION: An organization, including a faith-based organization, that is otherwise eligible to receive funds under this agreement for HIV/AIDS prevention, treatment, or care;

- (a) Shall not be required, as a condition of receiving such assistance—
    - (1) To endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or
    - (2) To endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and
- (b) Shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements for refusing to meet any requirement described in paragraph (a) above.

PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING:

- (a) The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons. None of the funds made available under this agreement may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides.

- (b)(1) Except as provided in (b)(2) and (b)(3), by accepting this award or any subaward, a non-governmental organization or public international organization awardee/subawardee agrees that it is opposed to the practices of prostitution and sex trafficking.
- (2) The following organizations are exempt from (b) (1): U.S. organizations; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Health Organization; the International AIDS Vaccine Initiative; and any United Nations agency.
- (3) Contractors and subcontractors are exempt from (b)(1) if the contract or subcontract is for commercial items and services as defined in FAR 2.101, such as pharmaceuticals, medical supplies, logistics support, data management, and freight forwarding.
- (4) Notwithstanding section (b)(3), not exempt from (b)(1) are recipients, sub recipients, contractors, and subcontractors that implement HIV/AIDS programs under this assistance award, any sub award, or procurement contract or subcontract by:
  - (i) providing supplies or services directly to the final populations receiving such supplies or services in host countries;
  - (ii) providing technical assistance and training directly to host country individuals or entities on the provision of supplies or services to the final populations receiving such supplies and services; or
  - (iii) providing the types of services listed in FAR 37.203(b)(1)-(6) that involve giving advice about substantive policies of a recipient, giving advice regarding the activities referenced in (i) and (ii), or making decisions or functioning in a recipient's chain of command (e.g., providing managerial or supervisory services approving financial transactions, personnel actions).

The following definitions apply for purposes of this provision:

- Commercial sex act means any sex act on account of which anything of value is given to or received by any person.
- Prostitution means procuring or providing any commercial sex act and the —practice of prostitution‖ has the same meaning.
- Sex trafficking means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.
- The recipient shall insert this provision, which is a standard provision, in all sub awards, procurement contracts or subcontracts.

- Programs must have definable objectives that contribute to sustainable epidemic control, including addressing stigma and discrimination, HIV/AIDS prevention, care and/or (indirectly) treatment.
- Objectives must be measurable.
- These will normally be one-time grants. Renewals are permitted only where the grants show significant quantifiable contributions toward meeting country targets.
- According to Department of State's Administration /Office of the Procurement Executive's (A/OPE) grant regulations, before any single/individual grant estimated over $25,000 can be signed by grants officers in the field, the grant documents going into the grant file must be reviewed for accuracy and completeness by the authorized program office in Washington, D.C.
  - At least four (4) weeks prior to award, posts planning to issue a grant with PEPFAR funds in the amount of $25,001 or more (for a single grant) must submit grant documents to the respective Country Lead for review via email.
    - Country Leads will review the following documents for PEPFAR program specific accuracy and completeness (also see the S/GAC-PEPFAR Grant Review Checklist):
      - DS-1909
      - Award Specifics
      - SF 424, 424-A, project and budget narratives
      - Reporting Plan
      - Monitoring Plan
      - Competition or Sole Source justification
- S/GAC strongly encourages Posts to minimize the number of grants exceeding $25,000 so that additional work and extended timelines are not required on behalf of both Post and S/GAC country POCs.

Submission and Reporting

Funds for the program should be included in the COP under the appropriate budget category.

- Individual awards are not to exceed $50,000 per organization per year; the approximate number of grants and dollar amount per grant should be included in the narrative. Grants

should normally be in the range of $5,000 - $25,000. In a few cases, some grants may be funded at up to the $50,000 level for stronger applicants. The labor-intensive management requirements of administering each award should be taken into account.

- Once individual awards are made, the country or regional program will notify their SCL/CL of which partners are awarded and at what funding level. This information will be added in the sub-partner field for that activity.

- Successes and results from the Small Grants Program award should be included in the Annual Program Results and Semi-Annual Program Results due to S/GAC. These results should be listed as a line item, like all other COP activities, including a list of partners funded with the appropriate partner designation.

Additional Requirements for Construction/Renovation

- OU teams that have small grant applications for construction/renovation need to submit a ***Small Grants Program - Construction/Renovation Project Plan*** form for each construction/renovation project (under an already approved COP implementing mechanism) for review/approval throughout the year (there is no set time for submission, but is as needed based on the country's small grants award timeline).

- Please send the project plan form applications directly to your S/GAC SCL/CL (copy Latoya Cook from the Management and Budget team at PEPFAR-Construction-Renovation@state.gov) throughout the year during your small grant proposal review periods. Note, all form fields need to be completed.

- The form(s) will be uploaded into the **FACTS Info – PEPFAR Module Document Library** as part of the COP Submission after it is reviewed and approved.

- Once the OU receives confirmation from S/GAC that the small grant applications have been approved, the OU team needs to the upload the approved application forms (for construction/renovation only) into the **FACTS Info – PEPFAR Module Document Library** under the approved COP cycle (e.g., if the 'small grants program' implementing mechanism was approved in the FY 15 COP, then the S/GAC approved small grant applications need to be uploaded in the Facts Info Document Library under the FY 16 COP cycle).

- The ***Small Grants Program - Construction/Renovation Project Plan*** form template is located at pepfar.net within the COP 2016 Planning and Reporting cycle folder.

4. Construction and Renovation of Laboratories

This supplemental document is required for all new BSL-3 and BSL-2 enhanced laboratory construction or renovation projects. To submit, upload the completed template to the FACTS Info FY 16 COP document library as part of the COP submission. Please provide the following as a supplement to your project proposal:

- Receiving institution information:
    - Name of receiving institution
    - Address of receiving institution
    - A point of contact at the institution

- Purpose of proposed lab:
    - Expected containment level (BSL-2 enhanced or BSL-3)
        - If enhanced BSL-2, what specific enhancements are planned?
    - Rationale for why that containment level is required
        - Presentation of an analysis of alternatives, if appropriate, or plans to conduct one
    - List of Select Agents (if any) and toxins (if any) that the lab anticipates handling

- Proposed timeline:
    - Including additional planning, funding, design and construction
    - For transition to host country oversight

    Sustainability:
    - What Ministry/organization/institution will be responsible for the long term sustainability of the lab?
    - Involvement of other domestic/international partners

5. Technical Assistance Available for Global Fund Activities

A limited amount of central resources are available to support technical assistance for Global Fund activities. This support may be accessed through an online application. Applications are vetted and coordinated across USG agencies, other bilateral investments, the Global Fund Secretariat, and multilateral partners to ensure complementarity and non-duplication of support.

Website: http://www.pepfar.gov/partnerships/coop/globalfund/ta/index.htm

6. Pepfar.net Contacts and Help Information

Templates and guidance documents for COP 2016 development can be found on the Pepfar.net COP 16 website here: https://www.pepfar.net/Project-Pages/collab-48/SitePages/Home.aspx

For any questions related to access to or the use of pepfar.net in support of this year's COP process, please contact the pepfar.net help desk at help@pepfarii.net

NOTE: *The pepfar.net site is fully supported by the Microsoft Internet Explorer web browser ONLY. While other popular browsers, such as Google Chrome or Mozilla Firefox, may allow you to view pepfar.net, full site functionality cannot be guaranteed using those browsers.*

Logging in to Pepfar.net (Users *with* existing Pepfar.net accounts):

Please use this link to access https://www.pepfar.net.

Your user name and password are required to enter the site. For most users, your user name is **LastNameFirstInitial**

Users who have an account but have not yet logged into pepfar.net will need to create their own password upon logging in for the first time. To do so, navigate to Pepfar.net and click "Forgot your password." For most users, your user name is **LastNameFirstInitial**. For example: the user name for John Smith is **SmithJ.** You will then need to follow the on-screen prompts to create your new password.

Logging in to Pepfar.net (Users *needing* Pepfar.net accounts):

Field Users:

First time field team users will need to have an account established by a designated representative at their location. Contact your country team's pepfar.net Power User (or PEPFAR Coordinator if the Power User is unknown or not yet established), who will contact the pepfar.net Help Desk by sending an email to help@pepfarii.net, to request an account. After your account has been established, you will receive an email with a temporary password and instructions for resetting your password.

Agency Headquarters Users:

If you are based at headquarters, you will need to send an email to the Help Desk at help@pepfarii.net requesting access to the site. Please note: for HQ personnel, your request must include the name of an individual who can verify your involvement/role within the PEPFAR community, for example, a County Support Team Lead.

For any questions regarding access to or use of the site, email the Help Desk at help@pepfarii.net. Users can also request training on using the new site by emailing the Help Desk. Training materials, as well as a calendar of upcoming live training sessions, are available under the Help section of PEFPAR.net (https://www.pepfarii.net/help/SitePages/Home.aspx).

7. Public Private Partnership within the COP

Beyond the development and launch of a partnership, it is essential to systematically document and provide timely information updates across all PPPs within the OUs portfolio.

- All Public-Private Partnerships (PPP), including country PPPs, ongoing Incentive Fund PPPs, and Global PPPs/Central Initiatives should be planned for and reported in the FACTS Info portion of the COP.
- Accurate financial information is critically important as it allows PSE to calculate the leverage (ratio of PEPFAR resources compared to private sector resources).
- Each data field collected is used for PPP tracking and reporting. PSE does not collect superfluous information.
- PPPs are entered in the Implementing Mechanism section of FACTS Info. All PPPs should be linked to an existing or planned mechanism.

Summary of PPP COP 2016 FACTS Info System Updates:

- Funding tab
  - Within the USD Life of Project Commitment box, there exists a feature that will calculate the leverage ratio (adding country and central funds and dividing by private sector)
  - Within the USD Planned Funding for FY2016 box, there exists the ability for the user to enter planned funding levels by budget code with the option to enter a narrative for no budget code funding justification.
    - If defined by user, the total planned funding levels by budget code will populate the Country Funds field for FY2016.
- Partners tab
  - User can choose from six In-Kind contribution types (Time/Labor, Services, Supplies/Equipment, Intellectual Property, Land/Buildings, and Other) per private sector partner
  - User can define the private sector partner's individual life of project monetary commitment

- Indicator tab added to allow user to enter COP 16 targets for indicators associated with PPP mechanism as well as custom indicators

Please contact the PSE Team if you have any questions with regards to completing the PPP portion of the COP: Dr. Jeffrey Blander: blanderjm@state.gov, Neeta Bhandari: bhandarin@state.gov and Gary Kraiss: kraissgp@state.gov

Public Private Partnership Toolkit:

To help improve process development and knowledge management for PPPs a Community of Practice Toolkit has been developed to identify, create and strengthen PPPs in your country. It is important to remember that an integral component of driving quality of partnerships within PEPFAR is through sharing of best practices.

- Country Teams are encouraged to make use of the Community of Practice on pepfar.net and Toolkit materials (Table 4.5.1), which were developed by S/GAC to assist PPP practitioners with engaging with the private sector, opportunity identification, development, management, and reporting of PPPs. The PPP toolkit, in coordination with targeted TA assistance, can support country teams as they work through the various stages of PPP development process within their portfolios.
- The Toolkit is intended to assist PPP practitioners by engaging with the private sector in identifying opportunities, developing ideas, as well as the management, and reporting of PPPs.
- For all PPPs that involve the State Department, The Office of U.S. Global AIDS Coordinator and Health Diplomacy must be consulted to ensure appropriate State Department approval. Please visit The Secretary's Office of Global Partnerships for more information at http://www.state.gov/s/partnerships/.

Table 4.5.1: PPP Toolkit Index

Opportunity Identification	Idea Development	Management	Reporting
1. ITT PPP Questionnaire Template	6. Country Analysis Standard Operating Procedure (SOP)	11. Country Team PPP TWG Charter Template	16. Interagency PPP Valuation Handout
2. Presenting PEPFAR to the Private Sector Best Practices	7. Interagency PPP Funding Opportunities Guide	12. Example PPP Analysis Templates	17. PSE Monitoring & Evaluation Handout
3. Private Sector Expression of Interest Form	8. PPP Concept Note Example	13. Implementation Timeline Templates	
4. Private Sector Meeting Preparation Guides	9. PPP Ranking Ideas Template	14. PPP Meeting Notes Template	
5. Sample PSE Stakeholder Agendas	10. PPP Technical Assistance SOW Template	15. PPP 101 Overview Presentation	

The following represents suggested key steps for PPP development and fostering meaningful private sector stakeholder engagement:

- Step 1 Situational Gap Analysis: Use POART data to identify key programmatic and technical gaps ripe for partnership aligned with core and near core priorities identified by country teams within scale-up sub-national units (SNU's)

- Step 2 Private Sector Landscape Assessment: Conduct or review existing local and regional private stakeholder landscape analysis/assessment of companies and private providers likely to align with PEPFAR goals and geographic priorities.

- Step 3 Convening, Planning, and Conceptualization: Host convenings involving public, private, multilateral, civil society, and affected populations to advance partnership dialogue and submission of concept notes aligned to meet or extend core programmatic goals for inclusion into the COP for partnership consideration. For example the Accelerating Children's HIV/AIDS Treatment (ACT) initiative is supplementing COP planning in eligible countries through public private partnership to help support doubling the number of children on treatment. Private partners are coordinating funding and support through unified ACTplans aligned with the COP and established PEPFAR monitoring systems such as POART and DATIM respectively.

Convenings are held with multi-sector stakeholders to jointly plan activities and develop engagement 'roadmaps' at the country level as well as to review results on a quarterly basis to formulate shared responsibility for corrective action planning.

- Step 4 Approval: The Office of U.S. Global AIDS Coordinator and Health Diplomacy should be consulted on all such proposed PPPs (including any proposed MOUs) involving the Department of State to ensure appropriate State Department approval.
- Step 5 Implementation and Tracking: Beyond the development and public affairs (PA) announcement launch of a partnership, it is essential to systematically document and provide timely information updates across all PPPs within the OUs portfolio.

8. Implementation Science and Impact Evaluations

<u>Evaluation Planning</u>

In January 2014, the first version of the Evaluation Standards of Practice (ESoP) was released and contained 11 standards of practice to which all PEPFAR evaluations must adhere. In September 2015, ESoP (v2) was released, which included planning and reporting requirements.

PEPFAR defines evaluation as "the systematic collection and analysis of information about the activities, characteristics, outcomes, and impacts of programs and projects."

The four categories of evaluations include: process, outcome, impact, and economic. Process evaluations focus on intervention implementation and fidelity, while outcome evaluations focus on outputs and outcomes to assess program effectiveness. Impact evaluations measure the change in an outcome that is attributable to a specific intervention and requires a counterfactual. Economic evaluations identify, measure, value, and compare costs. Full definitions of these evaluation types can be found in ESoP vs 1 and 2 on pepfar.net.

For the first time, OUs are required to submit information on evaluations as part of their COP submissions. The information that is required includes: 1) an OU evaluation plan/strategy; 2) a national evaluation plan/strategy, if one exists; and 3) an inventory of all planned new evaluations.

- For FY2016, the USG OU evaluation plan may be in the form of a priority list, evaluation calendar, evaluation budget, evaluation questions, and the like. More specific guidance on the content and structure of an evaluation plan can be found in the American Evaluation Association's An Evaluation Roadmap for a More Effective Government, 2010, p.6 (www.eval.org/EPTF/aea10.roadmap.101910.pdf) and from UNAIDS, 2010, A National Evaluation Agenda for HIV. UNAIDS Monitoring and Evaluation Fundamentals, pp. 19-20 (www.unaids.org/sites/default/files/sub_landing/files/9_3-National-Eval-Agenda-MEF.pdf). OUs should also describe the processes undertaken to develop these plans.
- OUs are required to include with the COP submission a national evaluation plan, strategy or agenda. If a national plan does not exist, OU teams should engage with relevant stakeholders

over time to support efforts to develop a plan. OUs should ensure that the USG evaluation plan aligns with that of national partners.

- The evaluation inventory captures information for each of the proposed new evaluations identified in the FY2016 COP submission. The evaluation plan should form the basis for this inventory. The relevant Activity Manager, Project Manager, Agreement Officer Representative, Contracting Officer Representative, or implementing agency designee (AM/PM/AOR/COR/IAD) should identify all newly planned evaluations for projects, programs, interventions, or the like. All of the types of evaluations described above as well as impact evaluations (see section 8.2 below) should be included in the inventory. These evaluations should be in accordance with emergent needs to guide decision-making, to meet agency requirements, or to fulfill elements of the OU evaluation plan. The final inventory of planned evaluations will be confirmed at the conclusion of the COP review and receipt of the approval memo.

A two-part planning tool is provided to facilitate the planning process and is required as part of the COP submission. Part one of the tool facilitates development of the OU evaluation plan. Part two is the evaluation inventory. [OGAC to insert language on where to find this tool.]

Any questions regarding evaluation planning should be directed to SGAC_EWG@state.gov. [OGAC to confirm that this address is functional.]

Implementation Science and Impact Evaluation:
As PEPFAR programs move towards targeted services for HIV impact in resource-constrained environments, the need for evidence on which to base decisions has increased. An implementation science (IS) framework will be used to refine programs to maximize impact. IS seeks to describe and inform how to best deliver public health programs through approaches including, but not restricted to effectiveness studies, cost-effectiveness studies using the methods of impact evaluation. The PEPFAR IS framework is intended to:

- Emphasize impact evaluations (IEs) for PEPFAR core and near core programs
- Ensure the dissemination and use of evidence in decision-making and the adoption of best practices across PEPFAR programs
- Prioritize analyses of costs and cost-effectiveness of programs
- Guide policy and program development

- Inform the global community on best practices

- Align with overall PEPFAR and other USG standards for program evaluation

There is a distinction between the routine monitoring and evaluation of programs using PEPFAR standard metrics such as Monitoring, Evaluation and Reporting (MER), or site improvement through monitoring system (SIMS) data and Impact Evaluations. Impact Evaluations (IEs) permit the *causal attribution* of health outcomes to programs. IEs utilize the gold standard methodology within the IS spectrum and can incorporate the use of various data streams for estimating program impact. For additional information on IEs, please see the Impact Evaluation **FY 16 Technical Considerations**. If you have any questions, please contact Dr. Nareen Abboud with the Office of Research and Science AbboudN@state.gov and Mr. Steven Towers TowersSA@state.gov.

Impact Evaluation Submission and Review Process

PEPFAR IEs should be driven by in-country priorities as they fit within their definitions of core and near core. IEs should only be submitted where the causal attribution of health outcomes to programs is necessary and not yet demonstrated. This year, the review of IE concepts will take place in two phases:

Phase 1: A brief (2 page maximum) IE concept note, submitted to AbboudN@state.gov and TowersSA@state.gov one week prior to the start of your OU's COP Management Meeting in D.C.. The concept note must include:

- **Title and Program:** IE title and program or intervention being evaluated.

- **Key Contacts:** Principal Investigator, and Implementing Agency (primary) points of contact in the field and at headquarters. List any potential partners.

- **Implementing Mechanism** (primary) to be used.

- **Anticipated Timeline**, including timeline for all approvals (e.g. IRB), study launch, data collection, data analysis and final report out.

- **Specific Aims:** What is/are the main evaluation question(s)? What is the hypothesis underlying the expected association between program exposure and the outcomes (primary and secondary) of interest?

- **Portfolio Context:** Describe how the proposed IE fits within the full portfolio of recent and ongoing IEs supported by your OU.

- **Draft Budget:** Include budget and narrative with costs itemized into standard major categories (personnel, ARVs, other commodities, travel, etc.). Report the cost per year and total cost.

Draft IE concepts recommended for further development during the COP Management Meeting will move on to Phase 2.

Phase 2: For recommended IEs, please submit the following as a supplementary document entitled: IE_Country_Brief Title in FACTS Info with the rest of your COP submission.

- ✓ Cover page (0.5 – 1 page):
    - o IE title; Name of program or intervention being evaluated
    - o Implementing agency, partner, and mechanism
    - o Principal investigator, Country team contact, and headquarters contact
    - o Start and end dates of agreement for the IE implementing mechanism (to ensure no breaks in funding)
    - o Specific Aims (0.5 – 1 page): What is/are the main evaluation question(s) to be addressed by the proposed study? What is the hypothesis underlying the expected association between program exposure, and the primary and secondary outcomes of interest?

- ✓ Background/Justification (0.5-1 page): Why is this question significant to your country program? How will this IE add to the evidence base for your existing or newly funded activities? Describe how the IE results will inform current or future program(s). What evaluations or pertinent research has been conducted on programs like this to date, even in other countries? The background should include a description of the program and whether it is on-going or new. Please cite all relevant work.

- ✓ Logic Model. The logic model (sometimes called program theory or program model) describes the goals of the program; its inputs, activities, and immediate and long-term outcomes. It is often displayed as a figure accompanied by a few sentences that describe the model.

- ✓ Evaluation design: (5 pages)
    - o The main features of the evaluation must include:

- Definition of the target population as well as the potential for spillover including whether the evaluation will be conducted at the individual or group level
- The basic analytic framework
  - Measurement plan/data dictionary for exposure and the outcomes, inputs and activities depicted on the logic model as well as the source of data for each one. A rationale is required for *de novo* data collection.
  - Threats to study validity including: potential confounding factors; selection bias, loss-to-follow-up, inadequate exposure, measurement challenges and how they will be addressed.
  - Preliminary sample size
  - Impact heterogeneity. Specifically how might the results differ by characteristics of the beneficiary (age, gender and other demographic factors) or context (urban, rural, type of habitation)?

✓ Required Appendices
  - Budget and budget narrative. Cost per year itemized into standard major categories (personnel, ARVs, other commodities, travel, etc.) Please specify the total duration of the study (1-3 years) and the cost per year. IEs without budgets will not be reviewed.
  - Timeline: Specify the timeline for protocol development, submission, data collection and study end date.
  - Innovation (if applicable): Does the study challenge or seek to shift current programmatic, clinical practice, or evaluation paradigms? Does the study design include novel concepts, approaches or methodologies (including whether programs like this have had robust impact evaluations), instrumentation or intervention(s) to be developed or used? If so, describe them and explain any advantage over existing methodologies, instrumentation or intervention(s).
  - References: Cite relevant work and related other background information.

9. Long-term Strategy (LTS), Targeted Assistance (TA) and Technical Collaboration (TC) PEPFAR Operating Unit Assignments

Long Term Strategy (LTS)	Targeted Assistance (TA)	Technical Collaboration (TC)
Burundi; Cameroon; Cote d'Ivoire; DRC; Ethiopia; Haiti; Kenya; Lesotho; Malawi; Mozambique; Rwanda; Swaziland; Tanzania; Uganda; Zambia; Zimbabwe	Asia Regional (Laos, Thailand); Cambodia; Caribbean Regional (Antigua & Barbados, Bahamas, Barbados, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St Vincent & the Grenadines, Suriname, Trinidad &Tobago); Central America Region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama); Central Asian Republics (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan); Dominican Republic; Ghana; Indonesia; Ukraine; Burma; Papua New Guinea; South Sudan	Asia Regional (China); Brazil; India

Co-Finance Sub-group of LTS Countries Nigeria; South Africa	Co-Finance Sub-group of TA Countries Angola; Botswana; Namibia; Vietnam	