

The President's Emergency Plan for AIDS Relief

FY 2007

Supplemental
**COP GUIDANCE
RESOURCE GUIDE**

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Appendix 1 ACRONYMS LIST

A – Bureau of Administration (State Department Bureau)	CSH – Child Survival & Health (USAID funding account)
A&A – Acquisition and Assistance	DfID – Department for International Development (UK)
AB – abstinence and be faithful	DoD – U.S. Department of Defense
ABC – abstain, be faithful, and, as appropriate, correct and consistent use of condoms	DoL – U.S. Department of Labor
AF – African Affairs (State Department Bureau)	EAP – East Asian and Pacific Affairs (State Department Bureau)
AIDS – Acquired Immune Deficiency Syndrome	EUR – European and Eurasian Affairs (State Department Bureau)
ANC – antenatal clinic	FAQs – frequently asked questions
APR – Annual Program Result	FBO – faith based organization
APS – Annual Program Statement	FDA – Food and Drug Administration (part of HHS)
ART – antiretroviral treatment	FSA – Freedom Support Act (funding account)
ARV – antiretroviral	FSL – Foreign Service Limited
CBO – Community-Based Organization	FSN – Foreign Service National
CBJ – Congressional Budget Justification	FTE – full-time equivalent
CCM – country coordinating mechanism	FY – fiscal year
CDC – Centers for Disease Control and Prevention (part of HHS)	GAP – Global AIDS Program (CDC)
CIST - Country Implementation Support Team	GHAII – Global HIV/AIDS Initiative (funding account)
CN – Congressional Notification	GTZ – Deutsche Gesellschaft für Technische Zusammenarbeit (German)
COP – Country Operational Plan	HCD – human capacity development
COPRS – Country Operational Plan and Reporting System	

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

ICASS – International Cooperative Administrative Support Services

ID – identification

INR – Intelligence and Research (State Department Bureau)

IRM – information resources management

JICA – Japanese International Cooperation Agency

LES – Locally Employed Staff

M&E – monitoring and evaluation

M&S – Management and Staffing

MAARD – Mini Acquisition and Assistance Request Document (USAID term)

MICS – Multiple Indicator Cluster Survey (UNICEF)

MIPRS – Military Interdepartmental Purchase Request (DoD)

MOA – Memorandum of Agreement

MOU – Memorandum of Understanding

N/A – not applicable

NEA – Near Eastern Affairs (State Department Bureau)

NGO – nongovernmental organization

NPI – New Partners Initiative

NIH – National Institutes of Health (part of HHS)

OE – operating expense

OGAC – Office of the U.S. Global AIDS Coordinator

OGHA – Office of Global Health Affairs (part of HHS)

OMB – Office of Management and Budget

OS – Office of the Secretary (part of HHS)

OVCs – orphans and vulnerable children

PASA – Participating Agency Service Agreement

PAWG – Procurement and Assistance Working Group

PEPFAR – President’s Emergency Plan for AIDS Relief (Emergency Plan)

PFSCM – Partnership for Supply Chain Management

PLACE – Priorities for Local AIDS Control Efforts

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

PPP – Public-Private Partnership

PR – Principal Recipient

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

PSC – Personal Services Contract

QA – quality assurance

RSSA – Resource Support Services
Agreement

RFA – Request for Application

RFC – Request for Comments

RFP – Request for Proposal

S/APR – Semi-Annual Program Result

SAM – Service Availability Mapping
(UNAIDS)

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

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

SI – Strategic Information

SOAG – Strategic Objective Agreement
(USAID term)

SPA – Service Provision Assessment

TAACS – Technical Advisors in AIDS and
Child Survival

TAD – Temporary Additional Duty
(DoD/Navy)

TB - Tuberculosis

UNAIDS – Joint United Nations Program on
HIV/AIDS

UNICEF – United Nations Children’s Fund

USAID – U.S. Agency for International
Development

USDA – U.S. Department of Agriculture

USDH – U.S. direct hire

USG – United States Government

UTAP – University Technical Assistance
Project

VCT – voluntary counseling and testing

WHA - Western Hemisphere Affairs (State
Department Bureau)

WHO – World Health Organization

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Appendix 2 GLOSSARY OF TERMS

Central Funding (Central) – Central funding refers to the GHAI funding that is allocated to OGAC and Headquarters Agencies. This funding is used for Track 1 support, SI activities, staffing and other support to the countries.

Contracting Officer - A contracting officer is a person representing the U.S. Government through the exercise of his/her delegated authority to enter into, administer and/or terminate contracts and make related determinations and findings. Contracting Officers usually support an entire agency in country or will support an entire regional portfolio.

Core Team – please see the roles and responsibilities in [Appendix 22](#)

Core Team Leader – please see the roles and responsibilities in [Appendix 22](#)

Direct Hire - U.S. citizens employed under the general schedule (Civil Service) or excepted service (non-career or Foreign Service).

Direct Hire Equivalent - These are hired personnel who have signatory authority for the U.S. government (e.g. TAACS, PSC [except for Peace Corps], RSSA, PASA). These positions can be either "OE funded" or "Program funded."

Emphasis Area – This is the new term that we are using to replace "Activity Categories." Emphasis areas are the specific areas of work that make up an activity.

Field Funding – Field funding refers to the GHAI/GAP funding that is allocated to the countries to determine how it should be allocated.

Fiscal Year – The USG fiscal year is defined as the period from October 1 – September 30. Fiscal year 2007 is the period from October 1, 2006 – September 30, 2007.

Foreign Service National - These are positions filled by non-U.S. citizens and can include persons from the host country or third country nationals. These positions can be classified as either direct hire FSN or PSC FSN. They can be funded either out of OE or Program funds.

Funding Mechanism – A funding mechanism is defined by a discrete dollar amount passed through a prime partner entity and for which the prime partner is held fiscally accountable. A unique funding mechanism has four key characteristics that together make up a unique entry: funding mechanism type, USG Agency, funding source and prime partner. One or more of these key characteristics should be different for each funding mechanism entry.

Key Legislative Issue – A key legislative issue is an area of particular interest in terms of our reporting to Congress. These key legislative issues are gender, twinning, volunteers, stigma and discrimination and wrap-arounds. These issue areas are either outcomes of activities (in the case of gender or stigma and discrimination) or ways of undertaking activities (in the case of twinning or volunteers).

New Partners Initiative – Initiative that will provide \$200 million (over the course of the initiative) for grants to new partners providing HIV/AIDS prevention and care services in an effort to identify potential new Emergency Plan partner organizations, increase their capacity to provide care and prevention services, and to increase the total number of Emergency Plan partners.

Non-Direct Hire - These are hired personnel who do not have signatory authority for the U.S. government (e.g. institutional contractors, fellows). These positions are primarily “Program funded.”

Operating Expense funds - These are funds that can only be used to pay for an agency’s administrative expenses (i.e., rent, staff salaries, etc). Not all agencies pay for U.S. direct hires out of OE funds. Some agencies will list some of their U.S. direct hire staff in this row (i.e., USAID—with the exception of FSLs and the staff positions previously paid for by USAID/Washington listed above), other agencies will list no staff here (i.e., CDC), but will instead list staff under USDH/ FTE, number of program funded column.

Pipeline – The amount of funds in a pipeline is the difference between the amount of funding that has been obligated to a partner and the amount of funding that has been expended by that partner.

Program funded - These are funded positions that are paid for from a specific program appropriation, for example GHAI (Global HIV/AIDS Initiative), GAP (Global AIDS Program) or CSH (Child Survival and Health).

Public-Private Partnership - A public-private partnership (PPP) is a collaborative endeavor that combines resources from the private sector with resources from the public sector to accomplish the goal of treatment, care, and prevention of HIV/AIDS. PPPs enable USG and private sector entities to maximize their efforts, whereby issue identification, design and implementation are discerned jointly. Private sector partners could include a wide range of organizations such as: foundations, U.S. and non-U.S. private businesses, business and trade associations, unions, and philanthropic leaders, including venture capitalists.

SI Advisor – is an active member of the Core Team, and serves as the point person for all issues related to strategic information.

Sustainability – Please see [Appendix 18](#) for a more detailed explanation of sustainability

Track 1 – The original Track 1’s are a group of awards that were made very early on in the Emergency Plan, primarily in January and February of 2004. These awards were made at the Headquarters level and were intended to move programs forward very quickly. There are Track 1.0 awards in the following program areas: AB, Injection Safety, Blood Safety, OVC, and ARV Treatment. The Track 1’s continue to be managed by the Headquarters Agencies. Both Central funding and Field funding can be put toward Track 1.0 awards.

USG Agency – A USG Agency is any United States Government entity that is working in your country or which will receive Emergency Plan funding from your country. There are two

groups of USG Agencies, those that are considered to be core implementing members of the Emergency Plan in countries and those that play a more supportive role in the Emergency Plan. There are six agencies that are considered to be core implementing members: the Department of Defense, the Department of Labor, the Department of State, the Department of Health and Human Services, the Peace Corps, and the United States Agency for International Development. Other agencies that play a significant supportive role include, but are not limited to: the Department of Commerce and the Bureau of the Census.

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Appendix 3 CONTACT INFORMATION FOR QUESTIONS

CONTACT FOR GUIDANCE/CONTENT RELATED QUESTIONS:

For most questions, please contact your Core Team Leader or SI Advisor who will bring your issue to the Core Team for resolution. These individuals have been extensively oriented to the COP Guidance and content in an effort to ensure consistency in answers.

<p>Policy and COP Guidance Questions:</p> <p>Please contact your Core Team Leader who will work with the Core Team for resolution on questions about:</p> <ol style="list-style-type: none"> 1. the Emergency Plan program in your country 2. OGAC Policies 3. the content of what should be included in the COP 4. how things should be included in the COP

Please see [Appendix 24.2](#) for a complete list of core team leaders by country

NOTE: If you would like assistance from one of these working groups, please contact your core team leader to facilitate.

<p>Technical Working Groups</p> <p>Prevention</p> <ul style="list-style-type: none"> General Population and Youth Most at Risk Populations <ul style="list-style-type: none"> Substance Abuse Medical Transmission <p>Care and Treatment</p> <ul style="list-style-type: none"> Adult Treatment Counseling and Testing PMTCT and Pediatric ART Palliative Care TB/HIV <p>Orphans and Vulnerable Children</p> <p>Human Capacity Development</p> <p>Gender</p> <p>Food and Nutrition</p> <p>Commodity Procurement</p> <p>Procurement and Assistance (PAWG)</p> <p>Laboratory</p> <p>Strategic Information</p> <ul style="list-style-type: none"> Indicators and Reporting Monitoring and Evaluation Survey and Surveillance Health Management Information Systems <p>Public Private Partnerships</p> <p>Faith Based Organizations</p>
<p>Task Forces</p>

Medical Circumcision Prevention Integration into Treatment

Target Setting Questions:

- For any questions regarding target setting or the SI section of the COP, please contact your SI advisor.

COPRS Database Questions:

User Access- For questions regarding your user access contact your local database administrator

Connectivity problems, bugs or COPRS technical system problems-

Please contact the Help Desk for questions related to technology, bugs, connection problems, or other items related to the data system.

E-mail: COPRSSupport@s-3.com

Telephone: 1- 301-562-0770

The email address will be checked on a regular basis both on weekdays and on weekends. The warmline will be staffed on a regular basis both on weekdays and on weekends. The exact hours of operation will be sent in a News to the Field announcement in August. The warmline will not begin extended hours of operation until the 1st of September.

If you are still frustrated by slow internet connection, you might consider investing some of your FY2006 funding in upgrading your system. If you would like to find out more about how to improve internet connectivity in your country, contact Lyle Holden (lholden@s-3.com).

Public Private Partnerships

Please contact, Ms. British Robinson, Senior Advisor for Public/Private Partnerships at RobinsonBA1@state.gov or (202) 663-2577.

COPRS ACCESS QUESTIONS

Country	Administrator	Email	Backup/Alternate Administrator	Email
Botswana	Thierry Roels	Tbr6@cdc.gov	Negussie Taffa	nequ1@botusa.org
Cambodia	Jonathan Ross	jross@usaid.gov		
Cote d'Ivoire	Karen Ryder	RyderK@gapcdcci.org	Odette Tossou,	TossouO@gapcdcci.org
Ethiopia	Bob Mayes	Mayesb@ETCDC.com	Bob Emrey	bemrey@usaid.gov
Guyana	Julia Rehwinkel	jrehwinkel@usaid.gov	James Moore	moorej@gapcdcg.org
Haiti	Jean Solon Valles	Vallesjs@gapcdcht.org		
India	Anil Thapa	athapa@usaid.gov	Shrikant Bhonsle	sbhonsle@usaid.gov

Appendix 3: Contact Information for Questions

Kenya	Viviane Chao	vchao@usaid.gov	Washington Omwomo	womwomo@usaid.gov
Malawi	Tyler Sparks	sparkstk@state.gov		
Mozambique	Kimberly Marsh	Marshk@cdcmz.org	Juliet Born	Juborn@usaid.gov
Namibia	Madaline Feinberg	mfeinberg@usaid.gov	Aaron Daviet	davietAP@state.gov
Nigeria	Elisa Ballard	eballard@usaid.gov	Anja Minnick	aminnick@usaid.gov
Russia	Andrei Postovalov	apostovalov@usaid.gov	Oleg Semenikhino	semenikhin@usaid.gov
Rwanda	Regan Whitworth	rwhitworth@usaid.gov		
South Africa	Heidi Ehrlich	ehrichh@sa.cdc.gov	Annie Latour	alatur@usaid.gov
Tanzania	Lucy Nganga	Ngangal@tz.cdc.gov	Seranita Lewis	LewisS@tz.cdc.gov
Uganda	Julia Henn	jhenn@usaid.gov	Suzanne Theroux	theroux@ug.cdc.gov
Vietnam	Bill Slater	wslater@usaid.gov	Linh-Vi Le	levl@vn.cdc.gov
Zambia	Chibwe Lwamba	clwamba@usaid.gov	Marta Levitt-Dayal	mlevittdayal@usaid.gov
Zimbabwe	Daniel Rosen	rosend@zimcdc.co.zw		

Headquarter Agency	Administrator	Email	Backup/ Alternate Administrator	Email
OGAC	Noreen Mucha	muchanm@state.gov	Sarah Gorrell	GorrellSE@state.gov
DOD	Anne Thomas	thomas@nhrc.navy.mil		
Census	Kevin Kinsella	Kevin.g.kinsella@census.gov	Tori Velkoff	victoria.a.velkoff@census.gov
HHS/CDC	Xen Santas	xsantas@cdc.gov	Meade Morgan	wmm1@CDC.GOV
HHS/HRSA	Lois Eldred	ledldred@hrsa.gov	Jin Park	JPark1@hrsa.gov
HHS/OGHA	Hilary Mathews	HMathews@osophs.dhhs.gov		
Peace Corps	Praya Baruch	pbaruch@peacecorps.gov		
USAID	Katie Watson	kwatson@usaid.gov	Megan Gerson	mgeron@usaid.gov

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Appendix 4 TIMELINE FOR FY 2007 COP PROCESS

Activity	Timing
Final COP Guidance Distributed	By June 1 st
Partnership Consultations on COP Activities	April – October
FY 2007 COP Training for Core Team Members – DC	June 1 st
USG Day at Annual Meeting – COP sessions included	June 11 th
FY 2007 COP Training for Core Team Members – Atlanta	July 11 th
Technical Assistance – TWGs	April 1 st – August 12 th
Technical Assistance – Program	July 1 st – September 23 rd
COPRS Data System Live for Data Entry	beginning July 21st
Centrally-Funded Track 1.0 activity information inputted into COPRS by country team	August 31
HQ contacts enter funding data for centrally-funded Track 1.0 activities	September 15
Host Government Review and Approval	September 18 th – September 27 th
COP DUE TO OGAC	September 29th
Data Cleaning and Feedback	October 2 nd – October 13 th
Distribute Documents to Reviewers	October 6 th – October 13 th
Technical Reviews	October 16 th – October 26 th
Technical Reviews due to Programmatic Reviewers	October 27 th
Programmatic Reviews	October 30 th – November 3 rd
ANNUAL PROGRESS RESULTS DUE TO OGAC	November 14th
Prepare for Principals Review	November 6 th – November 17 th
Principals Reviews	November 20 th – November 21 st
Approval of Action Memos	November 24 th – December 15 th
Send Approval Memos to Field	January 3 rd , 2007

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Appendix 5 FULL LIST OF COPRS USER ACCOUNT TYPES

Countries	
Country-Level System Administrator	Has full system administrative rights to add users and modify records for a given country and submit the country's final COP or APR to OGAC for approval.
Country COP Read/Write/Finalize	Has full data modification rights to update or add records (e.g., enter data) to the COP for a given country. Users with this access are also able to finalize and submit the COP. This access will only be allowed during those times of the year when the COP is in the process of being submitted.
Country PR Read/Write/Finalize	Has full data modification rights to update or add records (e.g., enter data) to the Program Results for a given country. Users with this access are also able to finalize and submit the APR and S/APR. This access will only be allowed during those times of the year when the Annual and Semi-Annual Program Results are in the process of being submitted.
Country COP Read/Write	Has full data modification rights to update or add records (e.g., enter data) to the COP for a given country. Users with this access are NOT able to finalize or submit the COP. Country COP Read/Write access will only be allowed during those times of the year when the COP is in the process of being submitted.
Country PR Read/Write	Has full data modification rights to update or add records (e.g., enter data) to the Program Results for a given country. Users with this access are NOT able to finalize or submit the APR or the S/APR. Country PR Read/Write access will only be allowed during those times of the year when the Annual and Semi-Annual Program Results is in the process of being submitted.
Country Read/Write	Has full data modification rights to update or add records (e.g., enter data) to the Program Results or COP for a given country. Users with this access are NOT able to finalize or submit the APR, S/APR, or the COP. Country PR Read/Write access will only be allowed during those times of the year when the COP, Annual, or Semi-Annual Program Results are in the process of being submitted.
Country COP Read	Has data read access for the COP for a given country, but cannot update or add any data. This type of access is allowed year round.
Country PR Read	Has data read access for the Program Results for a given country, but cannot update or add any data. This type of access is allowed year round.
Country Read	Has data read access for the COP and Program Results for a given country, but cannot update or add any data. This type of access is allowed year round.

Headquarters	
USG COP Read	Has data read access to the COP across all or several countries, but cannot update or add any data. This access is primarily for Core Team Members or individuals involved in the COP review process.
USG PR Read	Has data read access to the Program Results across all or several countries, but cannot update or add any data. This access is primarily for Core Team Members or individuals involved in the Program Results

Appendix 5: Full List of COPRS User Account Types

	review process.
USG Read	Has data read access to the Program Results or COPs across all or several countries, but cannot update or add any data. This access is primarily for Core Team Members or individuals involved in the review process.
USG PR Read/Write	Has full data modification rights to update or add records to the Program Results across multiple countries. This individual does NOT have access to finalize the Program Results.
USG COP Read/Write	Has full data modification rights to update or add records to the COP across multiple countries. This individual does NOT have access to finalize the COP.
USG Read/Write	Has full data modification rights to update or add records to the Program Results or COPs across multiple countries. This individual does NOT have access to finalize the Program Results or COPs.
USG PR Read/Write/Finalize	Has full data modification rights to update or add records to the Program Results across multiple countries. This individual also has access to be able to finalize the Program Result. This user role is limited to Core Team Leaders and/or Core Team SI Advisors.
USG COP Read/Write/Finalize/Approve	Has full data modification rights to update or add records to the COP across multiple countries. This individual also has access to be able to finalize and approve activities in the COP. This user role is limited to Core Team Leaders.
USG Organization Administrator	Has access to add or update the organizations/partners across all countries or for a specific country.
USG Read-Access Administrator	Can grant read access (read-only) across all countries. There is one or more individual(s) at each USG Headquarters Agency who acts as the Administrator for that Agency.
USG System Administrator	Has full system administrative rights to add users and modify records across all countries. This role is very limited.
HQ Track 1 Data Entry	Only has the ability to edit funding amounts for Track 1 activities in the COP.

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Appendix 6 PROGRAM AREA/BUDGET CODING CATEGORIES

PREVENTION

1. **PMTCT (MTCT)** – activities aimed at preventing mother-to-child HIV transmission including counseling and testing for pregnant women, ARV prophylaxis for HIV-infected pregnant women and newborns, counseling and support for maternal nutrition and safe infant feeding practices. PMTCT-plus ARV-treatment activities should be described and coded under HTXD (3.3.10) and HTXS (3.3.11).
2. **Abstinence/be faithful (HVAB)** – A Abstinence/be faithful (HVAB) – activities (including training) to promote abstinence, including delay of sexual activity or secondary abstinence, fidelity (including partner reduction), and related social and community norms
3. **Medical transmission/blood safety (HMBL)** – activities supporting a nationally coordinated blood program, which includes policies; infrastructure, equipment and supplies; donor-recruitment activities; blood collection, distribution, testing and transfusion; training; and management to ensure a safe and adequate blood supply.
4. **Medical transmission/injection safety (HMIN)** – policies, training, waste-management systems, advocacy and other activities to promote (medical) injection safety, including distribution/supply chain, cost and appropriate disposal of injection equipment and other related equipment and supplies.
5. **Condoms and Other Prevention activities (HVOP)** – Condoms and Other Prevention activities (HVOP) – other activities aimed at preventing HIV transmission including purchase and promotion of condoms, STI management (if not in palliative care settings/context), messages/programs to reduce injecting drug use, and messages/programs to reduce other risks of persons engaged in high-risk behaviors.

CARE

6. **Palliative Care:** Basic health care and support (HBHC) – Basic health care and support (HBHC) – all clinic-based and home-/community-based activities for HIV-infected adults and children and their families aimed at optimizing quality of life for HIV-infected clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring, related laboratory services and management of opportunistic infections (excluding TB) and other HIV/AIDS-related complications (including pharmaceuticals); and culturally-appropriate end-of-life care. HBHC also includes clinic-based and home-/community-based support; social and material support such as nutrition support, legal aid and housing; and training and support of caregivers. Clinic-based and home-/community-based care and support activities for HIV-positive children within programs for orphans and other vulnerable children affected by HIV/AIDS fall under HKID (3.3.08). ARV treatment should be coded under HTXD (3.3.10) and HTXS (3.3.11).
7. **Palliative Care: TB/HIV (HVTB)** – includes exams, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis in HIV basic health care settings (including pharmaceuticals), as well as screening and referral for HIV testing, and clinical care related to TB clinical settings. If TB programs provide other basic health care and support services such as clinical or psychosocial services, these services would be coded under HBHC. If TB programs expand to provide clients with ART, such services would fall under HTXD (3.3.10) and HTXS (3.3.11). Note: General TB treatment, prevention and related programming must be funded with CSH/Infectious Diseases funds directed for TB, not with HIV/AIDS funds.
8. **Orphans and Vulnerable Children (HKID)** – activities aimed at improving the lives of orphans and other vulnerable children and families affected by HIV/AIDS. The emphasis is on strengthening communities to meet the needs of orphans and other vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents to meet their own needs, creating a supportive social and policy environment, etc. Activities could include training caregivers, increasing access to education, economic support, targeted food and nutrition support, legal aid, etc. Institutional responses would also be included. ARV treatment of children is excluded from this category and should be coded under HTXD (3.3.10) and HTXS (3.3.11). Palliative care, including basic health care and support and TB/HIV prevention, management and treatment, as well as their related laboratory services and pharmaceuticals, when delivered within programs for orphans and other vulnerable children affected by HIV/AIDS, should be coded under this category (HKID). Other health care associated with the continuum of HIV/AIDS illness, including HIV/TB services, when delivered outside a program for orphans and other vulnerable children affected by HIV/AIDS, should be coded under HBHC (3.3.06) or HVTB (3.3.07).
9. **Counseling and testing (HVCT)** – includes activities in which both HIV counseling and testing are provided for those who seek to know their HIV status (as in traditional VCT) or as indicated in other

contexts (e.g., STI clinics). Counseling and testing in the context of preventing mother-to-child transmission is coded under MTCT (3.3.01).

TREATMENT

10. **HIV/AIDS treatment/ARV drugs (HTXD)** – including distribution/supply chain/logistics, pharmaceutical management and cost of ARV drugs.
11. **HIV/AIDS treatment/ARV services (HTXS)** – including infrastructure, training clinicians and other providers, exams, clinical monitoring, related laboratory services and community-adherence activities. Clinical monitoring and management of opportunistic infections is classified under palliative care (HBHC-3.3.06 or HVTB-3.3.07).
12. **Laboratory infrastructure (HLAB)** – development and strengthening of laboratory facilities to support HIV/AIDS-related activities including purchase of equipment and commodities, provision of quality assurance, staff training and other technical assistance. Specific laboratory services supporting testing (e.g., under HVCT-3.3.09, MTCT-3.3.01 or HMBL-3.3.02), palliative care (HBHC-3.3.06 and HVTB-3.3.07) and treatment (HTXS-3.3.11) should be included under the codes for those activities.

OTHER

13. **Strategic information (HVS1)** – development of improved tools and models for collecting, analyzing and disseminating HIV/AIDS behavioral and biological surveillance and monitoring information; facility surveys; other monitoring and health management information systems; assisting countries to establish and/or strengthen such systems; targeted program evaluations (including operations research); developing and disseminating best practices to improve program efficiency and effectiveness; planning/evaluating national prevention, care and treatment efforts; analysis and quality assurance of demographic and health data related to HIV/AIDS; testing implementation models, e.g., to support the development or implementation of Global Fund proposals. Related training, supplies and equipment are included.
14. **Other/policy analysis and system strengthening (OHPS)** – other HIV/AIDS-related activities to support national prevention, care and treatment efforts. This includes strengthening national and organizational policies and systems to address human resource capacity development, stigma and discrimination, and gender issues; and other cross-cutting activities to combat HIV/AIDS.
15. **Management and staffing (HVMS)** – costs of supporting USG mission staff to manage, support and administer HIV/AIDS programs including related training, salaries, travel, housing and other personnel-related expenses. Implementing agency/grantee staffing costs are coded under the appropriate functional category rather than under HVMS.

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Appendix 7 REQUIRED INDICATORS/TARGETS BY PROGRAM AREA

Prevention of Mother-to-Child Transmission

- Number of service outlets providing the minimum package of PMTCT services according to national and international standards
- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results
- Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting
- Number of health workers trained in the provision of PMTCT services according to national and international standards

Prevention/Abstinence and Being Faithful

- Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful
- Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of the total reached with AB)
- Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful

Prevention/Medical Transmission/Blood safety

- Number of service outlets carrying out blood safety activities
- Number of individuals trained in blood safety

Prevention/Medical Transmission/Injection Safety

- Number of individuals trained in injection safety

Prevention/Other

- Number of targeted condom service outlets
- Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
- Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful

Palliative Care: Basic Health Care & Support

- Number of service outlets providing HIV-related palliative care (excluding TB/HIV)
- Number of individuals provided with HIV-related palliative care (excluding TB/HIV)
- Number of individuals trained to provide HIV palliative care (excluding TB/HIV)

Palliative Care: TB/HIV

- Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting
- Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease
- Number of HIV-infected clients given TB preventive therapy
- Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed)

Orphans and Vulnerable Children

- Number of OVC served by OVC programs
- Number of providers/caretakers trained in caring for OVC

Counseling and Testing

- Number of service outlets providing counseling and testing according to national and international standards
- Number of individuals who received counseling and testing for HIV and received their test results
- Number of individuals trained in counseling and testing according to national and international standards

HIV/AIDS Treatment/ARV Services

- Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)

Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)

Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)

Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)

Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)

Laboratory Infrastructure

Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests

Number of individuals trained in the provision of laboratory-related activities

Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring

Strategic Information

Number of local organizations provided with technical assistance for strategic information activities

Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)

Other/policy analysis and system strengthening

Number of local organization provided with technical assistance for HIV-related policy development

Number of local organization provided with technical assistance for HIV-related institutional capacity building

Number of individuals trained in HIV-related policy development

Number of individuals trained in HIV-related institutional capacity building

Number of individuals trained in HIV-related stigma and discrimination reduction

Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment

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Appendix 8 COUNTRY-SPECIFIC / CUSTOM TARGETS

CONTENT:

In addition to the indicators provided in the COPRS, you may add other, country-specific indicators that will assist you in managing your country program. If you have added such indicators, you will also need to provide targets for them for each Activity by Funding Mechanism.

If you add individual country indicators, these will appear for every Activity by Funding Mechanism entered in that program area. However, these indicators are not on the required list, and the default for these non-required indicator targets will appear as N/A. Therefore you will not need to fill in the target for each activity by funding mechanism, but only those for which you want the indicator to apply. Please do not add upstream (indirect) -support indicators. Finally, please be conservative in adding indicators. Indicators should only be added if a majority of activities in the program area will be contributing to their achievement.

Countries are encouraged, but not required, to set targets and monitor program achievements disaggregated by pediatric age groups: 0-4 years and 5-14 years .

Please be aware that indicators cannot be added to Table 2 country targets or Table 3.3 summary program area targets.

DATA ENTRY:

1. At the bottom of the targets page (see screen shot above under downstream (direct) targets), click the **Add Custom Target** button.
2. Type the title of the target into the **Target Title** box. The character limit is 200 characters.
3. Select whether the target is a count, percentage or ratio. The default is count.
4. Select the years which you would like to have the target available for. You can select only one, or all years.
5. Click the **Save Custom Target** button to return to the targets page.

Table 3.3.09: Program Planning: Activities by Funding Mechanism
Mechanism/Prime Partner: **HIV/AIDS Project/Partnership for a Better World**
Program Area: **Counseling and Testing**
Budget Code: **HVCT**
Program Area Code: **09**

Custom Target ⓘ

Target Title:

Data Type:

Years Available:

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Appendix 9 LIST OF HQ MECHANISMS BY AGENCY

HHS HQ Mechanisms

HHS Operating Division	Mechanism Type	Funding Mechanism Name	Prime Partner Name
Cooperative Agreements			
HHS/HRSA	Central or HQ	International Training and Education Center on HIV/AIDS (I-TECH)	University of Washington
HHS/HRSA	Central or HQ	Nursing Capacity Building	Georgetown University
HHS/HRSA	Central or HQ	Quality Improvement	NY AIDS Institute
HHS/HRSA	Central or HQ	Twinning	American International Health Alliance (AIHA)
HHS/HRSA	Central or HQ	Track 1 ARV	Catholic Relief Service (CRS)
HHS/HRSA	Central or HQ	Track 1 ARV	Harvard University School of Public Health
HHS/CDC	Central or HQ	Track 1 ARV	Elizabeth Glaser Pediatric AIDS Foundation
HHS/CDC	Central or HQ	Track 1 ARV	Columbia University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Baylor University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Columbia University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Harvard University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Howard University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	JHPIEGO
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	Tulane University
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of California San Francisco
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of Medicine and Dentistry New Jersey (FXB)
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of North Carolina
HHS/CDC	HQ	University Technical Assistance Program (UTAP)	University of Maryland
HHS/CDC	HQ	Technical Assistance	National Association of State & Territorial AIDS Directors (NASTAD)
HHS/CDC	HQ	Technical Assistance	Association of Public Health Laboratories (APHL)
HHS/CDC	HQ	Technical Assistance	United Nations Programme on HIV/AIDS (UNAIDS)
HHS/CDC	HQ	Technical Assistance	American Schools of Public Health (ASPH)
HHS/CDC	HQ	Technical Assistance	World Health Organization (WHO)
HHS/CDC	HQ	Technical Assistance	American Society for Clinical Pathology (ASCP)
HHS/CDC	HQ	Technical Assistance	American Society for Microbiology (ASM)
HHS/CDC	HQ	Technical Assistance	Clinical & Lab Standards Institute (CLSI)
Contracts			
HHS/CDC	HQ	Technical Assistance	MACRO
HHS/CDC	HQ	Technical Assistance	Danya International (NPIN)
	HQ	Information Technology Support Contract (CITS)	Must be competed among the following contractors: Northrop-Grumman and Lockheed Martin
HHS/CDC	HQ	Logistical and Travel Support	Professional and Scientific Associates
HHS/CDC	HQ	GAP Program Support and Technical Assistance Contract (GAP 6)	Must be competed among the following contractors: AED, EnCompass, FHI, JHPIEGO, John Snow Inc, & SSSI

USAID HQ Mechanisms

Please Contact Wyman Stone (wstone@usaid.gov) with any questions about USAID HQ mechanisms.

USAID Operating Division	Mechanism Type	Funding Mechanism Name	Funding Mechanism Name	Prime Partner Name
Cooperative Agreements / Grants				
GH/HIDN	HQ	GPH-G-00-02-00006	Training Programs in Epidemiology Public Health (TEPHINET)	AAAs
GH/HIDN	HQ	GHS-A-00-05-00012	The A2Z Micronutrient Project	Academy for Educational Development
GH/HIDN	HQ	HRN-A-00-99-00016	NeTMark Plus	Academy for Educational Development
DCHA/PVC	HQ	HFP-A-00-03-00020-00	Capable Partners Program (CAP)	Academy for Educational Development
GH/OHA	Central or HQ	GPO-A-00-04-00022	Track 1 ABY: Support to HIV/AIDS Prevention Through Abstinence and...	Adventist Development and Relief Agency
GH/HIDN	HQ	FAO-A-00-99-00025	Child Survival Grant - Africare Uganda	Africare
GH/OHA	Central or HQ	GPO-A-00-05-00015	Track 1 OVC: Community Based Orphan Care...	Africare
GH/OHA	Central or HQ	GPO-A-00-04-00005	Track 1 ABY: Scaling-Up Together We Can, Peer Education Program	American Red Cross
GH/OHA	Central or HQ	GPO-A-00-05-00020	Track 1 OVC: Increased Access to Care & Support for OVC	AVSI
GH/HIDN	HQ	GHS-A-00-03-00020	Country Research Activity	Boston University School of Public Health
GH/OHA	HQ	GPH-A-00-03-00001	CORE Initiative	CARE
GH/OHA	Central or HQ	GPO-A-00-04-00006	Hope for African Children Initiative - HACI (NON-TRACK 1)	CARE
GH/OHA	Central or HQ	GPO-A-00-04-00018	Track 1 OVC: Local Links	CARE
GH/PRH	HQ	HRN-A-00-99-00009	CARE RH Trust Fund [Care-MoRR, Endowment]	CARE
GH/OHA	Central or HQ	GPO-A-00-04-00002	Track 1 OVC: Support to OVC Affected by HIV/AIDS	Catholic Relief Services USCCB
GH/OHA	Central or HQ	GPO-A-00-05-00003	Track 1 ABY: Avoiding Risk, Affirming Life	Catholic Relief Services USCCB
GH/OHA	Central or HQ	GPO-A-00-05-00042	Track 1 ABY: Preserving the African Family in the Face of HIV/AIDS	Children's AIDS Fund
GH/OHA	Central or HQ	GPO-A-00-05-00021	Track 1 OVC: Community-based Care of OVC	Christian Aid
GH/OHA	Central or HQ	GPO-A-00-05-00016	Track 1 OVC: Weaving the Safety Net	Christian Children's Fund
GH/OHA	HQ	GPO-A-00-03-00001	MTCT Plus (Columbia University)	Columbia University
GH/PRH	HQ	HRN-A-00-98-00020	Contraceptive and Research Development (CONRAD III)	CONRAD
GH/OHA	HQ	GPH-A-00-02-00011	Call to Action Project	Elizabeth Glaser Pediatric AIDS Foundation
GH/PRH	HQ	GPO-A-00-03-00006	ACQUIRE	EngenderHealth
GH/OHA	Central or HQ	GPO-A-00-05-00028	Track 1 OVC: Community FABRIC	Family Health International
GH/PRH	HQ	GPO-A-00-05-00022	Contraceptive & Reproductive Health Tech. Res. & Utilization	Family Health International

USAID Operating Division	Mechanism Type	Funding Mechanism Name	Funding Mechanism Name	Prime Partner Name
GH/OHA	Central or HQ	GPO-A-00-05-00008	Track 1 ABY: Healthy Choices for Life	Food For The Hungry (FFH)
GH/OHA	Central & HQ	GPO-A-00-05-00010	Track 1 ABY: SIYAFUNDISA (Teaching Our Children)	Fresh Ministries
GH/PRH	HQ	HRN-A-00-97-00011	The AWARENESS Project (Georgetown)	Georgetown University, Institute for R H
GH/HIDN	HQ	GHS-A-00-04-00015	Global Alliance for TB Drug Development	Global Alliance for TB Drug Development
GH/HIDN	HQ	GHP-G-00-02-00010	Health Families, Health Forests I	Global Conservation International
GH/OHA	Central or HQ	GPO-A-00-05-00007	Track 1 ABY: HOPE Worldwide ABY	Hagler Bailly Services
GH/OHA	Central or HQ	GPO-A-00-05-00014	Track 1 OVC: ANCHOR	HOPE Worldwide South Africa & ANCHOR
GH/OHA	HQ	HRN-G-00-98-00010	International HIV/AIDS Alliance	International HIV/AIDS Alliance
GH/OHA	Central or HQ	GPO-A-00-05-00001	Track 1 ABY: Empowering Africa's Youth People Initiative	International Youth Foundation Alliance
GH/OHA	HQ	GPH-A-00-02-00007	Local Voices (Internews Network, Inc.)	Internews Network, Inc.
GH/PRH	HQ	GPO-A-00-04-00026	The Capacity Project (HCD)	IntraHealth, Inc.
GH/HIDN	HQ	GHS-A-00-04-00002	ACCESS	JHPIEGO
GH/PRH	HQ	GPO-A-00-05-00025	ACCESS-FP (Addressing Unmet Need for FP in Maternal...)	JHPIEGO
GH/HIDN	HQ	GHS-A-00-03-00019	Global Research Activity	John Hopkins University
GH/HIDN	HQ	GHS-A-00-04-00004	Immunization BASICS	John Snow, Inc.
GH	HQ	HRN-A-00-01-00001	Health And Child Survival Fellows Program III	Johns Hopkins University
GH/PRH	HQ	GPH-A-00-02-00003	Info and Knowledge for Optimal Health (INFO)	Johns Hopkins University/CCP
GH	HQ	GPH-A-00-02-00008	Health Communications Partnership (HCP)	Johns Hopkins University/CCP
GH/HIDN	HQ	GHS-A-00-05-00019	TB Control Assistance Program (TB CAP)	KNCV
GH/PRH	HQ	GPO-A-00-05-00024	Leadership, Management & Sustainability	Management Science for Health
GH/PRH	HQ	HRN-A-00-00-00002	ADVANCE Africa	Management Sciences for Health
GH/PRH	HQ	HRN-A-00-00-00014	Management & Leadership Development	Management Sciences for Health
GH/HIDN	HQ	HRN-A-00-00-00016	RPM <i>PLUS</i> *	Management Sciences for Health*
GH/OHA	HQ	GPO-G-00-03-00007	Medical Services Corp. International (MSCI)	Medical Service Corporation International
GH/OHA	Central or HQ	GPO-A-00-04-00001	Track 1 OVC: Sustainable Income & Housing for OVC	Opportunity International
GH/OHA	HQ	GPH-A-00-01-00007	Community REACH	PACT, Inc.
GH/OHA	Central or HQ	GPO-A-00-04-00024	Track 1 ABY: Y-CHOICES (Youth & Children With Healthy Options...)	PACT, Inc.
GH/HIDN	HQ	GPH-A-00-01-00005	Health Tech IV (Technologies for Child Health)	PATH
GH/OHA	Central or HQ	GPO-A-00-05-00009	Track 1 ABY: Scouting for Solutions	PATH
GH/PRH	HQ	GPO-A-00-05-00027	Extending Service Delivery (ESD) for RH and FP	Pathfinder International
GH/OHA	Central or HQ	GPO-A-00-05-00017	Track 1 OVC: Breaking Barriers	Plan USA
GH/PRH	HQ	GPO-A-00-04-00019	The Population Council Product Development Agreement	Population Council
GH/PRH	HQ	GPO-A-00-03-00004	Bringing Info to Decisionmakers for Global Effectiveness	Population Reference Bureau

USAID Operating Division	Mechanism Type	Funding Mechanism Name	Funding Mechanism Name	Prime Partner Name
GH/OHA	Central or HQ	GPO-A-00-05-00013	Track 1 OVC: Scaling-up OVC Support	Project Concern International
GH/OHA	Central or HQ	GPO-A-00-05-00019	Track 1 OVC: Sustainable Strengthening of Families of OVC	Project HOPE
GH/HIDN	HQ	HRN-A-00-00-00018	TB Coalition for Tech Assist	Royal Netherlands TB Assn.(KNCV)
GH/OHA	Central or HQ	GPO-A-00-05-00011	Track 1 ABY: Life Choices	Salesian Missions
GH/OHA	Central or HQ	GPO-A-00-05-00018	Track 1 OVC: Sustainable Community Support for OVC	Salvation Army World Service Office
GH/OHA	Central or HQ	GPO-A-00-05-00012	Track 1 ABY: MET Approach for Primary Behavior Change in Youth	Samaritan's Purse
GH/OHA	Central or HQ	GPO-A-00-04-00003	Track 1 OVC: SCALE-UP HOPE	Save the Children
GH/OHA	HQ	HRN-A-00-97-00012	HORIZONS	The Population Council
GH/PRH	HQ	HRN-A-00-98-00012	FRONTIERS	The Population Council
GH/HIDN	HQ	HRN-A-00-00-00017	U.S. Pharmacopoeia Drug Quality & Info. (USPDQI)	U.S. Pharmacopoeia, Convention, Inc. (USP)
GH/OHA	HQ	GHA-G-00-03-00007	UNAIDS II	UNAIDS
GH/HIDN	HQ	AAG-G-00-97-00021	UNICEF Umbrella Grant	UNICEF
GH	HQ	GPO-A-00-03-00003	Measure Evaluation Phase II	University of North Carolina/Chapel Hill
GH	HQ	AAG-P-00-97-00008	Peace Corps IAA	US Peace Corps
GH/PRH	HQ	AAG-G-00-99-00005	WHO Grant (Umbrella)	WHO
GH/OHA	Central or HQ	GPO-A-00-04-00023	Track 1 OVC: Community-based Care of OVC	World Concern
GH/PRH	HQ	GPO-A-00-04-00021	Grant Solicitation & Management (GSM)	World Learning, Inc.
GH	HQ	GPO-A-00-04-00021	Woodrow Wilson Center	World Learning, Inc.
GH/OHA	Central or HQ	GPO-A-00-04-00004	Track 1 ABY: Mobilizing Youth for Life	World Relief
GH/OHA	Central or HQ	GPO-A-00-05-00004	Track 1 ABY: Abstinence & Risk Avoidance Among Youth (ARK)	World Vision
Contracts				
GH	HQ	GPO-I-00-04-00007	Banking on Health (PSP--Abt. Associates, Inc.)	Abt Associates, Inc.
GH	HQ	GPO-I-01-04-00007	Private Sector Partnership One (PSP--Abt.--ComNet)	Abt Associates, Inc.
GH	HQ	GPO-I-05-04-00007	Point of Use Zinc (POU/Zinc Delivery Order)	Abt Associates, Inc.
GH	HQ	GPO-I-02-04-00012	Point of Use Zinc (POU/Zinc Delivery Order)	Academy for Educational Development
GH	HQ	HRN-P-00-97-00016	MEASURE IV (BuCen) (SCILS)	Bureau of the Census
GH	HQ	GPH-C-00-01-00006	CEDPA TAACS IV	CEDPA
GH	HQ	HRN-P-00-97-00014	MEASURE CDC/DRH	Centers for Disease Control and Prevention
GH	HQ	PHN-P-00-00-00001	CASU (Cooperative Administrative Support Units)	Department of Treasury
GH	HQ	GPO-C-00-03-00002	Measure DHS Phase II	Macro International, Inc.
GH	HQ	GPO-M-00-05-00043	Analysis, Information Mgt & Communication (AIM)	Masimax Resources, Inc.
GH	HQ	AAG-P-00-99-00004	NIH IAA	NIH
GH	HQ	HFM-P-00-01-00022	Global Health Care Support (Africa PASA)	OGHA/DHHS

USAID Operating Division	Mechanism Type	Funding Mechanism Name	Funding Mechanism Name	Prime Partner Name
GH	HQ	GHA-I-01-04-00002	BASICS III (New Child Health)	Partnership for Child Health Care, Inc.
GH	HQ	GPO-I-01-05-00032	Supply Chain Management System	Partnership for Supply Chain Management
GH	HQ	GHS-I-01-03-00034	TB Country Support (IQC)	PATH
GH	HQ	GHS-I-02-03-00028	POPPHI	Research Triangle Institute (RTI)
GH	HQ	GPO-C-00-06-00002	The COPRS Project	Social & Scientific Systems, Inc.
GH	HQ	GPO-I-01-05-00040	Policy Dialog & Implementation (PDI) TO1	The Futures Group
GH	HQ	PHN-P-00-03-00001	Support Services Contract (Triumph --GovWorks)	Triumph Technologies, Inc.
GH	HQ	HRN-P-00-98-00002	U.S. Census Bureau (HIV/AIDS PASA)	U.S. Bureau of the Census
GH	HQ	GPH-C-00-02-00004	QAWD (Quality Assurance and Workforce Development)	University Research Corp, Int'l.
GH	HQ	GPO-I-02-04-00007	Private Sector Program (PSP--Abt.--Summa)	Various
GH	HQ	AAG-P-00-01-00001	International Broadcasting Bureau/Voice of America	Voice of America
To Be Determined				
GH	HQ	TBD-GH-06-2006	<i>New</i> CDC-IAA Follow-on Agreement	Centers for Disease Control
GH	HQ	TBD-GH-01-2006	<i>New</i> PRH Office Commodity Management/Support Program	TBD
GH	HQ	TBD-GH-02-2006	<i>New</i> Infant and Young Child Feeding	TBD
GH	HQ	TBD-GH-04-2006	<i>New</i> Health Sector Program Support and Professional Development	TBD
GH	HQ	TBD-GH-07-2006	<i>New</i> GH Tech (TA IQC)	TBD
GH	HQ	TBD-GH-08-2005	<i>New</i> AIDSTAR (Prevention, Care and Treatment Technical Support)	TBD
GH	HQ	TBD-GH-08-2006	<i>New</i> Health Systems 20/20	TBD
GH	HQ	TBD-GH-01-2006	Deliver Follow On*	TBD*

*In the activity narrative, please provide a justification for why you have selected the Deliver follow on or RPM+. Please also explain how you plan to transition from this mechanism to Partnership for Supply Chain Management over the next 12 months.

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Appendix 10 FY 2007 TRACK 1.0 CENTRAL BUDGET GUIDANCE

In FY 2007, central funding for Track 1.0 ART grantees will be essentially straight-lined at FY 2006 central funding levels, not including any field funding transferred to Track 1.0 grantees in FY 2006. This has been done to ensure that Track 1.0 grantee activities are fully integrated into host country and embassy plans.

FY 2007 country budgets must cover:

- The continuing treatment costs of anyone already on treatment using Track 1.0 resources that exceeds those costs that can be covered by central Track 1.0 funding. See the table below for Track 1.0 country allocations for all central programs, including ART.
- The full cost of any expansion of treatment using Track 1.0 grantees.

Note that posts are not required to use Track 1.0 grantees if they are not performing. However, if posts wish to switch a treatment provider under Track 1.0 award to another provider, the post must ensure that all patients formerly treated by the original Track 1.0 grantee continue to receive treatment without a gap in service. Please be sure to include your Core Team Leader and the Track 1.0 program manager for your country in these discussions.

If you have not already done so, please meet with your Track 1.0 ART grantees to begin to determine their funding needs in FY 2007. Note that a key issue for the Track 1.0 grantees is that OGAC has not provided sufficient funding centrally to cover the entire cost of maintaining people on treatment that Track 1.0 grantees put on treatment in FY 2006. The costs that cannot be covered from central funding must come from the COP budget. A second key issue is that the Track 1.0 grantees will likely need funding early in FY 2007 to order drugs for delivery by March 2007 to avoid shortages. We are trying to address this issue centrally by determining Track 1.0 urgent drug procurement needs and notifying for this early in FY 2007. However, now that almost a third of the Track 1.0 grantee budgets come from COP budgets, Track 1.0 grantees may request posts to include funding for procurement as an "early funding request" (see instructions for Table 3.1 – Funding Mechanisms and Source Table, Early Funding Requested). These requests will receive priority attention.

Your Track 1.0 FY 2007 funding levels will be provided to you in early June.

We have identified contacts at agency headquarters to enter the Track 1.0 funding data.

Agency Headquarters Track 1 Data Entry Contacts		
Agency	Name	Email Address
USAID <i>(Backup)</i>	Kelly Manabe Sarah Wilhelmsen	kmanabe@usaid.gov swilhelmsen@usaid.gov
HHS/CDC <i>(Backup)</i>	Alexandra Zuber <i>Angeli Achrekar</i>	alexandra.zuber@cdc.hhs.gov angeli.achrekar@cdc.hhs.gov
HHS/HRSA <i>(Backup)</i>	Regine Douthard <i>Xiomara Brown</i>	regine.douthard@hrsa.hhs.gov xiomara.brown@hrsa.hhs.gov

Overseeing Department/ Agency	Overseeing Bureau/ Office	Mechanism Type	Partner Name	Program
USAID	GH/OHA	Central	Christian Children's Fund	OVC
USAID	GH/OHA	Central	Family Health International	OVC
USAID	GH/OHA	Central	Family Health International	OVC
USAID	GH/OHA	Central	Food for the Hungry	AB
USAID	GH/OHA	Central	Fresh Ministries	AB
USAID	GH/OHA	Central	Hope Worldwide	AB
USAID	GH/OHA	Central	Hope Worldwide	OVC
USAID	GH/OHA	Central	Initiatives, Inc.	Injection Safety
USAID	GH/OHA	Central	International Youth Foundation	AB
USAID	GH/OHA	Central	Opportunity International	OVC
USAID	GH/OHA	Central	PACT, Inc.	AB
USAID	GH/OHA	Central	Plan International	OVC
USAID	GH/OHA	Central	Program for Appropriate Technology (PATH)	AB
USAID	GH/OHA	Central	Project Concern International	OVC
USAID	GH/OHA	Central	Project Hope	OVC
USAID	GH/OHA	Central	Salesian Missions	AB
USAID	GH/OHA	Central	Salvation Army	OVC
USAID	GH/OHA	Central	Samaritan's Purse	AB
USAID	GH/OHA	Central	Save the Children	OVC
USAID	GH/OHA	Central	University Research	Injection Safety
USAID	GH/OHA	Central	World Concern	OVC
USAID	GH/OHA	Central	World Relief	AB
USAID	GH/OHA	Central	World Vision	AB

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Appendix 11 EMPHASIS AREAS

Emphasis areas for Program Areas 3.3.1 thru 3.3.12 and 3.3.14

- **Commodity Procurement**
This category is limited to the actual purchase of pharmaceuticals, diagnostics, medical equipment, medical commodities and supplies needed to provide care and treatment of persons with HIV/AIDS and related infections. This includes the actual ordering, purchase, shipment and delivery of the full range of HIV/AIDS related pharmaceuticals, diagnostics and other medical commodities.
- **Community Mobilization/Participation**
Activities that create community commitment and involvement in achieving Emergency Plan goals. This includes, but is not limited to: involvement of community groups (for example religious leadership or PLWHAs) in program planning and mobilization of community resources, peer education, education of local media and support groups.
- **Development of Network/Linkages/Referral Systems**
Activities that support the development and implementation of linkages and coordination between health service delivery institutions, program areas, and geographical areas, both vertically and horizontally, to increase efficiency and eliminate duplication. This includes geographical expansion and strengthening of coverage of organizations that own, operate and manage health service delivery networks.
- **Health Care Financing**
Activities designed to broaden access to HIV/AIDS related services through mechanisms that ensure stable and effective short and long term health care financing. Examples include: medical aid (health insurance) schemes, community-based health care financing, national health accounts and franchising schemes to provide free or discounted TB, OI and ARV drugs.
- **Human Resources**
Activities that help meet immediate and short-term workforce requirements through innovative approaches to recruitment, retention, deployment and rewarding of quality performance of health care workers and managers. In addition, long-term human resource requirements should be addressed through workforce assessments and policy and planning activities. Included in this category is the direct payment of salaries for health care workers, excluding government health care workers, for whom the USG cannot directly pay salaries.
- **Information, Education and Communication**
Activities involving the development, dissemination, and evaluation of linguistically, culturally, and age appropriate materials supporting Emergency Plan Goals. This could include, but is not limited to, curricula and training manuals, job aids, brochures, pamphlets, handbooks, posters, newspaper or magazine articles, comic books, TV or radio shows or spots, songs, dramas, puppet shows or interactive theatre.
- **Infrastructure**
Activities that involve construction, renovation, leasing, procurement (equipment, supplies, furniture, vehicles), overhead and/or installation needed for the implementation of Emergency Plan Programs.
- **Linkages with Other Sectors and Initiatives**
This category includes HIV activities that are programmed through/linked with other sectors and Presidential Initiatives, for example in education, food, microfinance, democracy and governance etc. This could include, for example school fees and uniforms for HIV OVCS, microcredit programs for PLWHAs, nutritional supplements for PLWHAs and activities that support the rights of PLWHAs. Ideally activities in this category will reflect co-funding from resources from other sectors, for example USDA food monetization programs, the Africa Education Initiative and other health programs such as family planning, child survival, safe motherhood, malaria and TB.
- **Local Organization Capacity Development**
Strengthening the ability of key local institutions to implement HIV/AIDS programs efficiently with diminishing reliance, over time, on external technical assistance. This includes activities to improve the financial management, human resource management, MIS, quality assurance, strategic planning, and leadership and coordination of partner organizations.
- **Logistics**
Activities that involve the support systems for pharmaceuticals, diagnostics, medical equipment, medical commodities and supplies needed to provide care and treatment of persons with HIV/AIDS and related infections. This includes the design, development and implementation of improved systems for forecasting,

procurement, storage, distribution, and performance monitoring of HIV/AIDS pharmaceuticals, commodities and supplies.

- **Needs Assessment**
Activities designed to identify baseline information and provide recommended actions for program implementation and/or progress.
- **Policy and Guidelines**
Activities that involve the development, dissemination and implementation of policies, guidelines and protocols for treatment, care, prevention and strategic information. This may range from high level policies such as those relating to stigma, gender and other issues as they affect care and prevention, through specialized areas such as, scientific protocols, counseling or nutritional guidelines, administrative procedures, etc.
- **Quality Assurance, Quality Improvement and Supportive Supervision**
Activities that assure the development, implementation and/or maintenance of proper standards for the delivery of services under the Emergency Plan, including: use of best practices and evidence-based approaches. In addition, this should include continuous quality improvement strategies to improve the processes that link to desired health outcomes and sound business practices; supportive supervision (monitoring, guidance, oversight and mentoring through site visits, technical assistance and performance evaluation); and periodic review by regulatory bodies and funding entities.
- **Strategic Information (M&E, IT, Reporting)**
Activities designed to ascertain direction and ultimate achievement of Emergency Plan goals, including: measurement of program progress; provision of feedback for accountability and quality; surveillance; and, implementation/upgrade of information management systems.
- **Targeted Evaluation**
Targeted evaluations will provide evidence-based information, beyond that derived from routine program monitoring and evaluation or disease surveillance, to provide rigorous assessment usually including pre- and post-test results of a study group or population with a comparison group or control in order to rule out the occurrence of reported change by chance. These studies are designed to answer specific questions about the overall efficacy and best practices of different models of prevention, care and/or treatment service delivery approaches for those infected or affected by HIV/AIDS and served by funded PEPFAR programs. The goal is to document the efficiency and effectiveness of scale-up programs in areas that have not been well studied in order to improve the quality and sustainability of HIV/AIDS services, as well as their availability, accessibility, and acceptability.
- **Training**
Activities that impart skills, knowledge, and attitudes to individuals, groups or organizations [HCWs, PLWHAs, women's groups, laboratory personnel, community leaders, political leaders], to enhance their ability to provide quality HIV/AIDS services that are responsive to clients' needs. This includes in-service training and continuing education delivered through a variety of modalities such as workshops, distance learning, on-the-job training, mentoring, etc. Support for building specific skill areas should also be included here, for example, strengthening interpersonal communication, improving laboratory skills, nutritional education for PLWHAs and their families, etc. Activities to strengthen or expand pre-service education, such as curriculum development or faculty training, are also included in this category.
- **Workplace Programs**
Activities, which promote private business, public employers, unions, and professional associations (teachers, farmers, fishermen, coffee growers etc.) to provide HIV/AIDS care, treatment and prevention for their members, employees and family members.

Additional Emphasis Areas for Program Areas 3.3.6, 3.3.7, 3.3.8 and 3.3.11

- **Food/Nutrition Support**
Activities that involve the planning and implementation of nutrition support for PLWHAs, PMTCT clients and OVCs. This includes development of policies, guidelines, and training and counseling materials; training, supervision and M&E associated with nutrition assessment, counseling and education; targeted therapeutic and supplementary feeding of malnourished ART and other AIDS patients, PMTCT clients and OVCs; targeted micronutrient supplementation; safe water; and linkages with programs addressing food security and livelihood assistance to improve food access for PLWHAs and OVCs.

Emphasis Areas for Program Area 3.3.13: Strategic Information

- **AIS, DHS, BSS or other population survey**

Funds used to support any population-based survey that collects behavioral data, HIV service data, and HIV prevalence/incidence data.

- **Facility survey**
Funds used to support any facility-targeted data collection using survey methods. Examples include Service Availability Mapping (SAM), Service Provision Assessment (SPA), and Facility Audit for Service Quality.
- **Health Management Information Systems (HMIS)**
Funds used to establish or support the system necessary to collect, report, analyze, and use routine patient or facility data. This can include but is not limited to consultation/technical assistance, policy development, system assessment, requirements gathering, consensus workshops, form design and distribution, data reporting and flow, software design, training clinic and district staff, hiring data clerks, data entry, data analysis and dissemination, data management and quality assurance.
- **HIV Surveillance Systems**
Funds used to establish or maintain the infrastructure necessary to support ongoing HIV surveillance activities. This can include but is not limited to laboratory capacity for serological diagnosis of HIV, ANC sentinel surveys, assessments of AIDS case reporting systems, STI surveillance, TB drug resistance surveillance, ARV drug resistance surveillance, HIV incidence pilots, and data analysis.
- **Information Technology (IT) and Communications Infrastructure**
Funds used to establish or support the infrastructure necessary to support routine data collection and use at every level of the Emergency Plan, or to support routine IT-related operation of USG facilities. This can include but is not limited to hardware, software, local/wide area networks, internet connectivity, software development and maintenance, trainings for hardware or software use, user support desks and documentation, system security.
- **Monitoring, evaluation, or reporting (or program level data collection)**
Funds used to establish or support the system(s) necessary to collect, analyze and use routine program data that is not facility based, for example OVC, community based care, or BCC interventions. This can include but is not limited to assessments, consensus workshops, form design, data flow design, training program staff.
- **Proposed staff for SI**
Funds used to hire USG staff dedicated to Strategic Information.
- **Targeted Evaluation**
Targeted evaluations will provide evidence-based information, beyond that derived from routine program monitoring and evaluation or disease surveillance, to provide rigorous assessment usually including pre- and post-test results of a study group or population with a comparison group or control in order to rule out the occurrence of reported change by chance. These studies are designed to answer specific questions about the overall efficacy and best practices of different models of prevention, care and/or treatment service delivery approaches for those infected or affected by HIV/AIDS and served by funded PEPFAR programs. The goal is to document the efficiency and effectiveness of scale-up programs in areas that have not been well studied in order to improve the quality and sustainability of HIV/AIDS services, as well as their availability, accessibility, and acceptability.
- **USG database and reporting system**
Funds used to establish or maintain a system that supports planning and reporting for all USG activities. HIV/AIDS programs are encouraged to implement country-specific solutions for their program data collection and management needs.
- **Other SI Activities**

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Appendix 12 KEY LEGISLATIVE ISSUES

Gender

Activities aimed at addressing the norms of women's and men's behaviors and inequalities between men and women that increase the vulnerability to and impact of HIV/AIDS. There are five specific subcategories for gender:

1. Increasing gender equity in HIV/AIDS programs – activities include:
 - collecting data to show breakdown of women and men receiving prevention activities, treatment, and care services
 - developing strategies to ensure that an equitable number of women are receiving treatment
 - developing and supporting strategies to reach an equitable number of women and men, such as community education to support treatment for women, comprehensive workplace policies, and costing schemes that account for economic constraints
 - mitigating the burden of care on women and girls by linking care programs with community efforts that provide resources such as food/school expenses, household help, farm labor and child care;
 - developing/supporting policies to increase access to information, services, and care for women and girls;
 - partnering with women's organizations in the design and implementation of programs and policies.
2. Male norms and behaviors – activities include: supporting counseling, peer education and community interventions with messages that challenge norms about masculinity, the acceptance of early sexual activity and multiple sexual partners for boys and men, and transactional sex.
3. Reducing violence and coercion – activities include:
 - mobilizing communities to address norms/behaviors re to cross-generational and transactional sex;
 - supporting workplace and school-based programs for the prevention of violence;
 - training health care providers and peer educators to identify, counsel and refer victims of sexual abuse and violence;
 - within PMTCT/VCT programming, providing training on couple counseling, risk assessment, and stigma reduction;
 - supporting women to mitigate potential violence or other negative outcomes of disclosure;
 - supporting activities and policies to strengthen sanctions against sexual and physical violence.
4. Increasing women's access to income and productive resources – activities include:
 - linking care and support programs to income generation activities and microfinance programs for women;
 - supporting initiatives to ensure that children and adolescents, especially girls, stay in school and are trained in vocational skills;
 - working with governments to develop policies that increase women's access to economic resources.
5. Increasing women's legal rights – activities include:

- working with governments and NGOs to eliminate gender inequalities in the civil and criminal code;
- working with governments and NGOs to promote and enforce inheritance rights;
- linking HIV programs with community efforts to provide children and families with legal assistance to protect property rights and ensure protection from abuse.

For additional guidance about Gender, please contact Nomi Fuchs-Montgomery at OGAC (Fuchs-MontgomeryNR@state.gov).

Wrap Arounds

Activities aimed at supporting linkages between HIV/AIDS and other sectors. These activities would reflect some co-funding by sources other than HIV/AIDS funding. There are five subcategories for wrap arounds:

1. Food – activities related to increasing food and nutritional resources for HIV affected and infected individuals. Please note that Food / Nutrition has also been added as an emphasis area.
2. Microfinance/Microcredit – activities related to increasing access for HIV affected and infected individuals to income generation.
3. Education – activities related to increasing the educational access of OVCs or other HIV-affected and -infected individuals.
4. Democracy & Government – activities related to increasing HIV-affected and -infected individuals' access to and participation in government.
5. Other – example, refugees, gender, reproductive health, etc.

Stigma and Discrimination

All activities that work to reduce either the stigma associated with HIV status, or that work to reduce the discrimination faced by individuals with HIV or AIDS and their family members.

Twinning

All activities that use Emergency Plan funds to support on-going or new formal partnerships to strengthen capacity of organizations, called twinning partnerships, whether through the Twinning Center; through south-south partnerships; or through individual projects/programs - should be tagged as "twinning."

Twinning partnerships are substantive, long-term, formal partnerships, that if facilitated by the Twinning Center, are accompanied by a signed agreement among the U.S. team, the MOH and the twinning organization, and that contribute to building sustainable capacity building. Twinning is not just collaboration or a contractual relationship between two parties where technical assistance is provided.

If you want a Twinning Partnership your budget allocation should include only travel and logistics for the U.S. twin and if needed for the in-country twin. US twinning organizations work on a voluntary basis and therefore do not require large overhead or salary.

A twinning partnership also makes use of volunteers who will work within the partnership. That is, volunteers from the United States, which will be identified and recruited from various sources and placed by the Twinning Center, will be used by the partnerships for enhancement of service delivery, on-site training, systems development,

and in other ways to enhance the ability of country institutions to provide services. For further information on making twinning arrangements, contact Matthew Newland (mnewland@hrsa.gov).

Volunteers

This relates exclusively to US-based volunteers. In addition to activities for which there is involvement of Peace Corps volunteers, activities that use Emergency Plan funds to support the recruitment and placement of US-based volunteers within twinning partnerships or for other short-term technical assistance programs, should be checked as "volunteer" activities. Activities that use local volunteers (i.e., community-based volunteers) should not be tagged under this label. This distinction is not being made due to any disparagement of local or community-based volunteers. However, the intention of the legislation was to increase the use of US-based volunteers and/or resources in addressing many of the short-term human capacity issues in the focus countries. Therefore, we are required to capture the information on US-based volunteers only.

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Appendix 13 TARGET POPULATIONS

General population

- Infants
- Children and youth (non-OVC)
 - Girls
 - Boys
 - Primary school students
 - Secondary school students
 - University students
- Adults
 - Men (including men of reproductive age)
 - Women (including women of reproductive age)
- Family planning clients
- Pregnant women

People affected by HIV/AIDS

- Orphans and Vulnerable Children
- People living with HIV/AIDS
 - HIV positive pregnant women
- HIV/AIDS-affected families
- HIV positive infants (0-4 years)
- HIV positive children (5-14 years)
- Caregivers (of OVC and PLWHAs)
- Widows/widowers

Special populations

- Disabled populations
- Most at risk populations
 - Commercial sex workers
 - Discordant couples
 - Injecting drug users
 - Men who have sex with men
 - Military personnel
 - Mobile populations
 - Migrants/migrant workers
 - Refugees/ internally displaced persons
 - Truck drivers
 - Out-of-school youth
 - Partners/clients of CSW
 - Prisoners
 - Seafarers/port and dock workers
 - Street youth
 - Transgender individuals

USG staff

- USG in-country staff
- USG headquarters staff

Community

- Business Community/private sector
 - Factory workers
- Brothel owners
- Community leaders
- Religious leaders
- Program managers
- Volunteers

Host country government workers

- Host country government workers
 - Policy makers
 - Teachers
 - National AIDS control program staff
 - Other MOH staff (excluding NACP staff and health care workers described below)

Health care providers

- Public health care workers
 - Doctors
 - Laboratory Workers
 - Nurses
 - Pharmacists
 - Traditional Birth Attendants
 - Traditional healers
 - Other health care workers
- Private Health care workers
 - Doctors
 - Laboratory Workers
 - Nurses
 - Pharmacists
 - Traditional Birth Attendants
 - Traditional healers
 - Other health care workers

Groups/Organizations

- Community-based organizations
- Faith-based organizations
- Non-governmental organizations/private voluntary organizations
- Implementing organizations (not listed above)
- Country coordinating mechanisms
- International counterpart organizations

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Appendix 14 STAFFING MATRIX

General Instructions:

A Staffing Matrix excel workbook is provided to each country team. Please export the excel workbook for your country, review and update existing data, and fill in the data requested below, and then upload the complete workbook into the Supporting Documents section of your FY 2007 COP submission.

Each country workbook contains a sheet for each USG implementing agency pre-filled with the existing positions as of September 30, 2006 as inputted during the FY2006 COP process, a blank sheet for input of Peace Corps staff and volunteers, and a cover sheet that will automatically total the staff from each of the agency worksheets. All yellow cells represent formulas that are locked to ensure that they are not accidentally changed and therefore, do not require any data input.

Please specify the number of positions in the appropriate columns. No person/position is to be counted more than once and one person/position cannot count as more than 100% time. Only include positions that devote more than 50% of their time to the Emergency Plan. The final column in the matrix named "Of Total – Number working 100% on the Emergency Plan" should be used to capture the number of staff dedicated entirely to working on the Emergency Plan. More instructions and definitions are included below.

Please note that this year a Peace Corps Matrix is also included which requires country teams to provide information on existing as well as new positions requested for staff and volunteers working more than 50% of their time on PEPFAR. Two additional columns have been added at the end of the Matrix to capture the number of Peace Corps volunteers working on HIV/AIDS. The rest of the table is to be used for any PC staff that is working more than 50% on the Emergency Plan in the same way as for any other agency. Volunteers should not show up in any of the other columns. Because Peace Corp volunteers are not USG staff the totals for staff and volunteers will not be merged. That said, volunteers are an important part of the Emergency Plan effort and need to be captured through the COP process.

Existing Staff: The matrices available for export from COPRS are pre-filled with existing staff information collected from country teams during the FY2006 COP development process. The existing staff sections for each agency should reflect positions approved through September 30, 2006. Even if the position is still vacant, the position exists, therefore should be included to capture the position not the person. Please review the existing positions to ensure that they accurately reflect the positions that have been approved by the USG agency. Please note that a Peace Corps matrix is included this year which requires country teams to include information on existing as well as new positions requested for staff and volunteers working more than 50% of their time on PEPFAR.

For USAID Only: the following reiterates guidance that was outlined in an email message to the field dated September 19, 2005.

- The 29 field positions, as referenced in the following cable from Ambassador Tobias, UNCLAS STATE 026657: These positions were previously funded by USAID/Washington in FY 2005 and FY 2006; these positions should now be funded entirely within the Mission's FY 2007 COP from FY 2007 onwards. This applies to both US direct and non-direct hire staff. Please note that this does not apply to those positions that provide regional services (RLAs and RCOs); these positions will continue to be funded by USAID/Washington.
- The three former NEPs sent to Focus countries and previously funded by USAID/Washington should be funded entirely in the Mission's FY 2007 COP from FY 2007 onwards.
- The five positions that were funded prior to FY 2006 by program to OE funds should continue to be financed from the COP budget. These staff include: Melissa Jones (Ethiopia), Karen Kasan

(Nigeria), Linda Lou Kelley (Mozambique), Marie McLeod (South Africa), and the vacant position in Tanzania (vice-Rene Berger).

New Staff: Please include any requested new staff positions for FY 2007. These should be new positions that are expected to work more than 50% on PEPFAR. Justification for these positions should be included in the activity narratives in the M&S section.

Estimated Staff: Please include any estimated change in staff positions for FY 2008. This information will be helpful in long-term budget and staffing planning.

Staffing Categories:

Technical Leadership /Management: Include in this row those positions that head up the health/HIV team within the agency; e.g., Health Officer, Chief of Party, and Deputy. This could be the head of the agency (as is usually the case with CDC) or could be someone who oversees all USG health activities and spends only part of the time on the Emergency Plan (for example the head of the PHN Office under USAID). A U.S. DH Foreign Service officer filling an HIV/AIDS advisor position and thereby leading an HIV/AIDS team would also be placed in this category.

Technical Advisors / Non Management and Staff: Include the technical staff within the health/ HIV team who spends most of their time implementing programs in technical areas. These are the positions allocated to specific program areas such as laboratory. These positions are not financed out of the Management and Staffing budget.

Technical Advisors / Program Managers / Public Health Advisors: Include the technical staff within the health/HIV team who spends most of their time managing programs or who work in more than two program areas, e.g. Cognizant Technical Officers (CTOs), or Project Officers (POs). These positions are financed out of the Management and Staffing budget. 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.

Contracting: Include contracting officers as well as other staff who support a contracting officer or office. A contracting officer is a person representing the U.S. Government through the exercise of his/her delegated authority to enter into, administer and/or terminate contracts and make related determinations and findings. Contracting Officers usually support an entire agency in country or will support an entire regional portfolio. If the agency utilizes the contracting officer services of another agency, include the position only in the contractor's home agency.

Financial / Budget: These positions include the "accountant" and "budget person" for the agency. These staff members support financial and budget analysis and financial operations functions.

Administrative / Support: Include any secretarial, administrative, and programmatic support positions within the health/HIV team, and other support positions (e.g., non-health/ non-HIV HIV staff which could include drivers who provide support to the health/HIV team). Like all positions being reported, only include those staff working more than 50% of their time supporting the Emergency Plan.

US Direct Hire (USDH) / Full Time Equivalent (FTE): USDH/ FTE are US citizens employed under the general schedule (Civil Service) and excepted service (non-career, Foreign Service Limited or Foreign Service).

OE Funded: Refers to Operating Expense funds. These are funds that can only be used to pay for an agency's administrative expenses (i.e., rent, staff salaries, etc). Not all agencies pay for U.S. direct hires out of OE funds. Some agencies will list most of their U.S. direct hire staff in this row (i.e., USAID—with the exception of FSLs and the staff positions previously paid for by USAID/Washington listed above),

other agencies will list no staff here (i.e., CDC), but will instead list staff under USDH/ FTE, number of program funded column.

Program Funded: These are funded positions that are paid for from a specific program appropriation, for example GHAI (Global HIV/AIDS Initiative), GAP (Global AIDS Program) or CSH (Child Survival and Health).

Foreign Service National (FSN), Locally Employed Staff (LES), and Locally hired PSC: These positions are typically filled by non-U.S. citizens, hired locally and can include persons from the host country or third country nationals. Third country nationals hired locally should be included in this category. Direct hire FSN, PSC, or LES can be funded either out of OE or Program funds. Please include the total number of staff who are FSN, locally hired PSC, and LES.

USPSC / Contractors: U.S. Personal Services Contractors (USPSC) are filled by U.S. Citizens and can be funded either out of OE or program funds. Non-USPSC contractors do not need to be U.S. citizens. Country teams should include third country nationals in this category if they are hired internationally. Please include the total number of staff who are USPSC or Contractors in this column.

Number of OE Funded Staff: This column should include the total number of OE funded staff from the USDH/FTE, FSN/PSC/LES and USPSC/ Contractors categories.

Number of Program Funded Staff: This column should include the total number of program funded staff from the USDH/FTE, FSN/PSC/LES, and USPSC/Contractors categories.

Total Number of Staff: This column will show the total number of existing approved positions through September 30, 2006 and will show the total number of requested positions for FY 2007. As in the entire matrix, only include positions that devote more than 50% of their time to the Emergency Plan.

Of Total—Percentage Working 100% on the Emergency Plan: Of the Total Number of Staff, please indicate the number of staff who work full-time on the Emergency Plan. Information should be entered as number of staff and not as a percentage.

Total Number of HIV/AIDS Volunteers Funded with PEPFAR Resources: This column should reflect the total number of PC volunteers that devote more than 50% of their time to GHAI specific HIV/AIDS activities and are funded *only* by GHAI.

Total Number of HIV/AIDS Volunteers Funded with Non-PEPFAR Resources: This column should reflect the total number of PC volunteers that devote more than 50% of their time to HIV/AIDS activities and are funded by sources other than GHAI (e.g. Peace Corps' annual appropriation).

Of Total—Percentage Working 100% on the Emergency Plan: Of the Total Number of Volunteers, please indicate the number of volunteers who work full-time on the Emergency Plan. Information should be entered as number of staff and not as a percentage.

2007 COP

Ethiambia Staffing Matrix - USAID

ETHIAMIBIA: EXISTING STAFF (Positions as of September 30, 2006) USAID STAFFING INFORMATION									
Staffing Categories	USDH/ FTE			FNS/ PSC/ LES	USPSC / Contractors	Number of OE Funded Staff	Number of Program Funded Staff	TOTAL NUMBER STAFF	Of Total-- Number Working 100% on EP
	Number of OE Funded	Number of Program Funded	Total Number of USDH/ FTE	Number	Number				
	a	b	a+b	c	d	e	f	e+f	
1. Technical Leadership & Management			0					0	
2. Technical Advisors--Non M&S Staff			0					0	
3. Technical Advisors/ Program Managers			0	1			1	1	100%
4. Contracting Staff			0					0	
5. Financial/ Budget Staff			0					0	
6. Administrative/ Support Staff			0					0	
Sub-Total	0	0	0	1	0	0	1	1	100%
ETHIAMIBIA: NEW STAFF (Positions requested for FY 2007)									
Staffing Categories	USDH/ FTE			FNS/ PSC/ LES	USPSC / Contractors	Number of OE Funded Staff	Number of Program Funded Staff	TOTAL NUMBER STAFF	Of Total-- Number Working 100% on EP
	Number of OE Funded	Number of Program Funded	Total Number of USDH/ FTE	Number	Number				
	a	b	a+b	c	d	e	f	e+f	
1. Technical Leadership & Management			0					0	
2. Technical Advisors--Non M&S Staff			0					0	
3. Technical Advisors/ Program Managers			0					0	
4. Contracting Staff			0					0	
5. Financial/ Budget Staff			0					0	
6. Administrative/ Support Staff			0					0	
Sub-Total	0	0	0	0	0	0	0	0	0
ETHIAMIBIA: NEW STAFF (Positions estimated for FY 2008)									
Staffing Categories	USDH/ FTE			FNS/ PSC/ LES	USPSC / Contractors	Number of OE Funded Staff	Number of Program Funded Staff	TOTAL NUMBER STAFF	Of Total-- Number Working 100% on EP
	Number of OE Funded	Number of Program Funded	Total Number of USDH/ FTE	Number	Number				
	a	b	a+b	c	d	e	f	e+f	
1. Technical Leadership & Management			0					0	
2. Technical Advisors--Non M&S Staff			0					0	
3. Technical Advisors/ Program Managers			0					0	
4. Contracting Staff			0					0	
5. Financial/ Budget Staff			0					0	
6. Administrative/ Support Staff			0					0	
Sub-Total	0	0	0	0	0	0	0	0	0
Total	0	0	0	1	0	0	1	1	100%

Ethiambia Peace Corps Volunteer Matrix

Staffing Categories	Peace Corp Volunteers Working 50% or more on HIV/AIDS / 1 (As of Sept. 30, 2006)		
	Funded with PEPFAR Resources	Funded with Non-PEPFAR Resources	Of Total-- Number Working 100% on EP
Number of Volunteers			0
			0
			0
			0
			0
	0	0	0
NEW PEACE CORPS VOLUNTEERS/1 (Estimated for FY 2007)			
Staffing Categories	Funded with PEPFAR Resources	Funded with Non-PEPFAR Resources	Of Total-- Number Working 100% on EP
Number of Volunteers			0
			0
			0
			0
			0
	0	0	0
NEW PEACE CORPS VOLUNTEERS/1 (Estimated for FY 2008)			
Staffing Categories	Funded with PEPFAR Resources	Funded with Non-PEPFAR Resources	Of Total-- Number Working 100% on EP
Number of Volunteers			0
			0
			0
			0
			0
	0	0	0
	0	0	0

1/ Please note that Peace Corps volunteer totals will not be merged with staffing totals because Peace Corps volunteers are not official USG staff. However, volunteers are an important part of the Emergency Plan and it is helpful to know how many volunteers are working on HIV/AIDS in each country. The Peace Corps Volunteer chart will not be used for reporting purposes without the clearance of PC/Washington.

Appendix 15 LIST OF ITEMS FLAGGED BY THE QUALITY ASSURANCE REPORT

Country Contacts

- √ Do you have contacts for all 5 required USG Agencies – US Embassy, HHS/CDC, USAID, DoD, Peace Corps?

Executive Summary

- √ Has the Executive Summary been uploaded?

Table 1

- √ Has the question been answered?
- √ If yes, has narrative been included?

Table 2

- √ Are targets included for all indicators, both direct (downstream) and indirect (upstream)?

Table 3.1

- √ Is the unallocated funding requested less than 5% of GHAI funding?
- √ Is the total funding requested for each funding source within the allowed ceiling?
- √ Are there any outdated funding sources which have been imported, but not updated?
- √ Are there any inactive partners?
- √ Is any partner receiving more than 8% of the total country budget, excluding Management and Staffing costs.

Table 3.2

- √ Does funding for a specific sub-partner exceed funding requested for the prime partner?
- √ Is there at least one program area box checked for each sub-partner?
- √ Are there any inactive sub-partners?

Table 3.3

- √ Is the M&S funding greater than 7% of the total budget?
- √ Does each of the required indicators have a target?
- √ Was each item that was imported from the FY05 COP updated?
- √ Are narratives submitted for all early funding requests?
- √ Does the cumulative percentage of emphasis areas exceed 100% when adding the lowest number in range
- √

Table 5

- √ Is there an answer to each of the questions included in Table 5?
- √ Is the M&S funding greater than 7% of the total budget?
- √ Does each of the required indicators have a target?
- √ Was each item that was imported from the FY05 COP updated?

Supporting Documents

- √ Have all required supporting documents been uploaded?

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Appendix 16 LIST OF ALL CELL NAMES AND VARIABLES

Country Contacts

Contact Type	First Name
U.S. Embassy Contact	<i>Assorted</i>
HHS/CDC In-Country Contact	
USAID In-Country Contact	Last Name
DOD In-Country Contact	<i>Assorted</i>
Peace Corps In-Country Contact	
HHS/HRSA In-Country Contact	Title
HHS/NIH In-Country Contact	<i>Assorted</i>
HHS/OS In-Country Contact	
DOL In-Country Contact	E-mail
MOH Contact	<i>Assorted</i>
State/PRM In-Country Contact	

Executive Summary

N/A

Table 1

Will you be submitting changes to your country's 5-Year Strategy this year?
Yes
No

Please briefly describe the changes which you will be submitting.

Assorted

Table 2

N/A

Table 3.1

Funding Mechanism Type	(USG Agency cont'd)
Central	State / A
HQ	State / AF
Local	State / EAP
Unallocated	State / EUR
	State / INR
	State / NEA
	State / OM
	State / PRM
	State / SCA
	State / WHA
	USAID
USG Agency	
DoD	
DoL	
HHS/CDC	
HHS/HRSA	
HHS/NIH	
HHS/OS	
HHS/SAMHSA	
Peace Corps	
State	

Funding Source

DoD
 GAC (GHAI account)
 DoL
 GAC (GHAI account)
 HHS/CDC
 GAC (GHAI account)
 Base (GAP account)
 HHS/HRSA
 GAC (GHAI account)
 HHS/NIH
 GAC (GHAI account)
 HHS/OS
 GAC (GHAI account)
 HHS/SAMHSA
 GAC (GHAI account)
 Peace Corps
 GAC (GHAI account)
 State (and all bureaus)
 GAC (GHAI account)
 USAID
 GAC (GHAI account)
 CSH account (*for certain countries only*)
 ESF account (*for certain countries only*)
 FSA account (*for certain countries only*)

Prime Partner Name

Numerous variables
 TBD

Table 3.2

Sub Partner Name <i>Numerous variables</i> TBD	Palliative Care: Basic Health Care & Support Palliative Care: TB/HIV OVC
Sub Partner Program Areas PMTCT Abstinence & Be Faithful Blood Safety Injection Safety Condoms and Other Prevention	Counseling & Testing HIV Treatment: ARV Drugs HIV Treatment: ARV Services Laboratory Infrastructure Strategic Information Other/Policy Analysis & System Strengthening

Table 3.3

USG Agency/Prime Partner/Mechanism/Funding Source <i>Drop down list of Table 3.1 Funding Mechanisms</i>	Planned Funding <i>Assorted</i>
	Activity Narrative <i>Assorted</i>

Indicators/Targets

Varies by program area (see [Appendix 15](#) for list)

Emphasis Areas (tables 3.3.1 – 3.3.12 & 3.3.14)

Community Mobilization/Participation
 Commodity Procurement
 Development of Network/
 Linkages/Referral Systems
 Health Care Financing
 Human Resources
 Information Education, and
 Communication
 Infrastructure
 Linkages with Other Sectors and
 Initiatives
 Local Organization Capacity
 Development
 Logistics
 Needs Assessment
 Policy and Guidelines
 Quality Assurance, Quality
 Improvement, and Supportive
 Supervision
 Strategic Information
 Targeted evaluation
 Training
 Workplace Programs

Emphasis Areas (tables 3.3.6 - 3.3.8 & 3.3.11)

Food/Nutrition Support

Emphasis Areas (table 3.3.13)

AIS, DHS, BSS or other population
 survey
 Facility survey
 Facility based information system or
 HMIS
 HIV Surveillance Systems
 IT
 Monitoring, evaluation, or reporting (or
 program level data collection)
 Proposed staff for SI
 Targeted evaluation
 USG database and reporting system
 Other SI Activities

Key Legislative Issues

Gender

Addressing male norms and
 behaviors
 Increasing gender equity in
 HIV/AIDS programs
 Increasing women's access to
 income and productive
 resources
 Increasing women's legal protection
 Reducing violence and coercion
 Stigma and Discrimination
 Twinning
 Volunteers
 Wrap Arounds
 Food
 Microfinance/Microcredit
 Education
 Democracy & Governance
 Other

Target Populations

General population
 Infants
 Children and youth (non-OVC)
 Girls
 Boys
 Primary school students
 Secondary school students
 University students
 Adults
 Men (including men of
 reproductive age)
 Women (including women of
 reproductive age)
 Family planning clients
 Pregnant women
 People affected by HIV/AIDS
 Orphans and Vulnerable Children
 People living with HIV/AIDS
 HIV positive pregnant women
 HIV/AIDS-affected families
 HIV positive infants (0-4 years)
 HIV positive children (5-14 years)
 Target Populations (People Affected
 by HIV)
 Caregivers (of OVC and PLWHAs)
 Widows/widowers
 Special populations
 Disabled populations
 Most at risk populations
 Commercial sex workers
 Discordant couples
 Injecting drug users
 Men who have sex with men

<ul style="list-style-type: none"> Military Personnel Mobile populations <ul style="list-style-type: none"> Migrants/migrant workers Refugees/ internally displaced persons Truck drivers Out-of-school youth Partners/clients of CSW Prisoners Transgender individuals Seafarers/port and dock workers Street youth USG staff <ul style="list-style-type: none"> USG in-country staff USG headquarters staff Community <ul style="list-style-type: none"> Business Community/private sector <ul style="list-style-type: none"> Factory workers Brothel owners Community leaders Religious leaders Program managers Volunteers Host country government workers <ul style="list-style-type: none"> Host country government workers <ul style="list-style-type: none"> Policy makers Teachers National AIDS control program staff Other MOH staff (excluding NACP staff and health care workers described below) Health care providers <ul style="list-style-type: none"> Public health care workers <ul style="list-style-type: none"> Doctors Laboratory Workers Nurses Pharmacists Traditional Birth Attendants Traditional healers Other health care workers Private Health care workers <ul style="list-style-type: none"> Doctors Laboratory Workers Nurses Pharmacists Traditional Birth Attendants Traditional healers Other health care workers Groups/Organizations <ul style="list-style-type: none"> Community-based organizations Faith-based organizations 	<ul style="list-style-type: none"> Non-governmental organizations/private voluntary organizations Implementing organizations (not listed above) Country coordinating mechanisms International counterpart organizations
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Coverage Area

Varies by country

Table 5

N/A

Appendix 17 BUDGETARY REQUIREMENTS WORKSHEET

ETHIAMIBIA
FY 2007 BUDGETARY REQUIREMENTS WORKSHEET
IN WHOLE USD
24-Sep-06

		GHAI Field Dollars	GAP Field Dollars	Total Field Dollars (GHAI & GAP)	GHAI Central Dollars (Track 1)	Grand Total (Field and Central)	Budgetary Requirements		
							Percent Calculations (automatically calculated)		Required/Recommended
							With Ped. AIDS in Treatment	With Ped. AIDS in OVC	
Prevention	PMTCT	\$10,560,000	\$0	\$10,560,000	\$0	\$10,560,000			
	Abstinence/Be Faithful	\$10,350,000	\$0	\$10,350,000	\$3,864,496	\$14,214,496	65.8%	65.8%	66.0%
	Blood Safety	\$0	\$340,000	\$340,000	\$4,100,000	\$4,440,000			
	Injection Safety	\$0	\$126,850	\$126,850	\$2,115,000	\$2,241,850			
	Other Prevention	\$7,400,000	\$0	\$7,400,000	\$0	\$7,400,000			
	Prevention: Unallocated	\$0	\$0	\$0	\$0	\$0			
	<i>Sexual Prevention Sub-Total</i>	<i>\$17,750,000</i>	<i>\$0</i>	<i>\$17,750,000</i>	<i>\$3,864,496</i>	<i>\$21,614,496</i>	<i>55.6%</i>	<i>55.6%</i>	<i>50.0%</i>
	<i>Sub-total</i>	<i>\$28,310,000</i>	<i>\$466,850</i>	<i>\$28,776,850</i>	<i>\$10,079,496</i>	<i>\$38,856,346</i>			
Care	Palliative Care: Basic health care and support	\$11,244,167	\$0	\$11,244,167	\$0	\$11,244,167			
	Palliative Care: TB/HIV	\$4,695,164	\$0	\$4,695,164	\$0	\$4,695,164			
	OVC*	\$6,645,000	\$0	\$6,645,000	\$3,427,168	\$10,072,168	6.3%	11.5%	10%***
	Counseling and Testing	\$8,238,600	\$0	\$8,238,600	\$0	\$8,238,600			
	Care: Unallocated	\$0	\$0	\$0	\$0	\$0			
	<i>Sub-total</i>	<i>\$30,822,931</i>	<i>\$0</i>	<i>\$30,822,931</i>	<i>\$3,427,168</i>	<i>\$34,250,099</i>			
Treatment	Treatment: ARV Drugs	\$33,610,000	\$0	\$33,610,000	\$0	\$33,610,000			
	<i>Pediatric ART**</i>	<i>\$4,033,200</i>	<i>\$0</i>	<i>\$4,033,200</i>	<i>\$0</i>	<i>\$4,033,200</i>			
	Treatment: ARV Services	\$30,102,963	\$5,000,000	\$35,102,963	\$10,405,680	\$45,508,643			
	<i>Pediatric ART**</i>	<i>\$4,212,356</i>	<i>\$0</i>	<i>\$4,212,356</i>	<i>\$0</i>	<i>\$4,212,356</i>			
	Laboratory Infrastructure	\$5,000,000	\$1,634,253	\$6,634,253	\$0	\$6,634,253			
	Treatment: Unallocated	\$0	\$0	\$0	\$0	\$0			
	<i>Sub-total</i>	<i>\$68,712,963</i>	<i>\$6,634,253</i>	<i>\$75,347,216</i>	<i>\$10,405,680</i>	<i>\$85,752,896</i>	<i>54.0%</i>	<i>48.8%</i>	<i>55.0%</i>
Total, Prevention, Care, and Treatment		\$127,845,894	\$7,101,103	\$134,946,997	\$23,912,344	\$158,859,341			
Other	Strategic Information	\$6,000,000	\$1,348,173	\$7,348,173	\$0	\$7,348,173	4.2%	4.2%	7.0%
	Other/policy analysis and system strengthening	\$1,735,000	\$0	\$1,735,000	\$0	\$1,735,000			
	Management and Staffing	\$6,233,830	\$2,000,000	\$8,233,830	\$0	\$8,233,830	4.7%	4.7%	7.0%
	Other: Unallocated	\$0	\$0	\$0	\$0	\$0			
	<i>Sub-total</i>	<i>\$13,968,830</i>	<i>\$3,348,173</i>	<i>\$17,317,003</i>	<i>\$0</i>	<i>\$17,317,003</i>			
Unallocated - Program Area Not Determined									
PROGRAM REQUEST TOTAL		\$141,814,724	\$10,449,276	\$152,264,000	\$23,912,344	\$176,176,344			

Pediatric AIDS Funding Attributed to (check one of the following):

- OVC 10% Earmark
Treatment 55% Earmark

Instructions:

*To fill in the rows marked "OVC" please use the information entered into your FY07 COP in program area 3.3.8 (OVC).

**To fill in the rows marked "Pediatric AIDS" please use the information entered into your FY07 COP in program areas 3.3.10 (ARV Drugs) and 3.3.11 (ARV Services) under the question "Amount of Funding Planned for Pediatric AIDS."

***As noted in the COP guidance, countries should strive to fund OVC programs at, or as close as possible to 10% of prevention, care and treatment programs when pediatric AIDS is not included in the calculation.

Calculations

AB calculation = AB Total divided by (AB Total + Other Prevention Total)

Sexual Prevention calculation = (AB Total + Other Prevention Total) divided by Prevention Sub-Total

OVC calculation without Pediatric ART = OVC Total divided by (Prevention Sub-Total + Care Sub-Total + Treatment Sub-Total);

OVC calculation with Pediatric ART = (OVC Total + Pediatric ART Drugs Total + Pediatric ART Services Total) divided by (Prevention Sub-Total + Care Sub-Total + Treatment Sub-Total)

Treatment calculation without Pediatric ART = (Treatment Sub-Total - Pediatric ART Drugs - Pediatric ART Services) divided by (Prevention Sub-Total + Care Sub-Total + Treatment Sub-Total)

Treatment calculation with Pediatric ART = Treatment Sub-Total divided by (Prevention Sub-Total + Care Sub-Total + Treatment Sub-Total)

Strategic Information calculation = SI Total divided by (Program Request Total - Central Funds Total);

Management & Staffing calculation = M&S Total divided by (Program Request Total - Central Funds Total)

**Instructions for entering funding information for Orphans and Vulnerable Children (OVC)
Programs and Pediatric AIDS Programs into the COP and Budgetary Requirements
Worksheet**

The policy related to funding for orphans and vulnerable children remains unchanged in FY 2007. However, because there was a good deal of confusion about OVC funding during FY 2006, we are seeking to further clarify the guidance this year.

General Guidance: All focus countries must allocate 10% of total prevention, care, and treatment resources towards OVC programs. OVC programs include activities that directly and indirectly support orphans and children with increased vulnerability due to HIV/AIDS. Because pediatric treatment is a part of comprehensive OVC services, countries may count pediatric treatment funds towards the 10% (PL 108-25, Section 314(a)). However, it is important to continue to place a high priority on funding non-pediatric treatment OVC activities to ensure that you are providing a comprehensive OVC program. To guarantee that these programs receive adequate funding, you should strive to fund OVC programs at, or as close as possible, the 10% level prior to including funding for pediatric treatment. Further, under no circumstances may OVC program funding be reduced below the FY 2005 or FY 2006 levels. If pediatric treatment funds are designated to meeting the 10% directive they may also not be attributed to the 55% treatment directive. Please indicate in your COP cover letter and on the budgetary requirements worksheet whether you are attributing your pediatric treatment funding toward the OVC 10% requirement or toward the 55% treatment requirement. Please note that your entire pediatric treatment funding must go either to the OVC 10% requirement or the 55% treatment requirement. It cannot be split up. Regardless of how you meet the budgetary requirement, all pediatric AIDS treatment activities should be described in the treatment program areas (Table 3.3.10 or 3.3.11).

The Following instructions explain how you should enter OVC and Pediatric AIDS funding information into the COP and Budgetary Requirements Worksheet.

Information to be included in the COP:

1. In the COP, please describe OVC programs, activities and associated dollar amounts in the OVC program area (Table 3.3.08). Please do not report any pediatric AIDS activities in the OVC program area in the COP.
2. For pediatric AIDS, please include all descriptions and activities in the AIDS treatment section. Under no circumstances should pediatric treatment be described in any section of the COP other than the Treatment section.
3. The AIDS Treatment section of the COP includes a box for pediatric AIDS funding in both the ARV Drugs (3.3.10) and the ARV Services (3.3.11) sections.
4. Please enter the total dollar amount of funding planned for pediatric AIDS ARV Drugs in the box in the ARV Drugs section.
5. Please enter the total dollar amount of planned funding for pediatric ARV Services in the box in the ARV Services section of the COP.
6. There should be no overlap between the entries in the ARV Drugs and ARV Services sections. In other words, the sum of the amounts entered into the ARV Drugs and the ARV Services sections should add up to the total amount of pediatric AIDS funding planned for FY 2007.

Information to be included in the Budgetary Requirements Worksheet:

1. Enter the amount of funding included in the OVC section of your COP into the OVC row in the worksheet. Under no circumstances should pediatric AIDS funding be included in this section of the worksheet.
2. As explained in the footnote on the Budgetary Requirements Worksheet, enter the amount of funding included in section 3.3.10 of your COP into the ARV Drugs/pediatric AIDS row in the worksheet.
3. Likewise, enter the amount of funding included in section 3.3.11 of your COP into the ARV Services/Pediatric AIDS row in the worksheet.
4. The amounts entered into the worksheet must be the same as the amounts entered into Sections 3.3.10 and 3.3.11 of the COP. The amounts entered into both the COP and the worksheet should reflect total funding for pediatric AIDS, not an adjusted number.
5. The worksheet has two columns that will automatically calculate the following information for you based on the information you entered in steps 1-4:
 - The percent of funding dedicated to OVC activities excluding pediatric AIDS; and
 - The percent of funding dedicated to OVC activities including pediatric AIDS.
6. Please check the appropriate box in your budgetary requirements worksheet to indicate whether you are attributing your pediatric AIDS funding towards the 10% OVC requirement or towards the 55% treatment requirement.
7. This worksheet should be viewed as a tool to help you determine whether the planned funding allocations meet the range of OVC needs in the country. As explained above, you should strive to fund OVC programs at or as close as possible to 10 percent of total funding for prevention, care, and treatment programs when pediatric AIDS funding is excluded. You should also ensure that OVC funding is not reduced below the FY 2005 or FY 2006 levels.

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Appendix 18 AVAILABLE REPORTS FROM COPRS

- Quality Assurance Report – This report checks for a predefined list of errors in the COP.

COP Reports	
COP Template	This template gives you a Word version of the COP tables that can be used for data collection.
Partner Data Entry Forms	These forms can be used to collect data from partners.
Populated Printable COP	This report provides the full version of what has been entered into the data system to date. It can be converted to Word, RTF or PDF files. It will run the live, "up to the minute" data.
Inputed COP without Budget Amounts	This report provides the full version of what has been entered into the data system to date, without budget numbers included. It can be converted to Word, RTF or PDF files. It runs the live, "up to the minute" data COPs by Section.
COP Report by Funding Mechanism	This will give you all the information from Table 3 for a specific "funding mechanism". This will include sub-partner data entered into Table 3.2 and activity information entered into Table 3.3.

Budget Reports	
Summary Budget Report (Table 4)	
Budget Summary	This table shows the amount of funding requested, by USG Agency and by Funding Source, for the selected country.
Budget Request by Program Area	This table shows the total amount requested for each program area and the percentage of Total funds for that program area, for the selected country.
Budget request and % of budget for management by country	This table shows the requested amount of the budget for the Management and Staffing program area and the percentage of the Total budget for Management and Staffing.
Request by Funding Source	This table shows the requested amount by funding source, for the selected country.
Amounts of request by USG agency and country	This table shows the requested amount by USG Agency and Country.
Request by Partner Type, by country:	All, Prime, Sub – This table shows the requested amount by Partner type, for the selected country.

Program Summary Reports

- Estimated 2007 progress toward end of initiative treatment target by country – This table shows the 2007 total treatment target, the end of initiative treatment target and the percent of the end target that will be reached by the end of FY2007, by country.
- Estimated 2007 progress toward end of initiative care target by country – This table shows the 2007 total care target, the end of initiative care target and the percent of the end target that will be reached by the end of FY2007, by country.
- Summary Program Level Targets Report – This report will let you print out the summary program level targets for each program areas.
- Amount of request by partner and country – This table shows the requested amount for each prime partner, for the selected country.
- Program Areas for Sub-Partners – This report gives a listing of each program area and all sub-partners working in that program area.
- Partner Summary – This table shows various partner data for the selected country, including total number of partners, number of prime partners, number of sub-partners, number of new partners, number of FBO partners, number of local partners, etc.

Ad Hoc Searches

- Partners by budget
- Activity Narratives by funding mechanism and prime partner
- Activity Approval Status Report – This report allows the user to view all or select activities, by approval status with several sort options (by USG Agency, by program area, by funding mechanism).
- COP Comment Report – This report will print out all of the Comments that have been added to the COP.
- Early Funding Request Report – This report will print out all of the activities which have been selected for early funding, with amounts and descriptions.

Miscellaneous Reports

- Printable COP Annex 2: Partner Names (online report) – This report prints a list of ALL active partners listed in the COPRS system. This is NOT a report of partners receiving funding in any time period.
- List of Sub-Partners, with Funding Amounts, by Sub-Partner or by Prime Partner – This table gives a listing of all of the sub-partners, with funding amounts. You can choose to have the list sorted either by Sub-Partner (which will show you when sub-partners are being funded under several funding mechanisms/prime partners) or by Prime Partner (which will show you all of the sub-partners funded under a specific funding mechanism/prime partner).
- Country-Specific Emergency Plan Targets for Total USG Support – This table gives a comparison of FY2004 targets, FY2005 targets, FY2006 targets, FY2007 targets and the increase each year.
- Program Level Targets Summary Report – This report summarizes the targets for each activity in each program area, or for each program area by USG agency, or for each prime partner by program area.
- Summary Program Area Report – This report has each activity (with just funding mechanism name, prime partner, and amount) within each program area by each agency or by program area.
- Coverage Area Report – This report lists each province/state in the country and all activities by funding mechanism (with funding mechanism name, USG Agency, prime partner and amount) selected as working in that coverage area.

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Appendix 19 SUSTAINABILITY INFORMATION SHEET

A guiding principle of the Emergency Plan is to build local and host-nation capacity so that national programs can achieve results, monitor and evaluate their activities, and sustain them for the long term.

What can the PEPFAR do in general to increase the sustainability of HIV/AIDS programs?

- Increase the number of indigenous partners actively engaged in carrying out EP service delivery activities and receiving funding directly from the USG or as principal subs under umbrella agreements so that most funding is going to in-country activities carried out by indigenous organizations;
- Strengthen the technical and management capacities of these indigenous partners so that they can operate independently and increasingly play leadership and oversight roles;
- Ensure that the host-nation and international policy environment, as well as, public opinions and beliefs, are conducive to success; and
- Enable a learning environment where international and host-nation organizations and individuals identify and share best practices and apply evidence based programming.

A critical assumption of the Emergency Plan is that the long-term financial sustainability of HIV/AIDS care, prevention and treatment programs will be attained through a combination of the mobilization of international partner and private financial flows, increases in host-nation government budget allocations, and more active fund raising by indigenous organizations. However, it is understood that international partner, including USG bilateral assistance, and private financial flows will be needed for the foreseeable future and the capacity of host nations to increase budget allocations will be variable and occur at different rates.

What can EP partners do to increase the sustainability of indigenous organizations?

EP partners, especially US contractors and partners, are in an important position to strengthen the technical and management capacities of indigenous organizations, to mobilize international financial resources for these organizations, and to help the organizations mobilize resources locally. US contractors and grantees should be working themselves out of service delivery, the provision of technical assistance, and out of program management. As such, PEPFAR partners are being required, within yearly work plans and annual program performance reporting, to address their plans for, and results of, building such capacities and increasing the likelihood that the indigenous organizations can continue to function at a higher level in a sustainable fashion.

USG agencies are required to review partner performance annually in strengthening indigenous organizations.

We define the strengthening of technical capacities of indigenous organizations for service provision to include such things as:

- Developing, disseminating and implementing appropriate treatment and care protocols and prevention programs;

- Developing and strengthening health infrastructure;
- Improving laboratory capacity to perform HIV testing;
- Upgrading routine health information systems;
- Promoting collaboration and coordination among partners providing prevention, care and treatment services;
- Linking indigenous organizations to international policy and service delivery networks;
- Developing, disseminating and sharing curriculum; and
- Building human capacity through training.

We define the strengthening of **management** capacities of indigenous organizations to include such things as improving:

<i>Strategic Planning</i>	organizations that have a Board of Directors ¹ , mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals
<i>Registration</i>	organizations that are registered with USG agencies or as legal entities in their own country
<i>Financial Management</i>	organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets
<i>Human Resource Management</i>	organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization
<i>Networks</i>	local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results
<i>Monitoring and Evaluation/Quality Assurance</i>	organizations that have institutionalized the capacity to collect, enter, store and retrieve program data for use in planning, monitoring, reporting, and improving quality, and are able to fulfill USG and other international partner reporting requirements
<i>Commodities, Equipment and Logistics Management</i>	organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services
<i>Facilities</i>	laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services; and
<i>Fundraising</i>	organizations that develop plans for raising funds from non-USG sources.

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¹ Oversight Committee/ Task Teams/ Leadership Group

Appendix 20 PARTNERSHIP FOR SUPPLY CHAIN MANAGEMENT

The supply chain management system contract was awarded by USAID on September 27, 2005 to a consortium of 15 organizations, with the primary partners being Management Sciences for Health (MSH) and John Snow International (JSI). The consortium is called the Partnership for Supply Chain Management, (PFSCM); more information about PFSCM is found at www.scms.pfscm.org.

PFSCM provides a full scope of supply chain management services including overall management, procurement (including drug forecasting), freight and freight forwarding, quality assurance, information systems management, and in-country technical assistance and support. It is expected that the PFSCM will increase efficiency and reduce costs by volume purchasing and being a single point of contact for manufacturers and consumers.

PFSCM is purchasing antiretroviral drugs (ARVs), other essential drugs, laboratory supplies and equipment (including rapid test kits), other medical supplies, vehicles, and other equipment (e.g., audio-visual). The contract does not include condom procurement. PFSCM will soon have a list of products and prices on its web-site, and, in addition, can be contacted to purchase items not on its list.

Use of the PFSCM is encouraged because of the efficiency of centralized procurement. However, PFSCM is not intended to supplant functional local or national systems when such is in place, and, indeed can work to assist and strengthen such national systems. Therefore, PFSCM can also provide technical assistance to strengthen existing local or national supply chain management systems even if no commodities are being procured through PFSCM.

Although the PFSCM is a USAID-managed contract, it is intended to support commodities procurement for all USG projects (i.e., projects managed by any USG Agency), and it is the intent of all USG agencies to phase out AIDS-related commodity procurement through other agreements (e.g., CDC's agreement with Crown Agents, USAID's agreement with RPM+ and Deliver, etc.). Each USG in-country team will need to collaborate such that commodities or services obtained from PFSCM for projects supported by Agencies other than USAID are placed in the COP as a USAID activity with the understanding that the goods and services will be consigned to the Agency managing the project.

If you have questions about PFSCM, please contact Heidi Mihm (hmihm@usaid.gov) or Michael Hope (mhope@usaid.gov).

HIV/AIDS Working Capital Fund

The HIV/AIDS Working Capital Fund is a Congressionally-authorized fund account that facilitates the procurement of commodities, serving primarily as a holding fund, which can be applied as needed to a variety of USAID procurement mechanisms, including the PFSCM. It has the flexibility to respond to unexpected changes in country needs to ensure protection against stock-outs. It was initially anticipated that the Working Capital Fund would also allow any USG Agency to place funding directly into the PFSCM (and/or other procurement mechanisms). At this time, administrative and budgetary measures are not in place to support this cross-Agency

use of the Working Capital Fund or PFSCM. However, PFSCM has instituted a similar flexible capacity to rapidly respond to shifting commodity requirements in countries. Accordingly, please do not select the Working Capital Fund as a mechanism in the FY 2007 COP. If you used the Working Capital Fund last year, please plan to use PFSCM or other procurement mechanisms instead this year.

Appendix 21 INFORMATION ON SOFT TARGETS

Appendix 21.1 PEDIATRIC AIDS

Pediatric AIDS

The World Health Organization (WHO), the United Nations (UN) Children's Fund, and the Joint UN Programme on HIV/AIDS estimate that approximately 660,000 children globally, including 370,000 in sub-Saharan Africa, currently are in need of ART (June 2005). Despite this obvious need, only a fraction of children living with AIDS receive ART. Without care and treatment, most children born with HIV will die before age five – but research shows most children who start ART early in life can and do flourish.

Scale-up for pediatric treatment is an urgent Emergency Plan priority. The international goal, set by UNICEF and others is that 15% of all people on treatment should be children. The President's Emergency Plan supports national scale-up to reach this goal. We request that this year you estimate the number of children to be targeted in your **downstream (direct)** treatment services.

Additionally, the Team should include a brief program description including:

- the proportion of ART patients who are children
- the number and proportion of USG-supported sites that are **currently** capable of managing pediatric care and ART
- the number and proportion of USG-supported sites that are **planned** to be capable of managing pediatric care and ART by the end of FY2007 (e.g., staff trained in pediatric HIV/AIDS, pediatric laboratory diagnostic support, pediatric ARVs and OI medications, etc.)
- a brief mention of any other activities that will support the care and treatment of children living with HIV/AIDS (e.g., quality initiatives, pediatric diagnostic laboratory network strengthening, policy, SI, etc.).

Setting targets

We recognize that different country epidemics result in varying numbers of children requiring ART.

In setting a target for FY2007 please take into consideration

- the type of epidemic and prevalence of infection in your countries
- the estimated number of children requiring ART
- treatment capacity
- the complexity and cost of treating children.

Some specific considerations for setting targets include:

- accurate diagnosis of HIV in the youngest children, when treatment may be most effective, is complex and difficult (early infant diagnosis is being recommended as a priority area for support by the PMTCT/Peds and Laboratory TWGs)
- Older children who may have survived are often hidden in communities without access to services, or remain undiagnosed on hospital wards

- Once a child is diagnosed, in resource poor settings, health providers may not be familiar with how to treat and follow children with AIDS
- ARVs in formulations appropriate for children may be limited
- The cost of pediatric ARV formulations may be up to three times that of adult formulations

Some countries may be able to target children as 15% of patients on ART in FY 2007, while others may be just beginning pediatric programs and more feasibly would target in the 5-10% range, with the goal of increasing to 15%.

Reporting

Bi-annual reporting of the number of children directly on treatment already occurs within the Emergency Plan. In the FY2007 COP, you are requested to estimate the number of children that you expect to report as directly on treatment by September 2007. (Children are defined as individuals from birth through 14 years of age).

Please place the FY2007 downstream (direct) target in the narrative section for Treatment (HIV/AIDS Treatment: ARV Services) in Table 3.3.11 along with a short description of activities to support national pediatric HIV efforts to scale up treatment for children. Specifically, please include a description of the host country national pediatric strategy and treatment targets (if there is one).

A discussion of how Emergency Plan support is complementing other resources that are being marshaled for pediatric HIV/AIDS would be welcome (e.g., Global Fund, World Bank, bilaterals, etc.). USG country teams are encouraged to develop, in conjunction with host governments, pediatric ART program monitoring indicators (e.g., age breakdown of children on therapy, loss to follow-up while on ART, etc.).

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Appendix 21.2 TB/HIV

National TB/HIV Estimates by Country

COUNTRY	Est. HIV prevalence in adult TB patients (%)	Est. No. of TB cases reported in 2006	Est. adult HIV+ TB cases to be registered by TB program in 2006	No. TB/HIV eligible for ART 2006 (of registered cases)		Est. No. of TB cases reported in 2007*	Est. adult HIV+ TB cases to be registered by TB program in 2007	No. TB/HIV eligible for ART 2007 (of registered cases)		Est. No. of TB cases reported in 2008	Est. adult HIV+ TB cases to be registered by TB program in 2008	No. TB/HIV eligible for ART 2008 (of registered cases)	
				50% of TB/HIV cases	80% of TB/HIV cases			50% of TB/HIV cases	80% of TB/HIV cases			50% of TB/HIV cases	80% of TB/HIV cases
Botswana	79	13,053	7,314	3,657	5,851	13,727	7,692	3,846	6,153	14,290	8,007	4,004	6,406
Côte d'Ivoire	39	18,378	5,084	2,542	4,067	19,327	5,346	2,673	4,277	20,120	5,566	2,783	4,452
Ethiopia	29	141,077	29,019	14,509	23,215	148,362	30,517	15,259	24,414	154,450	31,770	15,885	25,416
Guyana	14	541	46	23	37	555	48	24	38	557	48	24	38
Haiti	14	11,068	951	475	761	11,343		487	780	11,390	978	489	783
Kenya	51	102,567	37,102	18,551	29,682	107,863	39,018	19,509	31,215	112,289	40,619	20,310	32,496
Mozambique	47	32,675	10,893	5,446	8,714	34,362	11,455	5,728	9,164	35,772	11,925	5,963	9,540
Namibia	64	16,243	7,373	3,687	5,899	17,082	7,754	3,877	6,203	17,782	8,072	4,036	6,458
Nigeria	27	49,411	8,619	4,309	6,895	51,963	9,064	4,532	7,251	54,095	9,436	4,718	7,549
Rwanda	37	7,689	2,018	1,009	1,614	8,086	2,122	1,061	1,698	8,418	2,209	1,105	1,767
South Africa	60	275,172	117,107	58,553	93,685	289,382	123,154	61,577	98,523	301,256	128,208	64,104	102,566
Tanzania	34	77,141	18,603	9,302	14,883	81,124	19,564	9,782	15,651	84,453	20,367	10,183	16,293
Uganda	24	52,055	8,071	4,036	6,457	54,743	8,488	4,244	6,790	56,990	8,836	4,418	7,069
Viet Nam	2	139,761	1,691	846	1,353	134,706	1,630	815	1,304	127,653	1,545	772	1,236
Zambia	62	69,356	30,500	15,250	24,400	72,938	32,075	16,038	25,660	75,930	33,391	16,696	26,713

*It is hoped that PEPFAR programs can coordinate activities in such a way so as to contribute to these national goals and targets. Specifically, a coordinated review of national targets matched with a mapping of available resources for TB and TB/HIV programs (e.g., Global Fund, World Bank, USAID TB funding, other bilaterals, etc.) should assist each USG country program to determine its numerical and geographic targets in this important programmatic area.

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Appendix 22 FY2007 COP ACQUISITION AND ASSISTANCE

Background:

This appendix:

- provides additional guidance for increasing indigenous partners
- expands upon procedures for OGAC's review and approval of program activities where partners were not identified at the time of COP approval
- provides new guidance on construction and hiring PEPFAR coordinators

It is an update of last year's appendix.

Increasing Indigenous Partners:

As discussed in the sustainability annex, the Emergency Plan seeks to increase the number of indigenous partners that are actively engaged in carrying out service delivery activities and receiving funding directly from the USG or as principal subs under umbrella agreements so that most funding is going to in-country activities carried out by indigenous organizations.

The Coordinator's Office has instituted several policies and procedures to encourage the use of indigenous organizations, including community-based and faith-based organizations (C/FBOs). This has included authorizing the use of umbrella mechanisms to channel funding to indigenous organizations; setting limits on the percentage of country funding that can be allocated to individual organizations; launching the New Partner Initiative; and requiring USG implementing agencies to review partner performance annually in strengthening indigenous organizations.

OGAC has created the Community and Faith-Based Organization Integration Work Group to assist countries in increasing indigenous partners in the FY 2007 COP process. A member of this work group will be assigned to each core team as a resource and point of contact.

Objectives:

As you continue to design FY 2006 programs and acquisition and assistance (A&A) plans and begin to formulate FY 2007 plans, please remember the following objectives:

1. Add new organizations to implement all components of the Emergency Plan and ensure that non-local organizations build institutional capacity of indigenous organizations;
2. Assure within all solicitations a level playing field for all potential bidders, including those with limited previous experience working with the USG;
3. Promote the use of indigenous organizations as implementing organizations;
4. Avoid duplication of resources programmed by different USG agencies to the same implementing organization for the same purposes, for example two USG agencies funding the same partner to provide assistance to orphans or anti-retroviral therapy; and
5. In the assistance arena, limit the amount of funding for any single partner (as prime or sub) to less than 8% of the total COP budget (excluding management and staffing) for that year.

Best Practices:

This guidance focuses on identifying organizations that already reach populations not served, have expertise in the program area, and could partner with the USG with some technical assistance and capacity building.

Experience during the first two years of the Emergency Plan has yielded examples of creative program designs that successfully integrate FBOs, CBOs and indigenous organizations into Country Operational Plans.

- Some Annual Program Statements (APSS) were directed entirely at new partners, or set aside a portion of funding for new partners that are indigenous with an existing in-country presence or relationship.
- The language used in solicitation requests, such as Requests for Application (RFAs) and APSS, is critical in determining what types of organizations respond. Some word choices encourage the participation of FBOs, CBOs and indigenous organizations while other word choices discourage participation. A best practice is to issue a draft solicitation for comment or hold an in-country pre-bidders conference to determine if there are impediments to participation by FBOs/CBOs. Please provide any examples of problems faced and overcome.
- The dollar values identified in solicitations for size of grants may also influence which organizations apply because they are indicators that help local organizations decide if it is feasible to prepare an application. Statements indicating dollar value awards "up to \$5 million" can discourage local organizations because they are often viewed as "set-asides" for international organizations. Additional language, such as "small awards to local organizations will be a priority" may be helpful.
- Where local organizations are strong, umbrella grant programs have been designed to hire a strong local or international organization whose role is to run a grant making and administration program, using a relatively small percentage of the funds (usually around 7%) in the overall grant for these purposes.
- Where local organizations are weak, umbrella grant programs have been designed that include significant technical assistance, either as part of the responsibilities of the grant making organization or as a separate organization. The best examples again spend a relatively small proportion of the overall grant (typically 20% to 30%) on these services and are quite specific as to the responsibilities of the prime in strengthening local partners. Such awards are expected to move to the 7% range over time as the technical capacity of local partners is strengthened.
- Many solicitations now include specific objectives for capacity building within statements of work and assign points for capacity building plans as part of review criteria and scoring systems. (Examples will be posted on the PEPFAR extranet) During implementation, All USG implementing agencies to review partner performance annually in strengthening indigenous organizations and PEPFAR partners are being required, within annual work plans and annual program performance reporting, to address their plans for, and results of, building such capacities.
- In the acquisition arena, if an international organization is essential to provide technical leadership and oversight, use all available tools in award evaluation criteria and performance assessments to encourage use of local partners. To stimulate broader

participation in a contract, the award evaluation criteria can include points for including indigenous partners as sub-contractors or implementing partners. The evaluation of how broadly and effectively a contractor utilized and included indigenous partners during the performance assessment of that contractor has also been effective when done rigorously.

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

OGAC or HQ Involvement

Consistent with its coordinating responsibilities, OGAC will, from time to time, request information or provide further guidance during the A&A process. We instituted the following procedures for FY 2005 and will continue them:

- During the review of Country Operational Plans (COPs), OGAC will identify those activities for which the prime is to be determined (TBDs), that will be subject to further monitoring during the A&A process.
- Where additional monitoring is required, OGAC will review directly or request the HQ of the implementing agency to review the solicitation document before it is released and to take any additional steps it feels necessary to ensure that Emergency Plan objectives are being pursued and that the solicitation will have a high probability of being successful. The agency involved may call upon the expertise of other Emergency Plan agencies for help through its Principal or through the PAWG.
- On occasion, OGAC may request to be the Source Selection Official for the action. These actions will be clearly designated as early in the planning process as possible.

During the FY 2006 COP reviews several TBD activities followed these procedures. The solicitation documents were reviewed to ensure that the language did not discourage C/FBO participation; that there was a clear objective to strengthen indigenous organizations, and that review criteria assigned points for strengthening the technical and management capacities of indigenous organizations.

Construction:

DoD's Defense Security Cooperation Agency has informed the Coordinator's Office that it is unable to accept Emergency Plan funds, as was originally planned, to carry-out the construction of facilities such as laboratories. DoD is able to continue construction activities that are funded out of DoD's humanitarian assistance. HHS has also determined that it is unable to accept funding for construction.

Therefore, where USG involvement in new construction is necessary, construction funds should be assigned to the Department of State (as the USG Agency) with the Regional Procurement Support Office/Frankfurt (RPSO) being the prime partner. However, you must identify someone at post to be the technical advisor to RPSO for the construction activities. This technical advisor

can be from any of the USG Agencies, they do not need to be from the Department of State. Alternatively, posts may wish to consider convincing host governments to utilize other international partner resources, such as those of the World Bank, to finance and carry out construction activities.

Listing Partners:

Do not list partners on Table 3 of the COP until they have been formally selected through normal A&A processes, such as Annual Program Statements, Requests for Application, or Requests for Proposals. If a partner has not been formally selected, list the partner as To Be Determined (TBD).

Hiring PEPFAR Coordinators

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

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

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

International Hire Contractors: OGAC is working to obtain a delegation of Personal Service Contract (PSC) authority to the Africa Bureau of the Department of State for the purpose of hiring PEPFAR coordinators. This would become the preferred option, as opposed to using CDC or USAID PSC authorities to hire a person that reports to the Chief of Mission.

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Appendix 23 TARGETED EVALUATIONS

The overarching goal for targeted evaluations in the Emergency Plan context is to produce results which are generalizable in nature and can contribute to sustainability of country programs. Targeted evaluations will provide evidence-based information, beyond that derived from routine program monitoring and evaluation or disease surveillance, to provide rigorous assessment usually including pre- and post-test results of a study group or population with a comparison group or control in order to assess potential of the resulting change being due to chance. Targeted evaluations are not equivalent to randomized trials, but rather leverage quasi-experimental designs that utilize natural controls or other strategies that lend the greatest validity to study findings. These special studies are designed to answer specific questions about the overall efficacy and best practices of different models of prevention, care and/or treatment service delivery approaches for those infected or affected by HIV/AIDS. The goal is to document the efficiency and effectiveness of scale-up programs in areas that have not been well studied in order to improve the quality of HIV/AIDS services, as well as their availability, accessibility, and acceptability.

PEPFAR is currently examining its approach to targeted evaluations to ensure that they are nonduplicative and provide useful information for program improvement.

Emergency Plan Funded Targeted Evaluations
Study Background Sheet

Instructions:

- For new activities, please complete the protocol information. Completed sheet should not be more than two pages.
- For on-going activities that require new FY2007 funding, please complete the protocol and the progress report information. Completed sheets should not be more than two pages.
- For on-going activities that require no new FY2007 funding, please complete only the progress report. Completed sheet should not be more than one page

Country: _____
Program Area: _____
Budget to Date: \$ _____
Expected Budget for Completion: \$ _____
Budget Request FY2007 (if applicable): \$ _____
Mechanism/Prime Partner: _____
Activity ID # (from COP): _____

PROTOCOL

Project Description: (not to exceed 100 words)

Evaluation Question: (explain what the study intends to examine, its programmatic importance, and anticipated outcomes)

Methodology: (describe methods including comparison groups, study period, and instruments)

Population of Interest: (describe populations to be studied and strategies for achieving appropriate sample size)

Budget Justification: (explain the study costs, including incentives for clients)

PROGRESS REPORT (NOT TO EXCEED ONE PAGE)

Main Research Question:

Status of the Study:

Lessons Learned:

Appendix 24 ROLES AND RESPONSIBILITIES

Appendix 24.1 AGENCY ROLES AND RESPONSIBILITIES IN THE COUNTRY TEAM: THE INTERAGENCY APPROACH

The President's Emergency Plan for AIDS Relief (PEPFAR) seeks to achieve the goals of supporting treatment for 2 million people, prevention of 7 million new infections, and care for 10 million people with HIV/AIDS in an accountable and sustainable way. Much progress has been made (details found in annual report at www.state.gov/s/gac/), but efficiency of program delivery must continuously be improved, in order to meet these ambitious goals.

A unique aspect of PEPFAR is the management structure, in which there is a central coordinating organization, the Office of the Global AIDS Coordinator (OGAC), direct leadership in-country from Chiefs of Mission (COMs), and implementation through interagency teams both in the field and in headquarters. The participating implementing agencies include DOC, DOD, DOL, DOS, HHS/CDC, HHS/FDA, HHS/HRSA, HHS/NIH, HHS/SAMHSA, Peace Corps, and USAID. Each of these agencies brings significant expertise and capacity to PEPFAR.

The efficient integration of agency capacity is necessary to achieve the 2-7-10 goals, and must be achieved both in the field and in agency headquarters operations. In some in-country teams, staff members are performing similar work in the same program areas, but only for that agency's projects. This inefficiency will limit the ability of the Emergency Plan to reach its goals.

The most successful in-country teams are using approaches that foster efficient collaboration and eliminate redundancy. It is hoped that this approach will continuously improve program efficiency (in order to meet 2-7-10); tighten agency bonds through mutual appreciation of each others' roles; improve accountability through focusing specific responsibilities on specific agencies; reduce management costs by reducing overlap; leverage agency strengths to contribute to PEPFAR; and help in recruiting and orienting new staff to carry on in this interagency framework.

An example of a collaborative and interdependent country team is as follows: In one country, both HHS/CDC and USAID fund different groups to provide treatment. HHS/CDC provides a staff member to oversee the clinical treatment protocols for both agencies and USAID provides a staff member to oversee the behavior change activities and community links for all USG-supported treatment programs. Instead of four USG staff to oversee treatment protocols, prevention and community links (two for each agency), the team has two. Due to workload, those two may each have assistants to ensure they have reach and needed coordination to handle the increase in numbers of people on treatment, but the assistants are likely to be less costly than four technical experts.

Precisely how country teams could achieve the most efficient functioning of the interagency effort may vary country by country and should be decided at the country level. However, there is an integral relationship between roles and responsibilities within each specific in-country team and the particular strengths and capacities of each agency as a whole. In some cases there is

specialized capacity heavily concentrated in one agency (e.g. Peace Corps in the area of rural community outreach and DOD in the area of working with the uniformed services).

In many program areas, agency capacities overlap. Yet even when there is overlap of capacity within a single program area, there are often distinct activities within the program area, such that one agency would be most likely to undertake one specific set of responsibilities based on its strengths and another agency most likely to undertake another set, such as in the example above.

As the Emergency Plan continues to mature, there has begun to be substantial turnover of key staff at some posts. This presents a challenge: educating new staff on the advantages of and opportunities for true interagency collaboration and efficiency within country teams. This situation also presents an opportunity to move further toward the efficiency that this collaboration brings and toward institutionalizing this way of "doing business." It is anticipated that missions and headquarters will work together to examine the composition and function of each country team, and each agency within that team, to define the roles and responsibilities for each agency and its staff.

OGAC is proposing the following initial steps to maximize the efficiency of country teams:

- Country teams that have not already done so should immediately begin in-country discussion of the roles and responsibilities of each agency within the country team, asking questions about whether there should be a greater role for one agency's staff in certain projects, such that one agency can take a greater leadership role for projects on behalf of the entire country team. This discussion must include all agencies at post that work or can potentially work on HIV/AIDS. Those that have already assigned agency-specific roles and responsibilities should provide feedback on what the impact has been of this approach.
- In parallel with in-country considerations, in-country team leads and core teams should be included in discussions about this issue.
- Following initial discussions in-country and with core teams, senior management from agency headquarters will discuss with country teams, through in-person discussions in-country when feasible, and contribute ideas to approach collaborative and interdependent country teams,
- Following this formulation of ideas, the country team will be asked to include, within their FY 2007 COP management and staffing section, information about individual and agency primary functions/responsibilities. This will be used for OGAC and headquarters staff from implementing agencies to learn the scope of agency responsibilities in the field and configure agency support for core responsibilities that are common across countries.

There has been great progress toward 2-7-10, yet much work remains to achieve those goals. Promoting maximal efficiency of country teams, with each agency contributing in areas of greatest capacity, will be important in propelling PEPFAR towards achievement of its goals. Thank you for your attention to and participation in this activity.

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Appendix 24.2 CORE TEAM ROLES AND RESPONSIBILITIES

Core Team Structure:

The core team is a key interagency structure for coordinating the activities of the President's Emergency Plan for AIDS Relief. The core team consists of a small group of USG agency staff representing the mix of agencies working in the country, as well as a range of technical expertise. The representative from the Office of the U.S. Global AIDS Coordinator to the core team is the core team leader. Additionally, one USG agency staff person with skills in SI is identified and acts as the SI Advisor on each of the core teams.

Core Team Objectives:

- Support and strengthen country planning, implementation, and monitoring and evaluation towards Emergency Plan goals, by serving as the primary channel of information between country teams and OGAC and agency headquarters.
- Support and strengthen OGAC and agency oversight of implementation of country operational plans (COPs) and strategies through the COP review process.
- Represent the country program at headquarters.

Core Team Membership:

Each core team member should have country-specific or regional field experience in implementing USG health programs. Core team members are nominated by USG agency leadership and approved through the Deputy Principals group prior to being officially added to the core team. Following this approval, the agency should send a formal note of introduction to the core team leader. Members should inform the core team leader when their tenure on the core team will end, and should work with their agency leadership to identify a replacement. Open season for changing members of a core team is in April and May of each year. Most turnover should occur during this time period so that a dedicated team can support the USG field team through the COP development and review process.

All core team members are expected to have comprehensive, in-depth knowledge of the general, political and health environment of the country; the country's HIV epidemic; other donors and Global Fund priorities in the country; and the USG country program, including budget, management and staffing issues.

Core Team Leader Functions

1. Facilitate interagency coordination and regular communication, both within the core team and between the core and country teams.
2. Serve as the principal OGAC point of contact for their respective countries' issues, including with the country team, other OGAC sections, other USG agencies and other stakeholders.
3. Communicate Emergency Plan strategies, policies and guidance to the country team and core team.
4. Facilitate provision of technical assistance in support of country Emergency Plan implementation, including serving as liaison to the Technical Working Groups. The

core team leader will forward country-initiated TA requests to the respective OGAC TWG lead and TWG-initiated TA offers to their in-country contact(s).

5. Provide support for country team maintenance of accurate COPRS data, in collaboration with OGAC's SI and Budget sections.
6. Report to OGAC Program Services Director any issues needing higher-level attention.
7. Communicate country team concerns within OGAC and through the interagency process.
8. At the request of the appropriate USG agency, provide evaluation feedback of core team members.

Core Team Member Functions:

1. Participate regularly in core team communications and activities, including but not limited to conference calls, meetings and site visits.
2. Provide programmatic support to the country team and liaise with technical working groups, as appropriate.
3. Provide expertise on agency-specific regulations and issues.
4. Assist core team leader and/or country team with preparing documents (e.g., trip reports, briefing memoranda, scene setters, technical assistance plans, technical assistance scopes of work, position descriptions, COP narratives and supporting documents, notes from conference call, etc.) and reviewing country-specific reports (e.g., Mission Performance Plans, drafts of COP and APR/SAPR submissions, etc.).
5. Backstop the core team leader as requested, e.g. while core team leader is on travel or leave status; assist the core team leader in other tasks on request.
6. Serve as a point of communication concerning country issues to agency leadership.
7. Have a high degree of familiarity and competency with using the COPRS database.
8. The SI Advisor, in addition to other core team functions, should update the core team regularly on country progress toward achieving targets and other SI strategic objectives, assist with strategic planning and target setting, and in preparation for COP planning, collate and disseminate all SAPR and APR data to assist in planning.
9. At the request of OGAC management, provide feedback on Core team leader performance during annual reviews.

A primary core team member cannot be on more than two core teams; their core team participation should be reflected appropriately in their individual work plans. They are responsible for coordinating tasks and responsibilities with their respective agencies. The primary core team member should alert the core team leader when the secondary core team member will backstop for them and should brief the secondary member on current country issues.

Some agencies may request to designate a secondary member to backstop the primary core team member, subject to approval by the Deputy Principals' Group. The secondary member would be expected to keep current on country issues by participating core team calls and U.S.-based meetings. Secondary core team members will not be expected to participate in core team field visits, unless replacing the primary core team member.

Core Team Field Visits:

Approximately once a year *and* on country team request, a core team may conduct a field visit with three to five members participating. The visit should be based on a clear

scope of work, developed in advance, and its outputs should include a trip report describing highlights. The core team leader should forward the trip report to relevant technical working groups to address technical issues identified during the visit.

Additionally, core team members should also be expected to support country programs as needed on any number of tasks, ranging from technical assistance to management support. In fact, this may require the core team member to travel to the country in order to complete the requested task.

Southern Africa			
Regional Team Leader: Karina Rapposelli			
Focus Countries	Botswana	Karina Rapposelli	RapposelliKK@state.gov
	Mozambique	Karina Rapposelli	RapposelliKK@state.gov
	Namibia	Carl Fox	FoxCB@state.gov
	South Africa	Kristie Mikus	MikusKF@state.gov
	Zambia	Elizabeth Onjoro Meassick	OnjoroMeassickEA@state.gov
Countries over \$10 million	Malawi	Elizabeth Onjoro Meassick	OnjoroMeassickEA@state.gov
	Zimbabwe	Elizabeth Onjoro Meassick	OnjoroMeassickEA@state.gov
Countries with \$5-10 million (no core team; point of contact only)	Angola	Karina Rapposelli	RapposelliKK@state.gov
	Lesotho	Elizabeth Onjoro Meassick	OnjoroMeassickEA@state.gov
	Swaziland	Elizabeth Onjoro Meassick	OnjoroMeassickEA@state.gov
Regional Program(s)	HHS/CDC Southern Africa Regional Program		
	USAID Regional Center for Southern Africa (RCSA)		
	USAID Regional HIV/AIDS Program		

East and West Africa			
Regional Team Leader: Dana DeRuiter (Acting)			
Focus Countries	Cote d'Ivoire	Beverly Nyberg	bjn@gwu.edu
	Ethiopia	Dana DeRuiter	DeruiterDM@state.gov
	Kenya	Nomi Fuchs-Montgomery	Fuchs-MontgomeryNR@state.gov
	Nigeria	Reuben Granich	GranichRM@state.gov
	Rwanda	Beverly Nyberg	bjn@gwu.edu
	Tanzania	Kristie Mikus	MikusKF@state.gov
	Uganda	Dana DeRuiter	DeruiterDM@state.gov
Countries with \$5-10 million (no core team; point of contact only)	Democratic Republic of Congo	Dana DeRuiter	DeruiterDM@state.gov
	Senegal	Dana DeRuiter	DeruiterDM@state.gov
Regional Program(s)	Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA)		
	Western Africa Regional Program (WARP)		

Asia			
Regional Team Leader: Carl Fox			
Focus Countries	Vietnam	Joan Holloway	HollowayJP@state.gov
Countries over \$10 million	Cambodia	Joan Holloway	HollowayJP@state.gov
	India	Carl Fox	FoxCB@state.gov
Countries with \$5-10 million (no core team; point of contact only)	China	Chunnong Saeger	SaegerC@state.gov
	Indonesia	Carl Fox	FoxCB@state.gov
	Nepal	Carl Fox	FoxCB@state.gov
	Thailand	Carl Fox	FoxCB@state.gov
Regional Program(s)	HHS/CDC Asian Regional Program		
	USAID Regional Development Mission/Asia (RDMA)		

Latin America and the Caribbean			
Regional Team Leader: Ginny Gidi			
Focus Countries	Guyana	Ginny Gidi	GidiGE@state.gov
	Haiti	Ginny Gidi	GidiGE@state.gov
Countries with \$5-10 million (no core team; point of contact only)	Dominican Republic	Ginny Gidi	GidiGE@state.gov
	Honduras	Ginny Gidi	GidiGE@state.gov
Regional Program(s)	Caribbean Regional Program	Ginny Gidi	GidiGE@state.gov
	Central American Regional Program	Ginny Gidi	GidiGE@state.gov

Eastern Europe			
Regional Team Leader: Karina Rapposelli			
Countries over \$10 million	Russia	Karina Rapposelli	RapposelliKK@state.gov
Regional Program(s)	USAID/Central Asian Republics (CAR)	Karina Rapposelli	RapposelliKK@state.gov

Appendix 24.3 TECHNICAL WORKING GROUP ROLES AND RESPONSIBILITIES

Technical Working Group (TWG) Objectives:

- Provide technical leadership to advance the state-of-the-art and country-level scale up of best practices.
- Provide countries with technical assistance (TA) to develop comprehensive country plans, ensure evidence-based responses, evaluate the status of programs using a standardized framework, and ensure high quality of programs
- Provide specialized technical assistance and/or training if requested by countries, and building the capacity of field staff to provide TA to other countries (south-to-south TA)
- Conduct technical reviews of country COPs and technical documents, papers and abstracts, and identify areas for and facilitating development of target evaluations
- Strengthen country planning, implementation, and monitoring and evaluation towards Emergency Plan goals, by serving as the primary channel of technical information between country teams and OGAC and agency headquarters
- Compile and disseminate technical reports, publications, policy documents, training curricula and guidelines

Co-Chair Functions:

1. Provide overall leadership and direction for the TWG, including leading the group in identification of technical priorities based on the current state of the art as well as maintaining expertise on the latest scientific developments within the given technical area.
2. Organize communication with TWG members and develop process for operations within the TWG and interfacing with other TWGs.
3. Serve as the principal OGAC point of contact for technical issues, including with the country team, other OGAC sections, and other USG agencies.
1. Assist in the facilitation of technical assistance in support of country Emergency Plan implementation, including through liaison with the Core Teams.

SI Liaison Functions:

1. Communicates with TWG regarding SI information and policies.
2. Provides assistance in communicating SI guidance on country specific epidemiology, targets and indicators.
3. Assists TWG by running relevant data summaries from the COP related to specific technical areas.
4. Provides input and coordinates communication between TWG and any relevant TE activities.
5. Participates as a full TWG member.

TWG Member Functions:

1. Participates regularly in all TWG communications and activities, including but not limited to conference calls and meetings.

2. Provides technical support to the country teams as requested by the country or identified by the TWG.
3. Assists in the technical review of COPs, abstracts, guidance, protocols and other documents, such as commenting on technical briefing papers.
4. Provides technical assistance to the field as requested by country teams or as identified by the TWG and approved by country teams. TA visits include the development of an agreed upon SOW and the completion of a trip report.
5. Assists in the preparation of guidance, documents, meetings and other related events.

Appendix 25 INFORMATION TO ASSIST WITH TARGET SETTING

The information below is provided to give countries some information on how to set targets. This is not meant to be a formula or template to follow in setting your targets, but simply to give you a better idea of what roles different individuals play in target-setting, what documents would be useful in setting your targets and key concepts that relate to target setting.

What is target-setting in the context of PEPFAR?

Target-setting is an iterative, group process integral to program planning and program management to set partner-level, program-level, country-level and international standardized, measurable expected future achievements for PEPFAR.

Who does target-setting?

Target setting is a collaborative *group process* that is best conducted with the active participation of program managers/project officers (e.g. cognizant technical officers or CTOs), budgetary staff, implementing partners, strategic information staff (HQ SI advisors, in-country SI liaisons and other SI technical area personnel), core team staff (HQ and in-country) and technical work group members, who each have roles and responsibilities to the group process. All USG agencies in country should agree to and follow the same target-setting processes to arrive at consistent partner-, program- and country-level targets.

What are some expected roles and responsibilities of various staff in target-setting?

EXTERNAL STAFF

SI Advisor:

- Understands and communicates PEPFAR requirements regarding targets and results
- Knows and suggests resource materials for target-setting
- Communicates with SI Liaison (or other in-country SI staff) to promote understanding of PEPFAR requirements for targets and results
- Facilitates target-setting process with agencies, in-country program area workgroups and/or partners, as requested by in-country staff
- Suggests methods for estimating targets, especially upstream (indirect) targets
- Reviews targets and supporting explanatory documentation prior to and upon submission to OGAC

Other core team staff:

- Understands and communicates PEPFAR requirements regarding targets and results
- May, in collaboration with SI advisor, facilitate target-setting process with agencies, program area workgroups and/or partners, as requested by in-country staff
- Reviews targets prior to and upon submission to OGAC to assess whether targets are appropriate in light of technical considerations and fiscal stream

OGAC technical work group members:

- Understands and communicates PEPFAR requirements regarding targets and results in program area
- Reviews targets prior to and upon submission to OGAC to assess whether targets are appropriate in light of technical considerations and fiscal stream

IN-COUNTRY STAFF

SI Liaison (and, as appropriate, other in-country SI technical area staff):

- Understands and communicates PEPFAR requirements regarding targets and results
- Facilitates target-setting in all program areas with agencies, technical workgroups and partners. NOTE: The SI Liaison (or other in-country SI staff) is NOT solely responsible for the estimation of targets, rather target-setting is the result of strategic program planning with each partner and in each program area.
- Facilitates target-setting process and estimates targets as part of strategic program planning *in the SI program area* in collaboration with technical staff for M&E, surveillance and HMIS.
- Reviews all partner-level, program-level and country-level targets prior to submission to OGAC and encourages revision of targets, as appropriate
- Assists program managers/project officers in the preparation of supporting documentation to explain how targets were estimated

Program managers/project officers (e.g. CTOs):

- Understands national goals targets in program area and engages with appropriate host country institutions (e.g. MOH – NACPs, NACs, etc.) to reconcile PEPFAR targets with the national ones
- Consults with staff across USG agencies to ensure complementarity of USG investments within and among program areas
- Consults with representatives from other international donor representatives (such as UNAIDS, WHO, Global Fund, World Bank, DFiD) to ensure complementarity of USG investments in light of national goals and targets in program area
- Consults with SI staff in country to understand PEPFAR requirements regarding targets and results
- Engages in collaborative process with SI staff, implementing partners, technical work groups, budget staff and other agencies in country to estimate partner-level, program-level and country-level targets, based on previous results, fiscal stream and projected program growth/reduction.
- Assists SI liaison and other SI staff in the preparation of supporting documentation to explain how targets were estimated

Budgetary staff:

- Provides fiscal information necessary to conduct target-setting and assess cost per output. This information may include current and future budgets and other information required to estimate program growth/reduction.
- With program manager/project officer, ensures that budgetary requirements (as related to strategic program planning and target-setting) are met and that targets are appropriate in light of estimated fiscal stream

Implementing partner:

- Discusses with/reports to program manager/project officer all fiscal, program and other relevant information needed to accurately estimate results achieved in the past and targets expected in the future
- Estimates partner-level targets, according to guidance provided by program manager/project officer and in-country SI staff

How are targets defined?

Targets are defined by the *standard OGAC global indicators* with reference to a *specific time period* during which or by which they are expected to be achieved. Targets are classified as downstream (direct) or upstream (indirect) (see COP Guidance section on this) and targets are estimated for each program area and for each partner-activity funded in that program area.

COP Table 2 targets refer to expected country-level achievements in a given program area within a specified fiscal year (October 1st to Sept 30).

COP Table 3.3 program area summary targets refer to expected country level achievements in a given program area with the funding requested in a specified fiscal year. These targets represent the unduplicated (adjusted) sum of partner-level targets in the program area.

COP Table 3.3 partner-level targets refer to expected partner level achievements in a given program area with the funding requested for that partner-activity in a specified fiscal year. It is expected and acceptable that partners may refer to the same individuals and at times the same points of service (sites) in their partner level targets, but this work should be well-coordinated across partners and activities to eliminate duplication of effort.

What are some key steps in the target-setting process?

- *Defining:* This step involves understanding the specific indicator, the type of target (e.g. downstream (direct) or upstream (indirect)), the level of the target (e.g. country, program area, partner) and the time reference for the target.
- *Estimating:* This step involves the consideration of past results, funding stream and program strategic planning to estimate expected achievements in a program area within a specified time period or with a specified amount of money. downstream (direct) targets are often estimated with more certainty than upstream (indirect) ones. downstream (direct) targets reflect actual counts of uniquely identified individuals expected to receive services, whereas upstream (indirect) targets are based on the number of individuals who receive services beyond a USG point of service and as a result of USG contributions to national capacity building and systems strengthening. Estimations for targets should be based on the history of service delivery and adjusted for changes in funding and program planning. USG agencies should agree to a similar process for estimating partner level targets and work with implementing partners to arrive at accurate, consistent targets.
- *Documenting:* For both downstream (direct) and upstream (indirect) targets, it is critical that the USG team provide documentation of the basis for its downstream (direct) and upstream (indirect) estimations. As a general rule, this documentation will include source of information and method of estimation (for example, previous program progress reports from implementing partners, adjusted for changes in funding, target population or program emphasis) as well as an explanation of target trajectories that deviate from an expected pattern (e.g. a major partner's funding stream ceases and the program area summary target declines in the following year as a result).

- *Reviewing:* This step involves ensuring that targets make sense, are internally consistent within the COP, and are feasible given the nature of epidemic, populations to be reached, amount of resources available for program delivery and overall infrastructure of the USG team and national government. We strongly recommend that the USG team keep a master spreadsheet with targets by program area and partner in order to review the internal consistency of all targets, to track target changes through “plus-ups” and reallocations and to compare to actual achievements at a later time.

What are some tools and documents that might assist the target-setting process?

- *COP Guidance:* This guidance is revised and distributed by OGAC during the COP development process. It defines the targets, indicators, timelines, placement in the COP and suggested methods for estimation (in some program areas).
- *Indicator Guidance:* This guidance lists and defines all of the required and recommended program-level and outcome/impact indicators required under the Emergency Plan. There is guidance specific for the requirements of the focus countries as well as the other bilateral countries.
- *National HIV program documents:* These are documents that articulate national government strategy and targets and might include National HIV/AIDS Strategy, the National M&E Plan and MOH/NACP national strategic plans by program area.
- *Other international partner reports and strategies:* These are documents that lay out other donor investments and strategies in HIV program areas, and perhaps in non-HIV health sectors (e.g. reproductive health/family planning, sexually transmitted infections, tuberculosis) and non-health sectors (e.g. food assistance, education). Familiarity with other donor investments and targets is important to ensure that HIV programming efforts are complementary and maximize opportunities to leverage and/or “wrap around” other investments.
- *Data Quality Diagnostic Tool:* This tool was prepared by Measure Evaluation for OGAC to summarize experiences from and provide guidance to the field about methods to investigate and verify data quality for reporting. This document is useful for defining, estimating, documenting, and reviewing targets and results.
- *Spreadsheet summaries of budgets, targets and results:* These are spreadsheets prepared by the OGAC SI unit (or the Census Bureau for OGAC) and distributed to SI advisors and core teams. They summarize budgets (with directives), targets and results to date, usually by country and/or program area, and are revised after each reporting and COP cycle.
- *SI program summary (COPRS):* These are country-specific summaries, prepared by the SI advisors (or the Census Bureau for OGAC), which gather from COPs and SAPRs/APRs multi-year targets, results, and related explanatory information.
- *COPRS summary reports:* These are standardized reports that can be queried from the COPRS data base report function.

- *Program management documents (contracts, cooperative agreements):* Target-setting for partners and by program area is part of program planning and management. Thus, review of the portfolio of programmatic investments and related contractual agreements in the program area is suggested. The standard terms for these documents may differ by agency or type of agreement. This may also include results reported to agencies on a quarterly basis (like the USAID Performance Monitoring Plan or PMP).
- *Examples of partner target-setting or reporting templates from other countries:* These templates provide examples for country adaptation and are particularly useful for countries that are new to the COP process or that seek to revise their target-setting and reporting process.

What are some other useful questions to ask in the target-setting process?

COP DEVELOPMENT PROCESS

- What is the proposed process for target-setting by the USG team for the FY2007 COP?
- Has each agency agreed to a similar process for defining, estimating, recording, documenting and reviewing partner-level targets?
- Does everyone understand their roles/responsibilities for target-setting?
- Does everyone understand that SI staff do NOT solely create program or partner targets but rather facilitate the process of target-setting with a variety of other technical, program, and administrative staff?
- What sort of external technical assistance will the USG team need to set targets for the FY2007 COP?
- Would it benefit each in-country USG program area technical working group to hold an SI staff-facilitated session on target-setting in preparation for the FY2007 COP?

COP REVIEW PROCESS

- Have the targets been reviewed by program managers/project officers and SI staff (external and internal) prior to final COP submission?
- Are targets in line with results achieved in the previous years and necessary trajectories to meet future targets (e.g. to reach focus country-specific portion of the 2008 2-7-10 goals)?
- Does the Table 2 sum of downstream (direct) and upstream (indirect) targets and the ratios of downstream (direct):total and upstream (indirect):total in any given program area make sense in the context of past and future targets, national government program targets and other donor investments?
- Are the Table 2 and Table 3.3 targets consistent in each program area, recognizing that they reflect slightly different time references and funds (in magnitude and on a trajectory of program investment and growth)?

- Are the Table 3.3 program area summary targets consistent with the actual sum of the partner-level targets in the program area? Are the Table 3.3 program area summary targets adjusted downward for potential duplication of partner-level targets? (This is especially common in palliative care).
- Are the partner level costs-per-output generally similar across partners in each program area? Are there obvious outliers and what explains their difference from the other partners?
- Is documentation provided for the information source and estimation procedure for downstream (direct) and upstream (indirect) targets? Are explanations provided when targets seem inconsistent with an expected trajectory of program growth?

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Appendix 26 CONGRESSIONAL NOTIFICATION

Please note that Core Team Leaders can assist with preparing this document. Please engage them in this process at least a month before your COP is due. Ideally they will complete this during their technical assistance visit.

Instructions for Executive Summary/Congressional Notification:

1. Please note that Core Team Leaders can assist with preparing this document. Please engage them in this process at least a month before your COP is due. Ideally they will complete this during their technical assistance visit.
2. Please make sure to insert two spaces after each period. The Department of State will not clear on any document that does not follow this document format of including two spaces after each period.
3. Please also use correct grammar and spell out all acronyms the first time you use them in the document, followed by the acronym in parentheses if it is used later in the document. Please write in the active voice using direct and concise language, rather than the passive voice (a useful guide to understanding the active versus passive voice is available at: <http://grammar.ccc.commnet.edu/grammar/passive.htm>).
4. Please use only UNAIDS figures for the HIV/AIDS Epidemic information. The U.S. Government officially supports UNAIDS figures on HIV/AIDS.
5. For the Targets table, please follow the footnotes that explain where to obtain data for completing the table. Leave the FY 2006 row blank and your Core Team Leader will complete this row once the 2006 Annual Report data is final.
6. Please use the template provided in the COPRS Help section. OGAC will not accept any Executive Summaries that do not follow the format provided. Please provide the document as a Word file when submitting to OGAC. PDF files will not be accepted.
7. Please do not refer to partner organizations by name in the text of the Executive Summary *except* in the summary paragraph at the end of each program area section, as indicated in the template.
8. Spell out all numbers in the text that less than 10.
9. Use the following formulation in the text when referring to fiscal years: FY 20XX (not FYXX or FY20XX).

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Sample for Executive Summary/Congressional Notification:

ETHIAMIBIA

Project Title: Ethiamibia FY 2007 Country Operational Plan (COP)

Budget Summary:

Implementing Agency	Field Programs Funding by Account			Central Programs Funding by Account		Total Dollars Allocated: Field & Central Funding
	GAP	GHAI	Subtotal: Field Programs Funding by Account	GHAI	Subtotal: Central Programs Funding by Account	
HHS	1,500,000	13,076,000	14,576,000	2,545,000	2,545,000	17,121,000
USAID	0	19,319,000	19,319,000	800,000	800,000	20,119,000
DOD	0	1,137,000	1,137,000	0	0	1,137,000
State	0	98,000	98,000	0	0	98,000
DOL	0	0	0	0	0	0
Peace Corps	0	559,000	559,000	0	0	559,000
TOTAL Approved	1,500,000	34,189,788	35,689,000	3,345,000	3,345,000	39,034,000

HIV/AIDS Epidemic in Ethiamibia:

- Adult HIV Prevalence Rate – end 2003: 22% (UNAIDS 2004)
- Estimated Number of HIV-infected People: 230,000 (UNAIDS 2004)
- Estimated Number of AIDS Orphans: 93,000 (UNAIDS 2004)

Targets to Achieve 2-7-10 Goals:

Ethiamibia	Individuals Receiving Care and Support	Individuals Receiving ART
End of FY 2004*	33,000	4,000
End of FY 2005**	55,000	5,500
End of FY 2006***		
End of FY 2007****	115,000	23,000
End of FY2008****	150,000	32,000

*Results. "Engendering Bold Leadership: The President's Emergency Plan for AIDS Relief." First Annual Report to Congress submitted by the Office of the U.S. Global AIDS Coordinator, U.S. Department of State, March 2005

**Results. "Action Today, a Foundation for Tomorrow: The President's Emergency Plan for AIDS Relief." Second Annual Report to Congress submitted by the Office of the U.S. Global AIDS Coordinator, U.S. Department of State, February, 2006

***Results. Third Annual Report to Congress submitted by the Office of the U.S. Global AIDS Coordinator, U.S. Department of State, February, 2007

****FY 2007 Country Operational Plan

Program Description:

Ethiamibia is facing its most critical health, development and humanitarian crisis to date. An estimated 15.6% of the adult population is infected with HIV (18% of adult women and 13% of adult males);

920,000 Ethiopian adults and 90,000 children are living with HIV/AIDS in a total population of 10 million people. The repercussions of the HIV/AIDS epidemic continue to loom over the nation with 750,000 individuals having died from AIDS to date, leaving behind an estimated 630,000 orphans, and the continuing loss of 89,000 persons from AIDS every year (UNAIDS, 2004).

Although Ethiopia's HIV/AIDS epidemic is mostly transmitted through heterosexual contact and from mother to child, there are clearly identifiable high-risk groups that warrant special attention: commercial sex workers and their clients and partners; uniformed personnel including military and police forces; long distance truck drivers; bus drivers; fish camp traders; migrant workers; and discordant couples. Discordant couples, where one partner is sero-positive and the other is sero-negative, are estimated to make up 21% of all married couples. Deployments and long separations from their families place members of the Ethiopian Defense Force (EDF) at high risk for exposure to HIV. Orphans and Vulnerable Children (OVCs) are particularly vulnerable to property-grabbing, homelessness, sexual exploitation, violence, abuse, and a life of abject poverty. Youth are another high-risk group, with 11.2% of females aged 15-24 years and 3.0% of males in the same age group being HIV positive, resulting from an early age of sexual debut (mean age of 17.0 years) and multiple sexual partners. Since 1985, the number of TB cases has increased dramatically. It is estimated that over 50% of TB/HIV cases are co-infected.

Emergency Plan funding will be focused on the following programmatic areas to achieve the 2-7-10 targets:

Prevention: \$7,333,480 (\$6,388,480 Field and \$945,000 Central) (22% of prevention, care and treatment budget)

Prevention activities in Ethiopia include prevention of mother-to-child transmission (PMTCT), abstinence and faithfulness programs, blood and injection safety, and other behavioral prevention initiatives, including those that focus on high-risk populations. In FY 2007, USG will partner with GOE to strengthen the scope, quality and sustainability of PMTCT services. The USG will continue to support technical capacity-building in the MOH, support technical and managerial training for PMTCT staff (110 health workers trained by September 30, 2008) and will build the capacity of FBO/CBO/NGOs to deliver high-quality, sustainable PMTCT services, including support to 500 HIV-positive women and their children. Finally, the USG will support community mobilization and IEC activities to increase awareness of and demand for PMTCT services.

The USG will continue to support high-quality behavioral change programs, including life skills programs for school youth and media-based behavior change communication programs. In FY 2007, the USG will strengthen its ongoing activities, including training youth groups, schools and faith-based organizations for effective prevention efforts in ways to reach youth and deliver messages about abstinence, and training field officers to inform, educate, and mobilize communities. Through these efforts, the USG expects to reach 10,000 young people by September 2008.

Efforts to reduce new infections among high-risk or high-transmitter groups (such as uniformed services, mobile populations, and migrant workers), including the USG-supported national behavior change communication program and condom social marketing, will be expanded and targeted to locales where high-risk activities take place. The USG will target 8,000 individuals through these mass media prevention programs.

Finally, in order to strengthen systems for blood collection, testing, storage and handling, the USG is providing financial and technical support to strengthen GOE policies and systems, to strengthen human capacity, and to provide essential supplies and equipment for blood testing in 35 service outlets by September 2008. These activities are supported through Central Program funding.

Principal Partners: Academy for Educational Development (AED), AXIOM, Ethiamibia Defense Force, Educational Development Center, Harvard School of Public Health, John Snow Incorporated, International Training and Education Center (I-TECH), Ministry of Health (MOH), Ministry of Education (MOE), National AIDS Coordinating Agency (NACA), Safe Blood For Africa, University of Medicine and Dentistry of New Jersey, Youth Health Organization (YOHO).

Care: \$9,000,180; (\$8,600,180 Field and \$400,000 Central) (27% of prevention, care and treatment budget)

Care activities in Ethiamibia include counseling and testing (CT), basic palliative care, support to integration of TB and HIV programs, and support for orphans and vulnerable children (OVC). The CT strategy for 2007 will include deliberate and focused policy dialogue to permit routine, informed consent testing of high-risk groups, including TB and STI patients and active duty military personnel, and will increase attention to assuring quality of all voluntary and routine CT services provided. In FY 2007, a modest increase of 20 new U.S. government-initiated CT sites is planned. The testing will result in 246,000 new clients/patients knowing their HIV status by September 2008.

Palliative care activities will comprise delivery of a "preventive care package" of services and support base to HIV positive individuals and their families, targeted to the needs of asymptomatic, symptomatic, and chronically ill/end-of-life population segments. The health center is considered the key catalyst for care, and as such will be the focus of training, technical assistance, quality assurance, and provision of clinical equipment and supplies during the 2007 COP. At the community level, palliative care activities will include strengthening community- and faith-based organizations to promote "positive living" and to provide psychosocial, spiritual, bed nets (where appropriate), support, nutrition, and other support to individuals and families affected by HIV and AIDS. Stigma reduction will be addressed through information, education, and communication materials targeted to health care providers, caregivers, and communities within health networks. U.S. government efforts will reach an additional 270,575 HIV positive patients with basic palliative care by September 2008.

The U.S. government will continue its collaboration with the Ministry of Health and the World Health Organization to integrate Ethiamibia's TB and HIV/AIDS programs in 23 pilot sites by September 2008. The pilot includes provider-initiated clinical and diagnostic HIV counseling and testing for all persons with TB as part of standard TB care; screening of all HIV-infected persons for active TB disease as part of routine quality clinical care of persons infected with HIV; and establishment of a strong patient referral system between TB and HIV programs for HIV-infected persons. Based on the results of the pilot, during the 2007 COP the partners will plan for expansion beginning in FY 2008.

In the 2007 COP, the U.S. government will continue to leverage use of P.L. 480 Title II resources to provide care and support to OVCs in high-prevalence areas within U.S. government-assisted health networks, and to provide non-food subsistence, psychosocial, spiritual, and education/skills development support to OVCs nationwide through FBOs and NGOs in U.S. government-assisted health networks. The U.S. government and key partners will continue to provide advocacy and education to the nascent OVC Task Force to promote development of guidelines, norms, and standards for OVC care and support in Ethiamibia. Activities launched under two central programming awards launched in 2004 are expected to complement these efforts.

Principal Partners: Ethiamibia Program Funding to: CDC, DOD, USAID, U.S. Department of State Office of Population, Refugees and Migration (PRM), International Rescue Committee (IRC), Johns Hopkins University Health Communication Programs (JHU/HCP), JHPIEGO, International Training and Education Center on HIV/AIDS (ITECH), IOCC, CRS, Management Sciences for Health, Save the Children Federation.

Treatment: \$17,000,340; (\$15,000,340 Field and \$2,000,000 Central) (51% of prevention, care and treatment budget)

Treatment activities in Ethiamibia include the provision of antiretroviral (ARV) drug and service programs as well as laboratory support. Since January 2002, Ethiamibia has been providing free ARV treatment to PLWHAs. This program has grown to 27 treatment sites with 25,839 patients currently on treatment, and by September 2008, this number is expected to increase to 35 sites with a total of 35,000 patients on treatment. With FY 2007 funds, the USG will work with the MOH to ensure a safe and secure supply of ARVs in the country by procuring ARV drugs, installing a security system at Central Medical Stores (CMS), training CMS staff on supply chain management and quality assurance, and training Drug Regulatory Unit staff in good manufacturing practices, inspections and pharmaco-vigilance. The USG will improve HIV/AIDS treatment for children and adults, working with international technical assistance partners focusing on development of guidelines, policies, and curricula; training; and monitoring and evaluation. Treatment activities will also be carried out through Central Program funding.

To strengthen the laboratory infrastructure in Ethiamibia , the USG will work with the MOH to ensure that laboratories have increased space, improved quality assurance, well-maintained laboratory equipment, a continuous supply of reagents and an improved standard of practice among laboratory staff. The USG will increase support from 100 individuals trained in lab activities in October 2007 to 225 trained by September 2008.

Principal partners: Associated Funds Administrators/Ethiamibia, APHL, Baylor University, Georgetown University, Harvard School of Public Health, I-TECH, Ministry of Local Government, Ministry of Health, and University of Pennsylvania.

Other Costs: \$5,700,000

USG support will continue to strengthen the capability of the Ministry of Health, the National AIDS Council, and other agencies, to monitor and evaluate the progress and success of Ethiamibia's national response to HIV/AIDS and of Emergency Plan achievements. These efforts will be directed at developing and implementing routine information management systems for both program reporting and patient tracking; and at ensuring the HIV/AIDS surveillance (prevalence and behavioral), population-based surveys, targeted evaluation, and policy-related analysis essential to an effective response.

Principal Partners: Ministry of Health, National AIDS Council, Ministry of Women and Coordination of Social Action, other Government of Ethiamibia agencies, Mailman School of Public Health/Columbia University, John Snow Inc., The Futures Group International, and the University of California San Francisco.

The USG is collaborating with the Ministry of Health, WHO, and other donors on a national human capacity assessment focused on health workers. Findings will inform the priority uses of the considerable USG resources provided for training and system strengthening. To help increase the number of HIV/AIDS service providers, new initiatives will expand the number of medical students specializing in HIV/AIDS treatment and set up training programs for medical technicians. FY 2006 resources also will enable the National AIDS Council to improve its technical, programmatic, and administrative management of the increasing levels of funding being mobilized for Ethiamibia's national HIV/AIDS response.

Principal Partners: Ministry of Health, National AIDS Council, Ministry of Defense, JHPIEGO, Catholic University of Ethiamibia, and the Confederation of Ethiamibian Business Associations.

Management and staffing funds will support the in-country personnel needed for USAID, HHS, State, Defense, and Peace Corps. Funds will ensure program monitoring and accountability, ensure USG policy and technical leadership within the Ethiamibia national response, and cover compensation, logistics, and office and administrative costs.

Other Donors, Global Fund Activities, Coordination Mechanisms:

The United States is the largest bilateral donor to the Ethiamibia's health sector, having provided a total of \$100 million in support in 2004, the majority of which is for HIV/AIDS prevention, care and treatment. In addition to the Global Fund, other major donors include the European Union, the United Kingdom, Belgium, Netherlands, Australia, France, Sweden and Germany. The Global Fund has approved three grants from Ethiamibia, totaling \$65 million over two years for AIDS and TB programs. The primary HIV/AIDS coordinating body is the Ethiamibian National AIDS Council (ENAC). In addition to working with ENAC, the USG meets regularly with key officials of individual Ministries (Health, Social Development, Treasury, Defense, Education and Correctional Services) to ensure that USG assistance complements and supports the Ethiamibian Government's plans for prevention, care and treatment.

Program Contact: Emergency Plan Coordinator, Jane Smith

Time Frame: FY 2007 – FY 2008

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Appendix 27 FY 2008 FUNDING PLANNED ACTIVITIES

Instructions for Congressional Budget Justification:

General Instructions:

10. The Congressional Budget Justification narratives are used to justify funding of your programs and thus should be written with care. These narratives should be viewed as an opportunity to tell good news about the work your programs are accomplishing. Please keep to a strict one-page limit with one paragraph per section as reflected in the Fredonia Example. Each paragraph should provide a general overview of the relevant program area and provide the reader with a basic understanding of your programs. It should not simply consist of a list of facts.
11. Please keep in mind that the audience for these descriptions includes the U.S. Congress and the public. Thus, you should write it with non-HIV professionals in mind. Please provide a good overview of your programs without using overly technical terms.
12. Please use the template provided in the COPRS Help section
13. For the Targets table, please follow the footnotes that explain where to obtain data for completing the table. Leave the FY 2006 row blank and your Core Team Leader will complete this row once the 2006 Annual Report data is final.
14. Please do not refer to partner organizations by name in the text of the Executive Summary *except* in the summary paragraph at the end of each program area section, as indicated in the template.
15. Please provide the document as a Word file when submitting it to OGAC. PDF files will not be accepted.

Specific Formatting Instructions:

1. Please use full sentences.
2. Please write in the active voice using direct and concise language, rather than the passive voice (a useful guide to understanding the active versus passive voice is available at: <http://grammar.ccc.commnet.edu/grammar/passive.htm>).
3. Please be sure to insert two spaces after each period.
4. Please use correct grammar and punctuation and spell out all acronyms the first time you use them in the document, followed by the acronym in parentheses if it is used later in the document (*e.g.*, antiretroviral treatment (ART)).
5. Spell out all numbers in the text that are less than 10.
6. Use the following formulation in the text when referring to fiscal years: FY 20XX (not FYXX or FY20XX).

Please note that narratives that do not follow these guidelines will not be accepted.

Fredonia FY 2008 Funding Planned Activities (\$56 million GHAI)

Fredonia is experiencing one of the most severe HIV/AIDS epidemics in the world, with the third-highest HIV-prevalence in Sub-Saharan Africa. UNAIDS estimates that 28% of adults 15-49 years of age are infected with HIV. In Fredonia, approximately 110,000 adults and children with HIV/AIDS will receive antiretroviral therapy (ART) and 425,000 individuals will receive care and support by September 2008 as a result of programs funded by the Emergency Plan.

Prevention: Prevention activities will be scaled-up through the media, community action forums, door-to-door campaigns, and peer educator programs for high-risk groups such as the military, prisoners, police, truckers, other mobile workers, and commercial sex workers. Community interventions and media will be used to target individuals in relationships with the message to “know your status” and “be faithful.” Through grants to community- and faith-based organizations (C/FBO) that work with school health clubs, youth camps, and through community outreach, more than three million primary and secondary school students will be reached with abstinence messages. The Emergency Plan also will continue to assist in the GOF’s efforts to expand access and fully integrate high quality prevention of mother-to-child transmission (PMTCT) services into routine antenatal care.

Care: Emergency Plan funds will enable the expansion of programs offering nutritional care and other support services for people living with HIV/AIDS and their households. The GOF, CBOs and FBOs will increase the provision of health services, including diagnosis and treatment of opportunistic infections, and will help people link with ART treatment sites and other services. Emergency Plan funds will be used to expand innovative counseling and testing initiatives, such as door-to-door voluntary counseling and testing (VCT), as well as increase access to routine counseling and testing services. Support will be increased to HIV/TB centers to better integrate HIV testing and treatment programs for this high-prevalence population. Work with orphans and vulnerable children (OVCs) affected or infected by HIV/AIDS will accelerate and programs will expand from supporting 300,000 OVCs as of October 2007 to 425,000 by September 2008 [check dates].

Treatment: The Emergency Plan will continue to provide technical assistance, training, supportive supervision, and commodities to 50 hospitals and health centers in the 15 regions of Fredonia. Support from the Emergency Plan will enable the opening of an estimated four additional antiretroviral sites. Emergency Plan funds also will be used to develop a sustainable, government-centered antiretroviral procurement and distribution system and provide quality technical training for health care workers administering treatment. Furthermore, the Plan will support technical assistance for monitoring for adherence, resistance, and adverse effects from therapy. The US Government will provide a projected 50% of the ARVs needed in 2008.

Other: Financial and technical assistance will be provided to strengthen strategic information systems to monitor and evaluate the effectiveness of supported programs and to assist in building sustainable national information management.

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Appendix 28 PROGRAM AREA CONTEXT

Program Area: Palliative Care: TB/HIV
 Budget Core: (HVTB)
 Program Area Code: 07

Table 3.3.07: Program Planning Overview:

Fredonia has one of the highest estimated TB rates in the world, ranking 6th among high burden countries. HIV has significantly impacted the TB problem and in 2005, there were 279,000 reported cases of TB, a rate of 599/100,000 population. This represents a 30% increase over the past 10 years. Fredonia adopted the DOTS Strategy in 1988 and all districts have now implemented the core DOTS components. Despite Government of Fredonia (GOF) investments in TB control, progress to reach program objectives is slow. For the 2003 cohort, treatment outcomes were stagnant, with a 57% cure rate for new smear positive cases and 70% successful treatment completion. The national default rate decreased slightly from 13% to 12%. Key donors to the national TB control program include the USG, Global Fund and WHO.

According to recent representative sample, 55% of TB patients in Fredonia are co-infected with HIV. The GOF Comprehensive Plan recognizes that the integration of TB and HIV services is essential to ensure that patients affected by the co-epidemics receive appropriate care and treatment. As described in the Emergency Plan Five-Year Strategy, USG efforts are consistent with the MOH and the WHO TB/HIV Framework which highlights the need for integrated programming, decreasing the burden of TB among PLWHA and increasing the HIV care available for TB patients. The emphasis of USG support is to provide HIV counseling and testing to all TB patients, to screen all HIV-infected patients for TB, to link all HIV-infected TB patients to HIV care and treatment and to link all HIV-infected TB suspects to TB diagnosis and DOTS therapy. The GOF is now linking TB activities with accredited HIV treatment sites. USG efforts directly support GOF's capacity to effectively expand collaborative TB/HIV activities, including improving access to HIV counseling and testing for TB patients, supporting recording and reporting systems for improving program management and the addressing difficulties of TB diagnoses in HIV patients.

In FY 2006 USG resources and technical assistance complemented GOF efforts in a broad range of TB/HIV activities. A "Best Practice" model of increasing access to HIV services (including routine CT, HIV care, wellness and ART) among TB patients was implemented in three provinces at 20 sites and this model will be replicated in four additional provinces at 30 sites in FY 2007 (total of 15 districts). Support for TB/HIV surveillance continues to yield valuable data for monitoring/program management. Program data will be used to benchmark quality at the facility level and coordinated supportive supervision will be used to reach quality and program targets. Ongoing activities also aim to provide additional technical and financial resources for provincial and district health authorities to increase the effectiveness of referral networks between TB and HIV services. Public-private partnerships will continue to expand access to TB/HIV services, including cotrimoxazole preventive therapy and expansion of access to ART and isoniazid preventive therapy (IPT) among PLWHA, critical interventions in the integration of patient care. (While IPT is recommended as part of the SAG Comprehensive Plan, Emergency Plan targets for IPT are relatively low due to a lack of consensus in South Africa as to its public health impact, as well as poor adherence in certain sites.) Staff support to the national TB program and/or national HIV program to enhance TB/HIV program linkages to care and treatment. National laboratory network including EQA (i.e., onsite evaluation, panel testing and blinded rechecking) will be strengthened. It is expected that FY 2007 efforts will increase the following in the 15 districts:

- Proportion of TB cases tested for HIV per district from 40% to 75%
- Proportion of HIV-infected TB patients receiving cotrimoxazole preventive therapy per district from 20% to 80%

- Proportion of HIV-infected TB patients receiving ART (first dose) per district from 10% to 40%
- Proportion of PLWHA screened for TB per district from 60% to 80%

The Emergency Plan funds a variety of programs supporting TB services represented in other COP programmatic areas, such as the University of Fredonia treatment program associated with one of the largest TB clinics in Fredonia, the Measure Evaluation project with the Libre Province Department of Health to study determinants of ARV adherence with a particular focus on TB patients, and the National TB Reference Laboratory project. The national reference laboratory is expanding its services to provide EQA (e.g., onsite supervision, blinded re-checking and panel testing) to facilities in the 15 districts with plans for further expansion in FY 2008.

An increase in resources for TB/HIV activities is programmed for FY 2007. The USG team will continue to promote the integration of TB/HIV care into core programs, and efforts to improve the standard of care for TB/HIV co-infected patients by Emergency Plan partners, particularly those in care/treatment, PMTCT and VCT.

Fredonia was awarded Round 4 TB funding by the Global Fund. Once an agreement with the Global Fund is finalized, it is anticipated that these funds will reach program level in 2006. Other major donors supporting TB/HIV activities include The Gates Foundation which funds community-based trials of new strategies to combat TB in high HIV prevalence settings and the Belgian Technical Cooperation which provides infrastructure and personnel support for expansion of TB/HIV Training Districts. USG is working closely together to ensure strong coordination and leveraging of \$2 million from USAID Child Survival funds that is provided to support the national TB program. The USG meets regularly with all TB/HIV donors to coordinate planning, oversee program implementation and ensure rational use of resources. Additionally, small teams from the TB/HIV donor coordination group conduct joint supervision of TB/HIV service sites, laboratories and M&E activities.

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Appendix 29 ACTIVITY NARRATIVE

Program Area: Counseling and Testing
 Budget Core: (HVCT)
 Program Area Code: 06

Table 3.3.9: Program Planning: Activities by Funding Mechanism

Mechanism/Prime Partner:	USAID/HIV/AIDS Project/Partnership for a Better World
Planned Funds:	\$750,000

Activity Narrative:

This activity also relates to activities in Counseling & Testing (#0631), TB/HIV (#0724) and PMTCT (#0158).

This activity has several different components. One component is to provide comprehensive counseling and testing, through both stand-alone and integrated VCT services within hospital settings. Five mission hospitals will be supported in the provision of counseling and testing for diagnostic purposes for high numbers of in-patients and out-patients. Routine counseling and testing will be offered to the following principal target populations: pregnant women and TB patients. Additionally, VCT centers are being established at each hospital to promote self-referral for counseling and testing by the general public, including community outreach for uptake of services. This funding will go specifically to support the procurement of test kits, the renovation of the site locations at the hospitals to become VCT centers, the training of staff at the hospitals in providing counseling and testing, and the training of supervisory staff at the hospital in ensuring a minimum quality standard for services. This component of the activity will provide support for five service outlets, work to train 28 individuals in counseling and testing, and provide counseling and testing services to an estimated 5,000 individuals.

The second component of this activity is support for the Fredonia City Multi Purpose Center. This Multi Purpose Center aims to provide high quality HIV testing and counseling services to the Fredonia City community; to strengthen and expand counseling and other psychological support services and to strengthen and expand testing services; and to support post test clubs that are designed to decrease stigma and discrimination experienced by PLWHA's. This funding for the Multi Purpose Center will go to principally address the following emphasis areas: staffing, infrastructure support, training VCT staff and Multi Purpose Center volunteers, sponsorship of public speaking opportunities for community educators, and outreach to the Fredonia City community and workplaces. Specific target populations of the Multi Purpose Center include the Fredonia City community: adults, boys and girls, out-of-school youth, street youth, orphans and vulnerable children and people living with HIV/AIDS. The Multi Purpose Center was designed as a place that would bring all members of the community together in order to provide services and reduce the stigma (key legislative issue) surrounding HIV/AIDS. This component of the activity will provide support for one service outlet, work to train 12 individuals in counseling and testing, and provide counseling and testing services to an estimated 2,500 individuals.

The final component of this activity is a link to activity number #0631 in this program area. This partner will continue ongoing work with a USG supported training NGO which supports VCT by implementing an integrated counseling program to ensure effective VCT services through training and supervision of trainers/counselors in VCT. These two partners will work together to continue to build the capacity of NGO/FBOs and the MOH by training staff and volunteers to meet the increasing demand for counseling services in rapidly expanding VCT services. This component of the activity will work to train 100 individuals in counseling and testing.

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Appendix 30 EXPLANATION OF TARGETS CALCULATIONS

Explanation of Table 2 Downstream (Direct) / Upstream (Indirect) Targets

NOTE: All targets for FY2008 assume that Ethiamibia will receive an increase in budget in FY2008 comparable to the increase received in FY 2007.

1. Number of pregnant women receiving a complete course of antiretroviral prophylaxis for PMTCT

FY 2007	Direct=2,259	Upstream (indirect)=0
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Explanation of Calculation: The downstream (direct) target is an estimate based on the number of pregnant women who received HIV counseling and testing for PMTCT and received their test results according to the national HIS between July 2005 and June 2006 (10,122 women). It further assumes that uptake of PMTCT services will continue to increase at its current rate (doubling each year). It assumes an HIV prevalence of 12.4% (2004 national ANC surveillance) among pregnant women, assumes all HIV+ pregnant women will be identified, and that 90% of those pregnant women who are HIV+ receive a complete course of ARV prophylaxis.

$$[10,122 \times 2] \times 12.4\% \text{ prevalence} \times 90\% = 2,259$$

Explanation of Support: The downstream (direct) target of 2,259 women is also the national target for Ethiamibia. The USG provides downstream (direct) support to all women who receive a complete course of ARV prophylaxis in Ethiamibia through the following activities:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public facilities² in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing PMTCT services.
- Purchase of ARVs and payment for lab tests.

The USG also provides various kinds of upstream (indirect) support for PMTCT services, but since the USG target is the same as the national target for women receiving a complete course of ARV prophylaxis in the public sector, USG upstream (indirect) support is listed as 0.

FY 2008:	Direct: 4,769	Upstream (indirect): 0
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Explanation of Calculation: The downstream (direct) target is an estimate based on the number of pregnant women who received HIV counseling and testing for PMTCT and received their test results according to the national HIS between July 2005 and June 2006 (10,122 women). It further assumes that uptake of PMTCT services will continue to increase at its current rate (doubling each year). It assumes an HIV prevalence of 12.4% (2005 national ANC surveillance) among pregnant women, assumes all HIV+ pregnant women will be identified, and that 95% of those pregnant women who are HIV+ receive a complete course of ARV prophylaxis.

² The public hospital system includes five Mission (faith-based) hospitals. Although these five hospitals are managed by faith-based organizations, they are fully integrated into the GOE public hospital system and are considered to be public hospitals. Wherever the term 'public hospital' appears in this document it includes these five Mission (faith-based) hospitals.

$$[20,244 \times 2] \times 12.4\% \text{ prevalence} \times 95\% = 4,769$$

Explanation of Support: The downstream (direct) target of 4,769 women is also the national target for Ethiamibia. The USG will continue to provide downstream (direct) support to all women who receive a complete course of ARV prophylaxis in Ethiamibia in the public sector through the following activities:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public facilities in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing PMTCT services.
- Purchase of ARVs and payment for lab tests.

The USG also provides various kinds of upstream (indirect) support for PMTCT services, but since the USG target is the same as the national target for women receiving a complete course of ARV prophylaxis in the public sector, USG upstream (indirect) support is listed as 0.

2. Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test results.

FY 2007	Direct: 20,244	Upstream (indirect): 0
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Explanation of Calculation: The downstream (direct) target is an estimate based on the number of pregnant women who received HIV counseling and testing for PMTCT and received their test results according to the national HIS between July 2005 and June 2006 (10,122 women). It assumes that uptake of PMTCT services will continue to increase at its current rate (doubling each year).

$$10,122 \times 2 = 20,244$$

Explanation of Support: The downstream (direct) target of 20,244 women is also the national target for Ethiamibia. The USG provides downstream (direct) support to all women who receive PMTCT services in the public sector in Ethiamibia through the following activities:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public facilities in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing PMTCT services.

The USG also provides various kinds of upstream (indirect) support for PMTCT services, but since the USG target is the same as the national target for women receiving a complete course of ARV prophylaxis in the public sector, USG upstream (indirect) support is listed as 0.

FY 2008	Direct: 40,488	Upstream (indirect): 0
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Explanation of Calculation: The downstream (direct) target is an estimate based on the number of pregnant women who received HIV counseling and testing for PMTCT and received their test results according to the national HIS between July 2005 and June 2006 (10,122 women). It assumes that uptake of PMTCT services will continue to increase at its current rate (doubling each year).

$$20,244 \text{ women} \times 2 = 40,488$$

Explanation of Support: The downstream (direct) target of 40,488 women is also the national target for Ethiamibia. The USG provides downstream (direct) support to all women who receive PMTCT services in the public sector in Ethiamibia through the following activities:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public hospitals in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing PMTCT services.

The USG also provides various kinds of upstream (indirect) support for PMTCT services, but since the USG target is the same as the national target for women receiving a complete course of ARV prophylaxis in the public sector, USG upstream (indirect) support is listed as 0.

3. *Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for TB*

FY 2007	Direct: 38,927	Upstream (indirect): 0
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Explanation of Calculation:

Facility-based care – According to the national HIS, for every three HIV+ people evaluated in public health facilities, two are eligible for treatment and one is enrolled in ongoing clinical care because they are not yet eligible for treatment.

Number of individual enrolled in clinical care (15,000 on treatment x 1.5) = 22,500

Community and home-based care – Since by the end of FY 2007 the USG will have expended approximately half of FY 2006 funds during the first half of the FY 2007 implementation period (approximately April 1, 2007 – March 31, 2008), these targets are estimated to be approximately the difference between the targets achieved by the end of FY 2006 and those estimated to be achieved during the FY 2007 implementation period. The targets are as follows:

Indicator	FY 2006 funding target	FY 2007 funding target	Difference	Target as of September 30, 2007
# of people receiving home-based care	9,400	15,300	5,900	12,350
# HIV+ people receiving nutritional supplementation	4,000	5,100	1,100	4,550
Number of PLWHAs receiving legal advice and support	2,000	6,500	4,500	4,250
TOTAL				21,150

22,500 (clinical) + 21,150 (home/community) = 43,650 total

There will undoubtedly be some duplication between clients seen in the clinical setting and those seen in a home/community-based care setting. It is estimated that this duplication is between 8-10%.

43,650 x 10% = 39,285

There is also some overlap in terms of TB clients who are also receiving other Palliative Care services through either clinical or home/community based sites. It is estimated that this overlap is between 5-7% of those receiving treatment for TB.

$$39,285 - [5,120 \times 7\%] = 38,927$$

The USG also provides upstream (indirect) support to palliative care through a number of activities, but given available information it is not possible to assign an amount to this upstream (indirect) support. Upstream (indirect) support will therefore remain at 0.

FY 2008	Direct: 62,327	Upstream (indirect): 0
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Explanation of Calculation:

Facility-based care – According to the national HIS, for every three HIV+ people evaluated in public health facilities, two is eligible for treatment and two are enrolled in ongoing clinical care because they are not yet eligible for treatment.

$$\text{Number of individual enrolled in clinical care (26,500 on treatment} \times 1.5) = 39,750$$

Community and home-based care – During FY 2007 the USG plans to focus on quality in its home and community-based care programs. With regional TA assistance and the participation of the African Palliative Care Assistance we will focus on improving the quality and variety of services provided to clients. For this reason we do not expect our FY2008 target to increase by the same amount as our FY 2007 target. Also as service quality and reporting improves there will be an increasing amount of people who will receive both clinical and community/home-based care.

$$39,750 \text{ clinical} + 30,000 \text{ community/home-based care} = 69,750$$

There will undoubtedly be some duplication between clients seen in the clinical setting and those seen in a home/community-based care setting. It is estimated that this duplication is between 8-10%.

$$69,750 \times 10\% = 6,775$$

There is also some overlap in terms of TB clients who are also receiving other Palliative Care services through either clinical or home/community based sites. It is estimated that this overlap is between 5-7% of those receiving treatment for TB.

$$62,775 - [6,400 \times 7\%] = 62,327$$

The USG also provides upstream (indirect) support to palliative care through a number of activities, but given available information it is not possible to assign an amount to this upstream (indirect) support. Upstream (indirect) support will therefore remain at 0.

4. *Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the reporting period*

FY 2007	Direct: 5,120	Upstream (indirect): 0
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Explanation of Calculation: The downstream (direct) target is calculated based on data and assumptions from the national HIS. According to the HIS, approximately 66% (see activity 3894) of HIV+ people assessed in health facilities are eligible to begin treatment. Those not yet eligible for treatment are enrolled in ongoing clinical care and treatment for OIs. According to HIS records the

co-infection rate (and thus TB treatment rate) is estimated at 22% for patients newly on treatment this year, at 18% for those who have been on treatment since the previous year, and at 9% for those who have never been on treatment.

11,000 newly on treatment (22%) + 10,000 who have been on treatment for a year (18%) + 10,000 never on treatment (9%) = 5,120

Explanation of Support: The downstream (direct) target of 5,120 is also the national target for Ethiamibia. The USG provides downstream (direct) support to all people who receive TB treatment in the public sector in Ethiamibia through the following activities:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public hospitals in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing ART/OI services.

The USG also provides various kinds of upstream (indirect) support for TB services, but since the USG target is the same as the national, USG upstream (indirect) support is listed as 0.

FY 2008	Direct: 6,400	Upstream (indirect): 0
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Explanation of Calculation: The downstream (direct) target is calculated based on data and assumptions from the national HIS. According to the HIS, approximately 66% of HIV+ people assessed in health facilities are eligible to begin treatment. Those not yet eligible for treatment are enrolled in ongoing clinical care and treatment for OIs. According to HIS records the co-infection rate (and thus TB treatment rate) is estimated at 18% for patients newly on treatment this year, at 14% for those who have been on treatment since the previous year, and at 8% for those who have never been on treatment. These co-infection rates are lower than estimated in FY 2007 because it is assumed that treatment and prevention of HIV will reduce co-infection rates.

13,000 newly on treatment (18%) + 20,000 who have been on treatment for a year (14%) + 15,750 never on treatment (8%) = 6,400

Explanation of Support: The downstream (direct) target of 6,400 is also the national target for Ethiamibia. The USG provides downstream (direct) support to all people who receive TB treatment in the public sector in Ethiamibia through the following activities:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public hospitals in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing ART/OI services.

The USG also provides various kinds of upstream (indirect) support for TB services, but since the USG target is the same as the national, USG upstream (indirect) support is listed as 0.

5. Number of OVC served by an OVC program during the reporting period

FY 2007	Direct: 32,500	Upstream (indirect): 83,100
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Explanation of Calculation: – downstream (direct): Since by the end of FY 2007 the USG will have expended approximately half of FY 2007 funds during the first half of the FY 2007 implementation period (approximately April 1, 2007 – March 31, 2008), these targets are estimated to be

approximately the difference between the targets achieved by the end of FY 2006 and those estimated to be achieved during the FY 2007 implementation period.

FY 2006 COP target: 20,000

FY 2007 COP target: 45,000

Difference: 25,000

End FY 2007 target is therefore $45,000 - (.5 \times 25,000) = 32,500$

Upstream (indirect): Total number of OVC in Ethiamibia in 2007 as estimated by a 2003 MoH/UNICEF report = 115,600

$115,600 - \text{Number of OVC receiving downstream (direct) support (32,500)} = 83,100$

Explanation of Support:

Direct: Through home-and-family-based care programs the USG will directly reach OVC with a range of services including: psychosocial support, targeted nutritional supplementation, home-based care services, support for staying in school (school fees, books, uniforms, advocacy etc.), job training and income generation. Using the information gained from the two OVC databases (see below), with FY 2007 funds USG will support the Urban Trust of Ethiamibia (UTE) to train and fund Community-Based Volunteers to initiate school/community/parental initiatives in six target education regions of northern Ethiamibia to provide after-school mentoring and tutoring, extra-curricular activities for OVC, and training for OVC caregivers.

Upstream (indirect):

- Coordination of the national OVC Permanent Task Force. The four working groups of the Task Force guide OVC policy and programming decisions at a national level.
- Streamlining of process for OVC and their caregivers to access the funding set aside in government social grants.
- Capacity building and maintenance of the national OVC registry in support of the MGECW (see below). The registry was created with USG support and will be used to register all OVC in Ethiamibia to ensure that their needs are being met.
- USG, working closely with the Ministry of Education HIV/AIDS Unit (HAMU), the Ministry's Education Management Information System (EMIS) Unit, and the Ministry of Gender Equality and Child Welfare (MGECW), has begun to develop a school-focused OVC database that will provide information on the educational status and outcomes of HIV/AIDS-related OVC, and their access to CBO or NGO support initiatives.

FY 2007	Downstream (Direct): 50,000	Upstream (indirect): 65,600
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Explanation of Calculation:

Direct: It is estimated that in FY2008 the USG will further scale up activities to reach a total of 50,000 OVC with downstream (direct) support.

Upstream (indirect): Total number of OVC in Ethiamibia in 2008 as estimated by a 2003 MoH/UNICEF report = 115,600

$115,600 - \text{Number of OVC receiving downstream (direct) support (50,000)} = 65,600$

Explanation of Support: See above explanation for FY 2007 OVC targets.

6. *Number of individuals who received counseling and testing for HIV and received their test results.*

FY 2007	Downstream (Direct): 112,800	Upstream (Indirect): 0
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Explanation of Calculation:

The formula provided in Appendix 6.2 was used to calculate targets. Through downstream (direct) support, the USG provides counsel and test approximately 60% of the target.

Steps:

1. CT ARV target
25,000 (New ART patients) – 1,500 (PMTCT) = 23,500
2. Number needing CT in medical facilities
 $\frac{23,500 \text{ (CT ARV target)} \times 80\% \text{ (percentage of people tested by medical facilities)}}{40\% \text{ (%HIV positive in medical facilities)} \times 50\% \text{ (%ARV eligible in medical facilities)}} = \frac{18,800}{0.2}$
Total = 94,000
3. Number needing CT in VCT facilities
 $\frac{23,500 \text{ (CT ARV target)} \times 20\% \text{ (percentage of people tested by VCT)}}{20\% \text{ (%HIV positive in VCT)} \times 25\% \text{ (%ARV eligible in VCT)}} = \frac{4,700}{.05}$
Total = 94,000
4. 94,000 + 94,000 = 188,000
5. 188,000 x 60% = 112,800

FY 2008	Downstream (Direct): 151,200	Upstream (Indirect): 0
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Explanation of Calculation:

The formula provided in Appendix 6.2 was used to calculate targets. Through downstream (direct) support, the USG provides counsel and test approximately 60% of the target.

Steps:

6. CT ARV target
35,000 (New ART patients) – 3,500 (PMTCT) = 31,500
7. Number needing CT in medical facilities
 $\frac{31,500 \text{ (CT ARV target)} \times 80\% \text{ (percentage of people tested by medical facilities)}}{40\% \text{ (%HIV positive in medical facilities)} \times 50\% \text{ (%ARV eligible in medical facilities)}} = \frac{25,200}{0.2}$
Total = 126,000
8. Number needing CT in VCT facilities
 $\frac{31,500 \text{ (CT ARV target)} \times 20\% \text{ (percentage of people tested by VCT)}}{20\% \text{ (%HIV positive in VCT)} \times 25\% \text{ (%ARV eligible in VCT)}} = \frac{6,300}{.05}$
Total = 126,000
9. 126,000 + 126,000 = 252,000
10. 252,000 x 60% = 151,200

7. Number of individuals receiving ART at the end of the reporting period

FY 2007	Downstream (Direct): 19,500	Upstream (Indirect): 0
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Explanation of Calculation: Based on current uptake of services according to the HIS, assuming a net increase in number of clients of 9,000, and a predicted 10% drop-out rate = 18,000 public sector. An additional 1,500 clients are counted in the private sector.

Explanation of Support:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public hospitals in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing PMTCT services.
- Purchase of ARVs and payment for lab tests
- Support and training for members of the HIV Clinicians Society (public & private sector clinicians)

The USG also provides various kinds of upstream (indirect) support for ARV services, but since the USG target is the same as the national target, USG upstream (indirect) support is listed as 0.

FY 2008	Direct: 31,350	Upstream (indirect): 0
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Explanation of Calculation: Based on current uptake of services according to the HIS, assuming a net increase in number of clients of 12,000, and assuming a drop-out rate of 10% = 28,350 public sector. An additional 3,000 clients are counted in the private sector.

Explanation of Support:

- Training and salary support for medical staff (doctors, nurses, pharmacists and pharmacist's assistants, and medical records clerks) to supplement the existing staff in public hospitals in the scale up of the national ART and PMTCT programs.
- Training of all medical staff in public facilities that are trained in providing ARV services.
- Support and training for members of the HIV Clinicians Society (public & private sector clinicians)

The USG also provides various kinds of upstream (indirect) support for ARV services, but since the USG target is the same as the national target, USG upstream (indirect) support is listed as 0.

Explanation of downstream (direct) Summary Targets by Program Area

Prevention of Mother to Child Transmission

1. *Number of service outlets providing the minimum package of PMTCT services according to national and international standards (100)* – Total number of PMTCT service sites in Ethiamibia are listed under activity #3882. All other activity targets are part of these 100.
2. *Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results (30,500)* – Target under activity #3882 is the program area target. All other activity targets are part of these 37,500.
3. *Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting (3,500)* – Total program area target is listed under activity #3882. All other activity level targets are part of these 3,500.
4. *Number of health workers newly trained in the provision of PMTCT services according to national and international standards (385)* – No duplication among listed targets.

Prevention/Abstinence and Being Faithful

1. *Number of individuals reached through community outreach that promotes HIV/AIDS prevention through promotion of abstinence and being faithful (320,000)* – Although most of the activities in this program area target different groups (military, general population of Northeast region, high-risk girls in border areas, community action forums in 17 communities, members of Catholic, Evangelical Lutheran and Anglican Churches) it is anticipated that there will be some overlap in certain political regions, most notably the Lake, Northern and Oshipa regions where Total Control of the Epidemic (TCE) activities (#3927) will target 90,000 members of the general population of these regions through door-to-door AB educational activities. In addition, under activity #4048 (JHU) will target members in areas of 17 of Ethiamibia's larger communities, also resulting in

likely overlap with other activities. For both activities #3927 and #4048 overlap is most likely with activities conducted by the Catholic (#4720), Evangelical Lutheran (#4720) and Anglican Churches (#3773) who are all working in their respective congregations/parishes throughout all of Ethiamibia. Straight addition of all activity level targets is 371,900, but to account for potential duplication of people reached we estimate that the total program area target should be approximately 320,000.

2. *Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (40,000)* – Similar to the target above, we expect there will be a limited amount of overlap in targets between the proposed activities. Addition of all activity level targets in this program area is 48,500 but to account for overlap we are estimating a total of 40,000 people reached.
3. *Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful (2673)* – Program area total is sum of all activity level targets.

Blood Safety

1. Number of individuals trained in blood safety (**65**) – No overlap expected.
2. Number of service outlets/programs carrying out blood safety activities (**7**) – Only one activity contributes to this target.

Injection Safety

Only one activity in this program area.

Condoms and Other Prevention

1. *Number of targeted condom service outlets (459)* – No duplication of outlets across activity level targets.
2. *Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful (200,000)* – The simple sum of all activity level targets in this program area is 221,840. As under A/B activities above, the activities in this program area largely target different populations (Military, high-risk girls, workplace interventions, people who practice risky sex, etc.) there is expected to be a limited amount of overlap in the number of people reached. Peace Corps (#3784) volunteers are usually placed in sites where other USG partners are already working in order to support existing activities. There may be some overlap in the Northwest region between activities #3880, #4726, and #4749. As well as some overlap between activities #3931 and #4749 in the Lake and Oshipa regions. For these reasons the total number of people reached under this program area is estimated at 200,000.
3. *Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and being faithful (1980)* – No duplication anticipated across activity level targets.

Palliative Care: Basic Health Care and Support

1. *Number of service outlets providing HIV-related palliative care (excluding TB/HIV) (286)* – Breakdown of service outlets is as follows:
 - a. *Government/faith-based hospitals – 29 sites*
 - b. *Home and community based care outlets – 240 sites*
 - c. *New Start Counseling and Testing Centers - 14 sites*
 - d. *Military service outlets - 3*
2. *Number of individuals provided with HIV-related palliative care (excluding TB/HIV) (51,000)* – It is estimated that 10% of clients receiving palliative care services at the five faith-based hospitals (500) are also receiving HBC services from the faith-based organizations affiliated with those hospitals. It is also expected that there will be an overlap in clients between those receiving E'pap at New Start CT sites, because they work closely with, and clients may be referred to them by, health facilities in the same community. A sum of all the activity level targets is 53,000

people reached. Due to the expected areas of overlap described above the total for this program area is being estimated at 51,000.

3. *Number of individuals trained to provide HIV palliative care (excluding TB/HIV) (4,250)* – No overlap is expected in number of people trained.

Palliative Care: TB/HIV

1. *Number of service outlets providing clinical prophylaxis and/or treatment for TB to HIV-infected individuals in a palliative care setting (34)* – There is only one activity that addresses this target in this program area.
2. *Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (5,120)* - There is only one activity that addresses this target in this program area.
3. *Number of HIV-infected clients given TB preventive therapy - (4,485)* - There is only one activity that addresses this target in this program area.
4. *Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (250)* – Number of people trained discussed under both activities in this program area are the same individuals.

Orphans and Vulnerable Children

1. *Number of OVC served by OVC programs (48,000)* – An estimated 25% of OVC being reached under activity #3780 are expected to overlap with those reached under activity #4750, once this Track 1 activity gets underway. Most of the OVC reached under Project Hope activity #3779 will have been identified in collaboration with sub-grantees under activity #3780, who are already working with these individual OVC. Activity #3781 will focus on northern regions where the largest numbers of OVC are located. As the precise schools that will benefit from the activity have not yet been selected, it is not possible to know if there will be overlap between OVC reached through these programs and those reached through activity #3780, although some degree of overlap is expected. For the reasons explained above it is estimated that the total number of OVC reached under this program area is 48,000, rather than the simple sum of all activity level targets which would be 53,556 OVC.
2. *Number of providers/caretakers trained in caring for OVC (4,198)* – Overlap across activities is not expected.

Counseling and Testing

1. *Number of service outlets providing counseling and testing according to national and international standards (119)* – Total MoH/Faith-based hospital sites (100) + Total freestanding/mobile sites (19) = 119 total sites.
2. *Number of individuals who received counseling and testing for HIV and received their test results (133,000)* – The 13,000 people tested under activity #4736 are also included under activity #3926.
3. *Number of individuals trained in counseling and testing for HIV according to national and international standards (970)* – The 290 individuals trained under activity #3897 are also included under activity #3868.

HIV/AIDS Treatment/ARV Drugs

There are no indicators for this program area.

HIV/AIDS Treatment/ ARV Services

1. *Number of service outlets providing ART (34)* – Total program area target is taken from activity #3876. All other activity level targets are a portion of the same 34 sites.
2. *Number of individuals newly initiating ART during the reporting period (12,500)* – Total program area target is taken from activity #3876. All other activity level targets are a portion of the same 35 sites.

3. *Number of individuals who ever received ARV by the end of the reporting period (32,900)* – Total program area target is taken from activity #3876. All other activity level targets are a portion of the same 32,900.
4. *Number of individuals receiving ART at the end of the reporting period (29,600)* – Total program area target is taken from activity #3876. All other activity level targets are a portion of the same 29,600.
5. *Number of health care workers trained to deliver ART services, according to national and/or international standards (1,525)* – No overlap anticipated across activities.

Lab Infrastructure

1. *Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 and/or lymphocyte tests (4)* – All other targets are part of this 4.
2. *Number of individuals trained in the provision of laboratory-related activities (74)* – No overlap expected across activities.

Strategic Information

1. *Number of local organizations provided with technical assistance for SI activities (58)* – Several activities provide support to the same organizations, most notably the MoH. Local organizations receiving TA are: 19 Community Action Forums, MIB, MoH, 13 RACOCs, the University of Ethiamibia, Medicines Control Council, Central Medical Stores, Regional Medical Stores, and 20 USG sub-partners.
2. *Number of individuals trained in strategic information (757)* – No overlap is anticipated across activities.

Other/Policy Analysis and Systems Strengthening

1. *Number of local organizations provided with TA for HIV-related policy development (47)* – MoH, Ministry of Defense, five faith-based hospitals, 40 CBOs = 47
2. *Number of local organizations provided with TA for HIV-related institutional capacity building (123)* – Medicines Control Council, MoH, University of Ethiamibia, 20 USG sub-partners (NGOs/FBOs), five FBO hospitals, 95 TBD CBOs = 123
3. *Number of individuals trained in HIV-related policy (137)* – No overlap expected across activity level targets.
4. *Number of individuals trained in HIV-related institutional capacity building (610)* – No overlap expected across activity level targets.
5. *Number of individuals trained in HIV-related stigma and discrimination reduction (1985)* – No overlap expected across activity level targets.
6. *Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment (3,108)* - No overlap expected across activity level targets.

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Appendix 31 GFATM SUPPLEMENTAL

USG Ethiamibia Response FY 2007 Support to Global Fund HIV/AIDS Grants

TOTAL FY 2007 COP - \$325,000

USG Ethiamibia has allocated \$325,000 in COP FY 2007 to our Enabling Environment partner, ASSURE, to support Global Fund grant implementation. The final details of this support are still being negotiated. Possible assistance may include embedded staff in the Country Coordinating Mechanism (CCM) secretariat, external short term technical assistance to the CCM or the Principal Recipients (PRs), management training, or support for specific program elements identified by the Country Implementation Support Team (CIST).

In collaboration with the Global Fund in-country entities -- PR, CCM, or sub-recipient (SR) -- the USG team will identify specific activities that will assist primarily with systems strengthening. In addition, the USG has expressed a desire to participate on one or more of the technical sub-committees (such as monitoring and evaluation) and could provide specific support in that capacity.

Apart from the regular -- and at times, extensive -- in-country technical assistance (TA) that is provided to the CCM, PRs and the SRs by program managers, the General Development Officer, and the HIV/AIDS Team Leader, there are no other sources of funding for the Global Fund in our budget.

Currently the USG:

- Is a voting member on the CCM
- Actively participates in the CIST
- Provides informal secretariat support for CCM meetings
- Provides in-country TA to write, select, and submit grant applications
- Provides upstream (indirect) support to the PRs and SRs through our implementing partners for activities such as logistics systems strengthening, development and implementation of M&E systems, and national surveillance activities

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Appendix 32 JUSTIFICATION FOR BUDGETARY REQUIREMENTS

There are justifications for why a country would not be able to reach any mandatory budgetary requirement (AB, OVC or Treatment). Possible justifications for each of the budgetary requirements are listed below. If you feel that you have a justification that is not listed below, please contact your Core Team Leader. An example of a justification for not meeting the treatment budgetary requirement is also shown below.

For those of you wishing to submit a request for waiving a budgetary requirement, please submit this justification with your COP as an uploaded supplementary document.

1. *Please complete the template for each budgetary requirement as applicable.*
 - *50% sexual transmission*
 - *66% AB*
 - *10% OVC*
 - *55% ART*
 - *8% to any one partner*
2. *Note that the justification should not be longer than 3 pages. Line D (tradeoff or cost to program) is very relevant to the discussion; please provide detail in this section.*
3. *The Program Services Team is available by phone should you have any question or need of assistance. Please do not hesitate to call us!*

COUNTRY: FREDONIA

BUDGETARY REQUIREMENT: 66% AB

A) CONTEXT

The youth of Fredonia, in contrast to many other countries, are not sexually active at an early age. The 2002 Fredonia Demographic and Health Survey found the age of first sexual intercourse and the age of marriage to be essentially the same, 20 years.

Sexual transmission, mostly through commercial sex, has largely determined the course of the Fredonia HIV/AIDS epidemic in the early and mid-1990s, producing 90% of new infections in 1990 and 70% in 1995. Data and modeling exercises suggest that the epidemic is becoming more generalized, with HIV spreading from male clients to their non-commercial sexual partners (i.e. their wives and 'sweethearts'). According to a 2004 health survey conducted by the Fredonia Ministry of Health (FMOH), condom use among male sentinel groups (military, police and taxi drivers) with 'sweethearts' remains low at 23-40.2%. Condom use by sex workers with their 'sweethearts' is also relatively low at 43.8% when compared to condom use with clients. Reported condom use by female sex workers with clients is 83.4-92% and condom use by clients with female sex workers is 81.4-90.2%. Female sex workers continue to have the highest HIV infection rates with 24.8% of brothel-based female sex workers being infected, 15.7% of female beer promoters in comparison to 2.5% of police and 1.2% of pregnant women who attended ANC.

Fredonian society tolerates men, including those who are married, visiting brothels; and when visiting brothels is coupled with power imbalances between men and women, the biggest risk factor for HIV infection among married women is being married. Traditional gender roles often prevent women from talking about sex or negotiating condom use with their partners and promoting fidelity within marriage.

The success of the HIV/AIDS program in Fredonia is largely due to the Government of Fredonia's (GOF) recognition that men visiting sex workers and men's reluctance to use condoms with sex workers have been the main drivers behind the epidemic. The GOF, with assistance from the U.S. Government and other donors, has included a major focus on partner reduction and correct and consistent condom use with high risk partners. The subsequent reduction in general population prevalence rates from 3.0% in 1997 to 1.9% in 2004 clearly supports that this as an effective prevention strategy.

B) WHAT IS THE PLANNED PERCENTAGE FOR THE BUDGETARY REQUIREMENT AND HOW DOES IT COMPARE TO FY05?

The planned FY 2007 percentage for the AB budgetary requirement is 51% and in FY 2006 it was 23%.

C) WHERE ARE YOU IN MEETING YOUR OTHER BUDGETARY REQUIREMENTS (e.g. OVC, ART)?

Fredonia will meet the FY 2007 budgetary requirements for sexual prevention at 50%, but will not meet the other budgetary requirements. The program has only planned to direct 8% of funds toward OVCs, given that HIV/AIDS prevalence rate in the general population is low and the number of OVCs is rather minimal (see the request for waiving the OVC budgetary requirement document), and 51% of funds toward treatment (see the request for waiving the treatment budgetary requirement document).

D) WHAT HAS BEEN THE TRADE OFF OR COST TO YOUR PROGRAM TO REACH THE CURRENT BUDGETARY REQUIREMENT?

As described in The President's Emergency Plan for AIDS Relief, U.S. Five-Year Global HIV/AIDS Strategy for Fredonia, USG Fredonia will continue to work with the GOF on the implementation of interventions that are coordinated with Fredonia's national HIV/AIDS strategy, evidence-based and responsive to local needs and circumstance. As stated in the five-year strategy, *prevention remains the primary strategy to combat HIV/AIDS* -- Fredonia has taken this message to heart by targeting programming on interventions that have been proven effective in reducing HIV prevalence.

Four factors influence prevention programming in Fredonia: the relatively late age of sexual debut and marriage; the generalized nature of Fredonia's HIV epidemic; the documented successes of the GOF's prevention strategy targeting interventions to MARPs, especially sex workers; and the large, fixed amount of funding for medical transmission (Track 1.0). If 66% of the sexual transmission prevention budget were spent on AB, then continued success in preventing new HIV infections would be constrained because funding targeting sex workers and their clients would be reduced. Additionally, both PMTCT and MARPs programs would need to be reduced to the point of stopping services to those already receiving services.

AB interventions have and will continue to be an important part of the USG Fredonia HIV/AIDS program, but need to be implemented on a scale that is evidence-based and responsive to local needs and circumstances.

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Appendix 33 JUSTIFICATION FOR PRIME PARTNER EXCEEDING 8%

FY 2007 COP EXAMPLE Request to Waive 8% Funding Limit to Any One Partner

For those of you wishing to submit a request for waiving a budgetary requirement, please submit this justification with your COP as an uploaded supplementary document.

1. Please complete the template for each budgetary requirement as applicable.

- **50% sexual transmission**
- **66% AB**
- **10% OVC**
- **55% ART**
- **8% to any one partner**

2. Note that the justification should not be longer than 3 pages. Line D (pipeline information) is very relevant to the discussion; please provide detail in this section.

3. The Program Services Team is available by phone should you have any question or need of assistance. Please do not hesitate to call us!

COUNTRY: FREDONIA

BUDGETARY REQUIREMENT: 8% to any one partner

A) Context: (state role of the organization)

The Truckers for Life Project, implemented by Healthy People Services International (HPSI) provides HIV/AIDS prevention education, outreach and counseling and testing services to high-risk populations in 10 transport corridor cities. This is a unique project that fills an important gap. It addresses vulnerable communities in and around transport corridors – areas that were not being addressed by any other program or donor. These are potential high-risk situations where millions of casual workers are employed. The program had an external mid-term evaluation in March 2006 that was very positive, stating that the project was an excellent opportunity for USG to testing innovative models. The evaluation also recommended continuation of activities in all the transport corridors.

B) What is the planned percentage for FY 2007 and how does it compare to FY 2006?

Of the total budget FY 2007 of \$71.9 million, HPSI funding level will be \$7.2 million, which is 10% for FY 2007 total allocation. This represents a drop in funding from the FY 2006 level of \$8.5 million or 15% of the total \$56.9 million USG budget.

This is the last year of planned funding for this partner. A new funding mechanism will need to be developed for any future funding. Furthermore, the scope of work will change from

implementation to capacity building of local partners to continue prevention efforts of the project.

C) How is the performance of the organization in terms of achieving targets?

Performance has been good. For the period October 2005 - July 2006, indicators show an increase in preventive behavior and knowledge in specified areas; and 18,931 men counseled received their results. Data shows that 89% of counselors follow standard counseling protocols.

D) Provide some brief financial information that may contribute to the rationale. For example, what is their pipeline? How cost-efficient are they relative to other implementing partners?

The current request is a reduction in funding from FY 2006. There is minimal funding available in the program's pipeline because of high demand for cost outlay; their FY 2006 pipeline will carry them for four months. Many of the project sites are new and funds were used to set up direct service delivery outlets. This model also requires a more intensive level of infrastructure support and staff training for high quality communication interventions, which could set a standard for outreach and C&T activities. The management burden for this project is heavy, and implementation is spread widely over the country and in remote areas. Yet despite these high costs, the partner has used its funding efficiently and effectively.

E) What plans are in place to transition the organization, i.e., are there plans to move the activities towards alternative partners, in particular indigenous organizations?

The Truckers for Life project is scheduled to end in July 2007. This year's funding is targeted to support activities that continue efforts to strategize and identify alternate, local funding sources. Current opportunities include a potential public-private relationship with one of the major companies transporting goods along the corridors and capacity building of a local NGO to manage and implement similar activities.

F) Summary rationale

The Trucker for Life Project is entering its final year of funding, and during this period HPSI will finalize implementation of its plan for other local and international donor funding for future years. Furthermore, HPSI was able to work with USG to identify cost-savings in order to reduce funding request by a more than \$1 million. The program is well-run, demonstrating results and has only four months of funding remaining in their pipeline.

Appendix 34 BUDGET ADJUSTMENT STRATEGY

This section is intended to provide a few examples of potential budget adjustment strategies. It is by no means an exhaustive list. We have intentionally not provided a template because we wanted to give country teams maximum flexibility.

EXAMPLE 1: Cut the entire budget by 5%

This option would allow you to maintain your budgetary requirements, although you would have to manually update all planned funding and targets.

EXAMPLE 2: Cut specific activities entirely

If you choose this option, please provide the following information:

Program Area	Activity ID	Prime Partner Name	Planned Funding Amount
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Providing this level of detail will allow us to give the information to the appropriate TWG and therefore eliminate the need for a second review process.

If you choose this option, please make sure you meet all your budgetary requirements after you eliminate these activities.

EXAMPLE 3: Cut funding for specific activities by X amount

Again, if you choose this option, please provide the following information

Program Area	Activity ID	Prime Partner Name	Original Planned Funding Amount	New Planned Funding Amount
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Not to be redundant, but please make sure you meet all of your budgetary requirements ☺.

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Appendix 35 FY2007 COP REVIEW PROCESS

Appendix 35.1 STRUCTURE OF FY 2007 COP REVIEWS

The COP Reviews are separated into several different sections. First, there are Technical Reviews of the COPs undertaken by the Technical Working Groups. The Technical Reviews are undertaken for each technical area, with reviewers evaluating only that particular technical area for each country. Second, there is a Programmatic Review of the COPs, which is done for each country and incorporates the evaluation of each Technical Review of the COP into a comprehensive whole. Finally, there is the Principal's Review of the COPs, which is also done for each country and highlights the work of the previous two reviews.

For the Technical Reviews, a standard review form has been developed. Below is a sample evaluation form for the Care and Treatment Technical Review (the specific Care & Treatment review criteria are italicized under the Overall Technical Review Criteria). Each of the Technical Reviews of the COPs will follow this format. There are Technical Review Criteria which are specific to each Technical Review. These review criteria are outlined in the next Appendix.

In addition to the technical review criteria described above, certain activities within the COPs will also be reviewed by either the Targeted Evaluation Working Group or the Public Affairs staff. The Targeted Evaluation sub-committee will be conducting the review of proposed TE items in a different manner, but on the same time schedule (please see [Appendix 28](#) for the specific information related to TE). The Public Affairs staff will also conduct a review of any public affairs related activities. At the end of [Appendix 29.2](#) you will find the specific criteria for review of Public Affairs related activities.

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Appendix 35.2 FY 2007 COP TECHNICAL REVIEW FORMAT

**Evaluation Form for the Technical Review of the
FY 2007 Country Operational Plans (COP):
*Workgroup Name***

Country: _____

Confidence of your technical review based on amount of information in the COP (circle one):	
<p>1-----2-----3-----4-----5 low high</p>	<p>1 = Overall gaps in information; the activities and programs could not be adequately assessed with the information provided 2 = Several areas have major gaps in information 3 = No major gaps in information, but limited information provided 4 = Adequate information provided but more would have been helpful 5 = Complete information provided; activities and programs were easily assessed</p>

Narrative Assessment (Limit to two pages.)

- 1) Strengths – Please provide narrative and identify any activities of particular note and include activity identification number.**

- 2) Weaknesses – Please provide narrative addressing any activities (include identification number), technical or policy issues of concern.**

- 3) Activities or Issues to be Discussed by Programmatic Review Panel**

Appendix 35.3 FY2007 COP REVIEW TECHNICAL CRITERIA

For All Technical Reviews:

Activity-Specific Technical Criteria

1. The proposed specific technical activity has an achievable, measurable result.
2. Activity is in keeping with Emergency Plan policy and strategic direction.
3. Activity contributes to achieving the U.S. country five-year strategy.
4. The proposed partners are appropriate and, where possible, the activity includes work with new, indigenous partners.
5. The budget is appropriate for proposed activity.\
6. The focus of the activities is/includes downstream (direct) service delivery.
7. If not, there is sufficient description/evidence that the activities are essential to program success.

Program Area: Overall Program Assessment [PMTCT has slightly different criteria, see below]

1. The proposed activities reflect implementation of best practices in the technical area.
2. The text provides reasonable rationale that the proposed activities address population/geographic areas where the programs will have major impact.
3. The overall approach reflected in the proposed activities corresponds with the country five-year PEPFAR strategy.
4. The text describes a plan that is consistent with the national HIV strategy, including coordination and where appropriate facilitation and implementation with other donors and the Global Fund.
5. No critical activities are missing in this technical area. (Technical areas being addressed by other donors should be described).
6. The activities lead to achieving the results needed to meet the targets in this technical area.
7. The implementation mechanism(s) are/is appropriate for the technical activities proposed.
8. The technical areas adequately address gender issues.
9. The technical areas adequately address sustainability.
10. The plan appropriately leverages other U.S. Government investments including, for example, activities being conducted in other technical areas. (e.g. wraparound services, research sites).

Technical Area-Specific: Overall Technical Review Criteria

HIV Care and Treatment

1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.
2. The proposed activities describe advancement of mechanisms for quality assurance, quality standards and quality of care within the technical programs.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute and provide drugs and health commodities and ensure the secure and consistent supply in 2007 and subsequent years.
4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents and quality assurance for lab services, ENSURING adequate supply chain management for diagnosing and treating HIV and OIs (e.g. TB) and evaluating drug toxicities.
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected number of persons who will be treated and cared for each year.

6. The proposed activities include advancement of plans for community-based prevention-focused promotion of HIV/AIDS care services, stigma reduction and adherence to ART. Activities involve people living with HIV/AIDS (PLWHA) and other affected groups (ex. TB patients) when possible and appropriate.
7. Proposed activity includes multi-disciplinary approaches to ensure adherence to ARV medications, and ensure adequate follow up and retention of patients in care.
8. Integration of USG plan for laboratory support of intervention into National Treatment plan: Is the USG plan for laboratory support to interventions an integral part of the national HIV prevention and care plan?
9. Commodities Management: Are the systems to select, procure, store, track, distribute, provide, and maintain laboratory equipment, reagents, and other essential laboratory commodities adequate to ensure uninterrupted operations in 2007 and subsequent years?
10. Laboratory Standards: Are there written national laboratory policies, guidelines and Standard Operating Procedures and are they acceptable as a tool to ensure proper diagnosis and effective patient management in 2007 and subsequent years.
11. Monitoring and Evaluation: do plans describe ongoing analysis of key programmatic indicators and onsite supervision. M and E should monitor the scale-up of treatment services, identify programmatic successes and failures, and make corrections based on data and observations in the field.
12. Laboratory Services: Are the physical infrastructure, trained staff, and systems for specimen handling, and quality assurance for lab services acceptable for prevention activities, patient diagnosis, treatment of AIDS, TB, and OIs and for monitoring patients on therapy?
13. Laboratory Training: Are the plans to train laboratory managers, technicians, and technologists adequate for the projected number of persons who will be diagnosed and monitored.
14. Laboratory Monitoring and Evaluation: Are the plans and indicators for monitoring laboratory processes and service outcomes adequate for measuring laboratory contribution to the prevention, treatment and care objectives.

Counseling and Testing

1. The proposed activities represent an expanded and a strategic mix of clinical, diagnostic and community-based counseling and testing models.
2. The proposed activities promote the availability of routinely offered clinical counseling and testing and diagnostic testing in order to reach those most in need of ART, particularly through TB, STI, and hospital inpatient services.
3. The proposed activities promote the availability of community-based counseling and testing, including efforts to make CT available to youth (e.g. pre-marital CT), couples, and families.
4. The proposed activities promote the availability of CT to high-risk and vulnerable populations, such as truck drivers, commercial sex workers, injection drug users, MSM, migrant workers, the military and their families, refugees, internally displaced persons, and prisoners.
5. The proposed activities promote both high-quality counseling and high-quality rapid testing, including plans for training, supervision, quality assurance, and systems for referrals and linkages to other services.
6. The proposed activities support the training and use of lay counselors to provide CT services in countries with human resource constraints.
7. The total target for individuals receiving counseling and testing in the FY2007 COP is both feasible and adequate to meet the country's care, treatment, and prevention goals.
8. The proposed activity budgets are appropriate for the number of individuals to receive CT services. (See Counseling and Testing Technical Considerations for the FY2007 COPs for more information).
9. The proposed activities seek to stimulate demand for CT services, and to normalize CT-seeking behaviors.
10. The proposed activities encourage partner disclosure/notification and partner/family testing as appropriate.
11. The proposed activities encourage the use of whole blood (finger prick) rapid testing.

Gender

1. Gender Legislative Codes. Activity narratives include descriptions of gendered approaches and contain sufficient information to justify checking legislative code boxes (i.e., increasing gender equity in HIV programs, addressing male norms and behaviors, reducing violence and coercion, increasing women's access to income and productive services, and increasing women's legal rights).
2. PMTCT. Proposed activities address barriers to women's access to quality PMTCT services and ensure that PMTCT clients receive appropriate, comprehensive, follow-up care and support including ART (when eligible), OI prevention and treatment, infant feeding and support, and organization of basic necessities such as nutrition, housing, and financial and legal assistance. Efforts to effectively engage women's partners in PMTCT programs (e.g., couples counseling and testing) are supported at service delivery and community levels.
3. Prevention among General Population and Youth. Proposed activities ensure equitable access to gender-appropriate prevention messages and services by girls and boys, women and men; include comprehensive, integrated efforts (including activities to change male norms and behaviors) to reduce the practices of cross-generational and transactional sex, multiple sexual partners, and gender-based violence; support girls' equal education and ensure that school environments are safe for girls; and include strategies for reducing stigma towards persons with HIV.
4. Most At Risk Populations. Proposed activities (as relevant to the country context): (1) support interventions to eradicate gender based violence and the exploitation of women and girls by prostitution, sex trafficking, rape, and sexual abuse; (2) ensure that vulnerable girls and women are reached with prevention services that empower them to prevent HIV infection, including strategies to increase women's access to employment and income generation; (3) ensure the importance of inheritance and property rights of women and orphans; (4) provide behavior change education on male norms, violence, and alcohol abuse to military populations, uniformed services, and mobile populations; (5) address the double stigma surrounding MSM; and (6) address the unique needs of male and female IDUs.
5. TB/HIV. The proposed activities facilitate collaboration between national HIV and TB programs and services for women, e.g. PMTCT programs, so that HIV-positive women can receive information about TB, periodic screening for TB, and treatment for TB infection.
6. Counseling and Testing. Proposed activities acknowledge the potential for violence, abandonment, or fear of these and other negative outcomes that women may face in disclosing HIV-positive status and support interventions to prevent or mitigate these situations, such as couples counseling and testing, referral to social services for women who experience negative outcomes, and stigma reduction. When appropriate, activities incorporate a family-centered approach that supports counseling and testing of partners and children.
7. HIV Care and Treatment. Proposed activities ensure equitable access to care and treatment services by identifying and addressing barriers that women and men selectively may face in adhering to treatment or receiving on-going care, creating bridge programs to draw traditionally excluded populations into care and treatment services, and incorporating as appropriate family-centered care.
8. Pediatric Treatment. Proposed activities encourage a family centered approach as appropriate and emphasize men's shared responsibilities for caring for HIV-positive children to prevent abandonment and unequal burden of care on mothers and other female household members.
9. Orphans and Vulnerable Children. Proposed activities lessen orphaned girls' vulnerability to sex trade, rape, sexual abuse, assault, exploitation, and HIV; and address the inequitable burden of care on women and girls to assume responsibility for heading households by providing them with the appropriate resources and support to fulfill this role, strengthening inheritance and property rights of women and orphans, and engaging men and boys in OVC care.
10. Palliative Care. Proposed activities ensure equitable access to care services by women and men and eliminate barriers that women selectively may face in receiving ongoing care; and address the disproportionate burden of care falling on women and girls by providing resources and support to

enable them to fulfill their roles, encouraging greater responsibility and participation of men as community and family caregivers, and/or increasing women's access to productive resources.

11. **Strategic Information.** Proposed activities include collection of sex disaggregated data or build capacity of data systems to enable collection of sex disaggregated data. Where there is a lack of data to enable gender sensitive programming, include activities to assess gender differentials in access to services, health-seeking behaviors, adherence to treatment, etc.

General Population and Youth

Policy criteria

1. Compliance with guidance. The proposed activities must comply with the Emergency Plan (EP) ABC guidance, and should reflect the "technical considerations" that have been developed and shared by the technical working group.

General criteria

2. Focusing on evidence-based best practices. Proposed activities should be backed by a solid base of empirical research and should reflect current best practices in HIV prevention and behavior change.
3. Linking activities to behavior change objectives: Activity descriptions should describe clear, plausible mechanisms through which program efforts will facilitate the adoption and maintenance of specific prevention behaviors.
4. Building the motivation and skills necessary to support behavior change: Prevention activities should extend beyond efforts to improve knowledge or awareness of HIV, to also provide individuals with the relevant motivation and skills needed to adopt safer behaviors.
5. Addressing social norms: Programs should address social norms and other elements of the social and policy environment which facilitate the spread of HIV. Activities should recognize that the beneficiaries of intervention efforts often should not be the sole targets of those efforts, and that efforts to engage leaders, peers, family members, local organizations, and the media may be essential to reach a "tipping point" of public sentiment that facilitates the widespread adoption and maintenance of safer behaviors.
6. Don't neglect the "B": Activities that focus on reducing multiple partnerships which perpetuate the continued spread of HIV should be a primary goal of efforts to address the prevention needs of both adults and youth. Activities should also seek to increase individuals' perceptions of the risks of having multiple or concurrent sexual partners, and should try to cultivate broader social norms that facilitate partner reduction and fidelity.
7. Addressing gender issues. Proposed activities should address gender dynamics, and in particular the role they likely play in sustaining disproportionately high rates of HIV infection in girls and young women. Programs should seek to employ skills-based approaches to meet the prevention needs of girls and young women, and should place a strong emphasis on efforts to change the norms of male behavior that result in elevated infection risks in their partners. In most settings, specific interventions should aim to change social norms related to cross-generational sex, transactional sex, and coercive sex.
8. Targeting activities: Proposed activities should target populations and geographic areas where the country's epidemic is the most severe.
9. Coverage: Proposed activities should feature a scale and scope likely to contribute to population-level declines in HIV infection rates.
10. Quality: Activity descriptions should reflect efforts to ensure the delivery of an effective intervention "dose," through a structured implementation approach that includes multiple exposures, links to other relevant services, and the establishment of strong management and quality assurance mechanisms.
11. Prioritization and Coordination: The COP should reflect an attempt to prioritize key prevention messages and behavioral objectives based on the epidemic context, as well as efforts to coordinate the prevention activities and efforts across in-country partners.

12. **Ensuring linkages:** The COP should reflect efforts to mainstream quality prevention programming into care and treatment services. For example: Prevention services should be implemented to address the needs of HIV-positive individuals, their partners, and their families. Efforts should be made to link HIV counseling and testing services to prevention programming, and efforts should be undertaken to provide primary prevention services in the context of PMTCT, to prevent male partners from becoming infected, and to prevent further transmission to mothers and their infants.
13. **Partnering with local organizations.** Proposed activities should strive to engage all available local sources of social capital, and feature partnerships with local leadership, structures, and organizations such as churches, schools, local media, the private sector, and traditional leaders.

Population-specific criteria

14. **Addressing adults:** In high-prevalence, generalized epidemics, prevention efforts should address the fact that most new infections result from sexual activity among older youth and adults. Therefore, programming should not focus exclusively on adolescents, and should prioritize efforts to curtail multiple and concurrent sexual partnerships among the sexually active.
15. **Programming for youth.** Youth programming should be age-appropriate, address identified risk factors, engage parents and other adults, and be delivered in appropriate settings.
16. **Addressing MARPS:** Just as prevention programming should seek to address population-level priorities, it should also seek to address the diversity of individual level needs. A strategic prevention portfolio should ensure that individuals at higher risk of becoming infected have access to high-quality, comprehensive prevention programming. Programming funded under the "AB" directive should therefore feature linkages to "Condoms and Condoms and Other Prevention" programming where appropriate.
17. **Programming for HIV+ persons.** Programs should address the prevention needs of HIV infected individuals, linking prevention activities with care and treatment services and settings.

Human Capacity Development

1. Has an HR assessment/plan been done in this country, if so, was it taken into account in the planning?
2. If no assessment has been done previously, are there plans to do one?
3. There is an overall plan to improve human capacity that includes such aspects as:
 - In-service training
 - Pre-service training
 - Workforce planning
 - HR policy (regulatory barriers, prescribing practices, etc).
 - Involvement of the private sector
 - Twinning
 - Volunteers
4. Is there adequate coordination of HCD activities in the COP? (e.g. across geographic areas, USG partners, USG agencies)

Laboratory Support

1. **Laboratory Services:** Are there plans for an adequate laboratory network including physical infrastructure, trained staff, and systems for specimen handling, and quality assurance for lab services (e.g., prevention activities, patient diagnosis and treatment of HIV/AIDS, OIs including TB, children and adults on ARVs)? Does the network support or assist with the development of the host government laboratory network?
2. **Laboratory Standards:** Are there written national laboratory policies, guidelines and Standard Operating Procedures and are they used as a tool to ensure proper diagnosis and effective management of adults and children with HIV/AIDS in 2007 and subsequent years.
3. **Laboratory Human Capacity Development:** Are there plans to train laboratory managers, technicians, and technologists adequate for the projected number of adults and children who will be receiving USG laboratory support (e.g., counseling and testing, care, treatment, etc.).

4. Laboratory Supply Chain Management: Are there adequate systems to select, procure, store, track, distribute, provide, and maintain laboratory equipment, reagents, and other essential laboratory commodities.
5. Laboratory Monitoring and Evaluation: Are the plans and indicators for monitoring laboratory processes and service outcomes adequate for measuring laboratory contribution to the prevention, treatment and care objectives.
6. Laboratory Quality: Are there plans to support a laboratory network for external quality assurance for lab services for prevention, care and treatment for adults and children.

MARPs

1. The proposed plan includes a range of activities to address and overcome issues of discrimination that affect the delivery of prevention services for MARPS.
2. The proposed plan includes targeted activities to reach those at high risk for infection through outreach services and interpersonal approaches to behavior change,
3. The proposed activities include a range of prevention services for unformed personnel to eliminate or reduce risky behaviors.
4. The proposed activities include a range of prevention services for prostitutes to eliminate or reduce risky behaviors.
5. The proposed activities include a range of prevention services for mobile populations to eliminate or reduce risky behaviors.
6. The proposed activities include a range of prevention services for drug users to eliminate or reduce risky behaviors.
7. The proposed plan includes activities to expand access to clinical services to those most at risk, including diagnosis of and treatment of STIs.
8. The proposed plan promotes the correct and consistent use of condoms among those most at risk for infection, and seeks to ensure the availability to high risk populations.
9. The proposed plan promotes expanded access to substance abuse and treatment services.
10. The overall approach includes programs to identify and reach HIV-infected people and their sexual partners with prevention services.
11. The proposed activities incorporate linkages to HIV treatment and care services, including HIV counseling and testing.

Orphans and Vulnerable Children

1. The proposed activities:
 - Meet the best interest of the child
 - Fit within the country context
 - Where appropriate, include leveraging of any and all relevant resources
 - Include comprehensive referrals to education, care, medical and social services
 - Include active youth participation
 - Link with HIV/AIDS treatment and prevention programs
 - Address sustainability and scale of local systems and structures
2. The proposed activities address strengthening the capacity of families and community-members to meet the needs of OVC.
3. The proposed activities address mobilization and support of community-based responses to make informed decisions on who is vulnerable, what services do they need, and what local resources can be leveraged to meet the needs of community identified OVC.
4. The proposed activities address strengthening government systems and structures at multiple levels to protect the most vulnerable children through:
 - Improved policy and legislation
 - Mobilization of resources to communities to ensure comprehensive service delivery
5. The proposed activities address improving access to essential services through:
 - Use of community-led targeting of OVC
 - Leveraging of other resources

- Education, health care, psycho-social support, HIV prevention, food, social and legal protection, shelter, and economic opportunity.
6. The proposed activities facilitate a supportive social context for children and their families affected by HIV/AIDS.
 7. The proposed activities reflect adequate technical and management capacity to deliver on and monitor 10% budgetary requirement for OVC programming in a consistent manner across activities.
 8. The proposed activities address inter/intra-agency and/or cross-sector coordination with other components of the Emergency Plan program in-country to deliver comprehensive services to OVC using wrap-around programming.

Palliative Care

1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.
2. The proposed activities describe advancement of mechanisms for quality assurance and quality standards within the technical programs.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute, and provide drugs and health commodities and insure the continuous supply in 2007 and subsequent years.
4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services are adequate for diagnosing and treating HIV and OI's and evaluating drug toxicities.
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected number of persons who will be treated and cared for each year.
6. The proposed activities include advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART.
7. The proposed activities define and include a basic set of palliative care services that will be made available to all persons with HIV/AIDS.
8. The proposed activities include a preventive care package for HIV-infected adults and children, as part of the basic set of palliative care services.
9. The proposed activities define and include an approach to management of HIV-related conditions and or symptoms that is appropriate for the setting(s) in which the HIV infected persons are seen.
10. Food and nutrition has been given adequate technical and programmatic consideration.

Pediatric Technical Review

1. The text provides reasonable information about the basic context in which child care and treatment services will be delivered and targets for pediatric care and treatment, including:
 - Estimates of the number of HIV-exposed and infected children requiring care
 - Number of children receiving care
 - Estimates of the number of HIV-infected children requiring treatment
 - Number of HIV-infected children receiving treatment (and percent of all treatment that is being delivered to children)
 - Number and percent of referral and primary level facilities providing ART to children
 - Availability of pediatric formulations of ART
2. The proposed activities describe advancement of mechanisms for quality assurance, quality standards and quality of care within the technical programs.
3. The text describes a plan that is consistent with the national HIV strategy, including coordination and where appropriate facilitation and implementation with other donors and the Global Fund.
 - The present policy on regimen and indications for pediatric ART is described
 - The roles of the government health system and major donor partners is described in relation to the PEPFAR program

- The activities include description of how care and treatment activities will reach adequate scale to achieve final PEPFAR targets in this technical area.
4. Identifies HIV-exposed and infected children through all relevant entry points and linkages, such as PMTCT programs, pediatric hospitals and clinics, MCH clinics and testing adult cases identified in HIV and TB treatment programs
 5. Includes approaches for detection of childhood HIV infection, including antibody screening as appropriate
 6. Strategy for bringing children <2 into care and treatment, including PCR testing for early diagnosis of HIV infection in children as feasible
 7. Assures provision of basic preventive care (including cotrimoxazole prophylaxis, immunization, malaria and diarrhea prevention [including ITNs and household water treatment], nutritional evaluation and appropriate infant and young child feeding and micronutrient supplementation)
 8. Ensures provision of care for infected children, including treatment of OIs and other conditions
 9. Links with mechanisms for follow-up of HIV-exposed and infected children receiving care and treatment
 10. Links care and treatment to routine child health services, including MCH clinics, immunizations and growth monitoring and promotion
 11. Strategy for increasing the number of HIV-positive children receiving ART with appropriate pediatric formulations
 12. Links with food and nutrition programs for provision of complementary services
 13. Links to community level services and support and advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART.
 14. Activities included to address psychosocial support and other needs of child, parents and caregivers
 15. Training: Adequate plans in place to train a cadre of health care workers, including doctors, nurses, other health care workers and non-professionals, to provide pediatric treatment.
 16. Monitoring and Evaluation: Plans and indicators for monitoring and evaluation appropriate for measuring the overall program contribution to prevention, treatment and care objectives, including service delivery, program impact, and clinical and laboratory measures for children.
 17. Processes for determining need, procurement, distribution, control, logistic management, and provision of ARVs to children are described
 18. Advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services are adequate for diagnosing and treating HIV and OI's (e.g. TB)
 19. Includes multi-disciplinary approaches to ensure adherence to ARV medications, and ensure adequate follow up and retention of patients in care
 20. Adequate systems to select, procure, store, track, distribute, provide, and maintain laboratory equipment, reagents, and other essential laboratory commodities
 21. Physical infrastructure, trained staff, and systems for specimen handling, and quality assurance for lab services for prevention, diagnosis, treatment of AIDS, TB, and OIs and for monitoring children on therapy

Procurement

The commodities procurement technical working group will review FY 2007 COPs with the intention of understanding the following from each country's submission:

1. Are planning and implementation of commodities procurement clearly described and conducted in an interagency manner that will lead to forecasting/planning and execution of commodities procurement for the entire USG in-country team?
2. Do the commodities procurement mechanisms appear to be feasible and efficient?
3. Do the mechanisms for commodities procurement address and ensure the procurement of products for which appropriate quality standards are met?

Further information is available from the commodities procurement technical working group. Please contact OGAC Reuben Granich (granichrm@state.gov) or co-chairs Carl Hawkins (chawkins@usaid.gov) and Michael Johnson (mjohnso2@osophs.dhhs.gov).

Strategic Information

1. [HMIS] - The proposed activities will immediately support the collection, analysis and reporting of the M&E indicators required under the Emergency Plan.
2. [HMIS] - The proposed activities build on existing data and information system standards and build the generic health information infrastructure in the country.
3. [Surveillance] - The proposed activities are adequate to assure the ability to monitor HIV prevalence at the national level. (at minimum sentinel surveillance in ANC attendees in a generalized epidemic or in high-risk groups in a concentrated epidemics)
4. [Surveillance] - The proposed activities are sufficient to assure the ability to monitor HIV related risk behaviors at the national level (either general population for generalized epidemics or high risk groups for concentrated epidemics).
5. [M&E] - The proposed activities will result in effective program monitoring (including addressing data quality and data use for program management) for all programmatic components of the USG Program.
6. [M&E] - The proposed activities include, where appropriate, targeted evaluation studies that have program relevance, are linked to innovative interventions, or help to inform effective scale-up of interventions.
7. [Human capacity development] - The proposed staffing and activities will strengthen the in-country SI capacity in terms of (1) M&E, surveillance, HIS components; (2) program/project-, facility-, and population-based data collection and use; (3) operations research and evaluation studies; (4) coordination & collaboration.
 - The proposed staffing for SI (M&E, surveillance, HIS) is adequate
 - The proposed trainings/meetings/workshops are adequate

TB/HIV

1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach. This includes linking prevention, care and treatment programs and also linking these interventions with other non-Emergency Plan USG efforts, for example food programs and income generating programs.
2. The proposed activities describe advancement of mechanisms for quality assurance, quality standards and quality of care within the technical programs.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute and provide drugs and health commodities and ensure the secure and consistent supply in 2005 and in subsequent years.
4. The proposed activities include strengthening TB diagnostic capabilities for PLWHAs, including smear microscopy services, quality assurance, and support for national reference laboratories.
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing care and treatment services for the projected number of persons who will be treated and cared for each year.
6. Activities involve people living with HIV/AIDS (PLWHA) and other affected groups, including TB patients, when possible and appropriate.
7. Proposed activity includes multi-disciplinary approaches to ensure adherence to ARV medications, and ensure adequate follow up and retention of patients in care.
8. The proposed activities include providing HIV counseling and testing for all TB patients.
9. The proposed activities include screening all HIV-infected persons for active TB and a description of referral system for assuring TB suspects access to diagnosis and treatment for TB.
10. The proposed activities include working with the country's National Tuberculosis Program.
11. The proposed activities include strengthening the TB/HIV monitoring and evaluation systems.

12. The proposed activities include a description of systems for management and monitoring of TB/HIV co-infected patients across multiple health care programs.
13. The proposed activities include plans to provide cotrimoxazole prophylaxis for HIV-infected TB patients.
14. The proposed activities include cross-training health care workers on TB/HIV at all relevant administrative levels.
15. The proposed activities address short and long-term human resource needs to manage the enormous burden of HIV-infected TB patients.
16. The proposed activities describe how the USG-sponsored TB/HIV activities will work in synergy and leverage activities sponsored by other partners and large initiatives. (e.g., Global Fund, WHO, World Bank).

PMTCT

Program Area: Overall Program Assessment

1. The proposed activities reflect implementation of best practices in PMTCT, including
 - Routine offer of testing (opt-out approach)
 - Rapid testing with same day results
 - Optimal ARV prophylaxis regimen for the particular context, in keeping with WHO and national guidelines (specific regimen(s) should be delineated)
 - Linkages to care, treatment, and support (see specific items below)
2. The text provides reasonable information about the basic context in which the proposed services are being delivered, clearly stating:
 - The number of women delivering overall, and the percent delivering in facilities
 - The number and percent of HIV+ women receiving services
 - The number and percent of facilities providing services
 - The burden of HIV infection in various geographic areas of the country.
3. The overall approach reflected in the proposed activities corresponds with the country five-year PEPFAR strategy.
 - The national PMTCT country strategy is briefly summarized.
4. The text describes a plan that is consistent with the national HIV strategy, including coordination and where appropriate facilitation and implementation with other donors and the Global Fund.
 - The roles and activities of the various partners and donors involved in PMTCT are described.
 - The place of PEPFAR-funded projects within the larger country PMTCT program is clearly delineated.
 - The role of the National PMTCT coordinating committee is explained if applicable.
5. No critical activities are missing in this technical area. (technical areas being addressed by other donors should be described). Critical areas include:
 - Linkages to antiretroviral treatment programs for pregnant women with WHO indications.
 - Promotion of partner counseling and testing
 - Postnatal follow-up of infants and mothers, including:
 - Promotion and support for optimal exclusive infant feeding practice.
 - Breastfeeding cessation as soon as is AFASS, along with explanation of how complementary feeding will be supported.
 - Provision of nutritional support
 - Cotrimoxazole prophylaxis for infants
 - Approach to infant diagnosis
6. The activities lead to:
 - A measurable increase in the number of pediatric infections averted.
 - An improvement in overall child survival,
 - Enrollment of HIV+ mothers in care and treatment programs
7. The management plan, specifically staffing and implementation mechanism are appropriate for the technical activities proposed.

- Attention is given to building capacity to manage programs locally and transitioning management and supervision to the MOH as much as is feasible.
8. The technical areas adequately address the special needs of HIV+ pregnant women, including
 - Psychosocial support
 - Stigma reduction and prevention of domestic violence
 9. The plan appropriately leverages other U.S. Government investments including, for example, activities being conducted in other technical areas. (e.g. wraparound services, research sites) Ex.
 - One important example of this is nutritional support for infants after early cessation (e.g. WFP)

Overall Technical Review Criteria

1. The proposed activities describe service delivery as part of an integrated network system and advancement of the network approach.
 - Linkages to care and treatment services are clearly identified and contributions of PMTCT programs to upstream (indirect) care and treatment targets
 - Linkages to nutritional programs for pregnant mothers.
 - Linkages of programs for infants for nutritional support replacement feeding as soon as is AFASS
 - Linkages to OVC programs
 - Linkages to other routine maternal and child health services (i.e. immunizations)
2. The proposed activities describe advancement of mechanisms for quality assurance and quality standards within the technical programs.
 - An approach to monitoring and improving different aspects of the PMTCT cascade is explained.
3. The proposed activities address advancement of drug and health commodity systems that are adequate to select, procure, store, track, distribute, and provide drugs and health commodities and insure the continuous supply in 2005 and subsequent years
 - Where more complex PMTCT regimens are being used the supply-chain is described and is integrated with the treatment supply chain as much as is feasible.
4. The proposed activities include advancement of laboratory systems, including physical infrastructure, trained staff, equipment, guidelines, supplies, reagents, and quality assurance for lab services. These may specifically include:
 - Rapid testing capability
 - Capability to obtain CD4 test results for women in ANC
 - Infant diagnosis capability and CD4 % capability (see pediatric section)
5. The proposed activities address advancement of appropriate and adequate training for professionals and non-professionals in providing PMTCT services.
 - The training curriculum is specified. (use of CDC generic curriculum encouraged)
 - Sub-specialized types of training, such as infant feeding counseling, are delineated.
6. The proposed activities include advancement of plans for community-based promotion of HIV/AIDS care services, stigma reduction and adherence to ART.
 - There is a community strategy in place to increase uptake of PMTCT services.

In addition to the technical review criteria described above, certain activities within the COPs will also be reviewed by either the Targeted Evaluation Working Group or the Public Affairs staff. Below is additional information on criteria for these two reviews.

Targeted Evaluation

Please see [Appendix 28](#) for information on how targeted evaluation activities will be reviewed. The review process for TE activities will be concurrent with the technical reviews in FY2007.

Public Affairs

The proposed activities related to public affairs should:

1. Be fully integrate and capitalize on the resources of the country team especially if the program involves behavior change communications;

2. Be within the capacity of the Public Affairs Staff given the management and reporting requirements;
and
3. Add value and are not repetitive to existing programs in the COP.

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Appendix 35.4 FY 2007 COP PROGRAMMATIC REVIEW MATRIX

FY 2007 COP Summary and Evaluation Sheet

Instructions to Programmatic Review Panel:

As part of the programmatic review, the primary and secondary reviewers should complete this matrix and the attached narrative review form for each country operational plan they review prior to the programmatic review panel. This matrix along with the technical reviews for each program area will then serve as tools to help guide discussion during the programmatic review. Please note that the yellow- or red-lighted issues may not necessarily include all the ones listed from the technical reviews. After the panel, the review panel in collaboration with the core team leader will summarize the two matrices and discussion comments into one "report card" for the country team as a way to feedback and modify the COP if necessary. Please provide comments to each line-item in the matrix as needed at the end of the document.

Country: _____

Narrative Assessment:

- 1) Strengths

- 2) Weaknesses

- 3) Issues
 - a. Yellow Lights
 - b. Red Lights
 - c. Other

Broad Programmatic Criteria (aggregate criteria for all COP activities)	(a) Yes	(b) ³ No	(c) ¹ Not relevant
Targets:			
1. The goals of the COP link to the overall Emergency Plan 2-7-10 targets and country five-year strategy goals and builds on the FY04 and FY05 COP.			
Budgets:			
2. The budget is justified and appropriate for the proposed activities.			
3. Budget allocations meet the budgetary requirements for AB, OVC, and treatment (50% of prevention for sexual transmission and 66% for AB activities, 10% OVC, 55% ARV Treatment).			
4. Management costs are within 7% of the overall budget and adequately account for staffing and management needs and contracting services in country.			
Partners:			
5. The plan adequately brings in new partners (including faith-based, indigenous, private-sector, and other non-governmental partners).			
6. No more than 10% of the overall budget is allocated to one partner.			
Activities:			
7. The activities are appropriately balanced among prevention, care, and treatment.			
8. Activities are geographically appropriate and according to country epidemiology.			
9. The activities show an increased emphasis toward strengthening TB-HIV, pediatric treatment, and counseling and testing.			
10. Program linkages among various technical areas (e.g., among voluntary counseling and testing and treatment, incorporating the network model, etc.) are clearly developed.			

³ Further explanation on why particular criteria are not met is required in the programmatic review narrative form attached to this matrix.

11. The plans for procurement of commodities and drugs (e.g., condoms, anti-retroviral, etc.) are reasonable and realistic and ensure continuity of supply over the time period.			
12. The plan is consistent with the national HIV strategy and program.			
13. The plan accounts for Global Fund and other donor investments, how they will be coordinated, and how the U.S. Government is leveraging those resources.			
14. Activity narratives articulate how specific targets will be met.			
15. Staffing plans and management mechanisms for new and existing partners are included in proposed activities.			
16. The plan includes, if appropriate, programs targeted at vulnerable populations, including women, refugee populations, and migrant workers.			
17. The plan addresses the needs of the military.			
18. The plan adequately addresses gender issues. ⁴			
19. The plan includes activities that leverage and link with U.S. Government investments in other sectors, such as education and food security (wrap around programs)			
20. The activities adequately meet technical standards and criteria as defined by the technical working groups.			
21. There are no major elements missing from the COP.			

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⁴ Please refer to the gender background document.

Appendix 36 FY 2007 COP REPROGRAMMING INSTRUCTIONS

OGAC is regularizing the timing of country reprogramming requests to reduce workload in the field and at OGAC headquarters and to help ensure that these requests are processed in a timely and regular manner. Reprogramming requests will be due to OGAC by the following dates in FY 2007:

Jan. 15th
April 15th
June 1st
Oct. 15th

OGAC will complete its review of the reprogramming requests and send MOA amendments to the USG agencies to reflect any changes resulting from the approved reprogramming requests within 30 days after the due date. Additional guidance will be provided to the field at the beginning of FY 2007 to give additional instructions for submitting reprogramming requests.

We are also working to develop an automated process for submitting reprogramming requests through the COPRS database, but we do not have a firm implementation date at this time. When a definite implementation date is available, we will notify the field and provide instructions to explain the new process.

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