CSO Feedback on the draft 2016 Country Operational Plan Guidance

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Overall framework

The guidance note reflects a strong commitment to impact, ambition and focus—the right things, in the right places at the right time. And there is a strong recognition of the need for treatment, combination prevention, and key populations programming as the cornerstone of the response. However the draft needs improvement before finalization in several crucial areas. We suggest ways below to significantly strengthen this commitment to ensure it is consistently and ambitiously reflected in the directives throughout the guidance.

Below we make specific reference with corresponding page numbers where appropriate to specific concerns and priorities, as well as more general points under subject-specific headings. In addition two specific overall points are worth noting at the start:

- Even with the reality that PEPFAR resources are limited and cannot be the sole source of any country's AIDS response, the program can show leadership in concretely conceptualizing and identifying the way forward toward a comprehensive response. At various points in the Guidance, there is explicit mention of the reality that limited resources mean trade-offs will be made both between ART and non-ART interventions and between scaling up ART in some versus other geographic and population groups. Without substituting for national planning processes, the PEPFAR COPS process should identify those trade offs and identify gaps for urgent epi-impact critical programming that cannot be scaled up due to limited resources in the current COP cycle. This could be a critical value-add both for country planning processes and to help with resource mobilization for both PEPFAR and other mechanisms.
- There are also directives regarding individual interventions (VMMC, PMTCT, PrEP, rights-based strategies, etc.) that should be subjected to a gap analysis. This should be strengthened and consolidated in alignment with the comprehensive Fast-Track framework.
- Related to this, we strongly urge PEPFAR countries to develop in COP 2016 budgets for saturation in broader geographic areas—not only in response to the budget currently available. This is particularly helpful for countries with more homogenous epidemics where the population and geographic focus exercise is less useful, because the spread of yield data and clinic size is less wide. This also increases transparency and accountability to civil society around trade offs and priorities.
- PEPFAR COP 2015 outined a new expectation for civil society engagement through a quarterly review process that was supposed to have started in Quarter 4 2015, but to the best of our knowledge has not moved in most countries—civil society has not received data and meetings have not taken place in most countries we know of (with one or two exceptions). This is a serious problem, since the COP 2016 should be building on lessons learned from ongoing civil society engagement with program data—but that engagement over quarterly data is not taking place.
- We are aware of multiple examples of duplication of programming in multiple countries, where PEPFAR IPs seem unaware of existing efforts by non-PEPFAR funded programs. As such, we suggest the guidance should be more explicit about planning to avoid programming duplication by identifying much more specifically the key partners already engaged, especially in the geographic/population focus areas.

2.0 PEPFAR'S APPROACH TO PROGRAM PLANNING AND DECISION-MAKING p13 -33

Key Populations

p22 While it's commendable that the guidance is calling for increased data collection on key populations, there should be clarification on how these data will be gathered, analyzed, and disseminated without political interference from local health authorities as is currently the case with PEPFAR-funded MSM and FSW study data being blocked from release in Namibia and Zambia.

Defining the strategy needed to break the epidemic

Section 2.1 PEPFAR should endorse the Fast-Track framework overall as well as 90-90-90. Fast-track is inclusive of 90-90-90 but clearly signals the importance of prevention options beyond ART. The language that identifies some interventions as "critical" and then ART as being the sole strategy without which epidemic control is "impossible" is inaccurate based on Fast-Track—all of the interventions need to go to scale; indeed, it is impossible without all of them. Suggest reflecting that framing and connecting gaps in services PEPFAR is not emphasizing with gap analysis discussed in the intro paragraph above.

CS Engagement

p28 We endorse the suggestions here that the assumption be that all CS who want to be involved are involved.
We also support the idea that if the problem is a "too large" civil society then the answer is to break the group up into several meetings and not to move to a representative, restricted situation—this undermines principles of transparency and openness and does not align with the project of delivering a COP that is a product of robust and iterative consultation.
Notes about moving outside capitals is also important.
We are glad to see that CS will be invited to the country reviews.
We believe the point about unfunded groups can be strengthened by saying "Particular attention should be given wherever possible to including civil society and activist groups who are not funded directly by PEPFAR and who may not be as familiar to USG staff but provide important outside perspectives."

p. 28 – This is a good directive to increase civil society participation in the reviews, but the details need to be clarified. Two representatives for all civil society? Which groups are structured to "vote" on this where disagreements exist? A slightly more organic process that occasionally allows more than two is appropriate when, for example, CS is diverse in its views and input and makes a case for including more than just two people. Allow Coordinators or Chairs the flexibility here to expand this number, which is unlikely to be used often but at times will be important.

p29 Mention is made here of times when meetings must be capped for space limitations. We suggest removing this section as all PEPFAR Coordinators should have access in some way to rooms big enough to accommodate a good number of persons. Multiple consultations may need to be held, but meetings should **not be capped**, which conflicts with direction on page 28.
More importantly, we note that this is an unnecessary concern; in reality, there has never been a case in our knolwedge where civil society engagement has exceeded available space. In fact, more and more diverse civil society engagement is needed in all PEPFAR countries where we work.

We suggest here an explicit note that it is the responsibility of USG staff or funded partners where appropriate to share information with those who cannot attend, not to rely on some CS groups to control information provision to others.

Additionally, we recommend that PEPFAR teams – possibly via OGAC – should be required to publish a centralized and publicly available calendar of when civil society engagement meetings are expected to occur as well as when data are going to be made available.

p30 ***The Global Fund CCM alone is not an appropriate substitute for a PEPFAR engagement process.*** "Election" and "selection" processes for civil society seats be it on CCMs or government panels is a complex and often problematic process where politics, power, money can align to seat some people more often than others. It starts from the often-false analysis that civil society is a unified and self-governing bloc. In fact, marginalized groups including LGBT individuals and sex workers may not be able to muster the votes to secure one of the two available seats. The CCM of the GFATM is a body that is designed to write, validate and collectively ratify a proposal that it controls, to some extent. This isn't the nature of PEPFAR, which is ultimately controlled by the USG. Using the CCM buys into the politics of civil society described above—it can exclude those that haven't gained access to this system and it may or may not facilitate the kind of collaborative, collective info-sharing and strategic analysis that the best COP processes did last year.

Fundamentally, the roles and responsibilities of CCM members are different from civil society groups engaging in oversight, consultation and advocacy regarding PEPFAR COPs. It does not make sense to emphasize selection and representation; engaging flexible, independent, and representative teams of advocates should be the emphasis.

That being said, the GF CCM in some countries *can* be effective as one channel for engagement so long as it does not take the place of an effort aimed not at "representation" of CSOs but instead at gathering the best input from all sectors and all who want to come forward to provide insights. Aligning time-frames to piggy-back on processes with the GF could enrich both processes.

3.0 Modular Planning Steps to Implement Enhanced Strategic Approach p37 -134

Treatment

We strongly support the strong focus on 90/90/90 as the goal *within the treatment portfolio*. The focus on moving faster and reaching 90/90 by 2017/2018 in key areas is also welcome.

In addition, we welcome the call for a move to "Test and Start" as a statement of USG policy.

p21-22 Explicitly mentions new models of service delivery, yet there is little guidance about what and how PEPFAR teams should move to enable these as part of the COP, and how PEPFAR will change the status quo so that contracted service providers are held accountable for delivery services in alignment with models of care that deliver high rates of retention in care and viral suppression. Are these considered in a separate Technical Considerations sections? If so, suggest including more explicit expectations that teams *will* move IPs to make use of these. Especially important are models that move ART into communities and out of expectations of monthly or bimonthly facility-based care for stable and virally suppressed patients.

p 59 We appreciate the clear definition of different expectations of scale up based on classification. It is especially good to see the explicit point that that "sustained" districts will be scaled up to reach 90/90/90 by 2020. Is the goal to continue scaling at the current pace in these districts? If so, we suggest calling these "sustained scale up" districts instead—to indicate that goal.

p69 We welcome identification of the problem of guidelines that conflict with best medical and WHO evidence. Suggest a much more explicit request that teams address this problem by asking within the COP for:
1) analysis of barriers to implementing immediate ART as policy in the country
2) Explanation of the work that will be undertaken by USG to help govts get to immediate ART—could be TA to ministry, presentations on science, work with civil society experts, engagement of Ambassadors in advocacy, etc.

p80 As discussed further below, we are concerned about what we are already learning from a few districts where it seems likely that closing "low volume sites" and redirecting patients has a negative impact on patient access. We urge that where this is the plan, teams be asked to identify how far this would mean patients would have to travel to access ART and consideration be given to implementing alternative models of care. Likewise, quarterly COP review meetings were promised to civil society in order to extend the possibility of rapid course correction in response to such missteps—but they are not yet taking place, except in one country—leading to real program risk.

p96 Civil society should explicitly be incorporated into questions of monitoring and quality. CS can provide important feedback on quality, warnings of stock outs, etc. if they are funded to do so—and often much more effectively and inexpensively than existing IPs mandated only to gather data rather than seek to address governance challenges.

Overall, explaining the **gap** between what is needed on ART to "end" the AIDS crisis and what PEPFAR is able to fund is critical for this section in understanding hard choices being made by teams. In addition, treatment scale up must accompany scale up of other critical prevention activities to reach the full potential for communities and so trade offs need to be considered and articulated.

In addition, we note the strong need for PEPFAR programs with majority of investments in TA at the expense of DSD to shift in their COP2016 to a stronger emphasis on delivering treatment. There does not seem to be a signal here to that effect. This commitment should include timelines and targets beginning with COP2016 and be made explicit here in the guidance.

Key Populations

We strongly support the push for all OUs to collect data on key populations and especially the call within the guidance (p64) to make services accessible even where data is weak. We note that some of last year's COPS struggled with this—using lack of data to justify lack of action. As such, we think this point could be made even more forcefully.

p41 Good to see that all PEPFAR Operating Units are required to include data on MSM, FSW, and PWID. What about transgender women? (as mentioned on the same page, they are also a key population as defined by UNAIDS and are disproportionately vulnerable to HIV infection)

p41 Missing here is service coverage levels not just population size and epidemiology. This is challenging, but some qualitative proxies could be used.

p41 What guidance is being issued for countries (like Namibia and Zambia) where PEPFAR has funded key populations research, but where data dissemination is being blocked by country health authorities? Can OGAC advise here alternate channels for data being released to

implementing partners and civil society?

p56 How do key pops fit into the equations about spending per PLHIV? Direction to prioritize key populations and make services accessible likely has implications that higher spending per PLHIV will be needed for key pops, suggest including this point in considerations around interpreting spending data.

p64 Good that accessibility work needs to happen despite lack of data. What proxies can be used for epi data to show that services are actually accessible? How will that be measured and accountable for progress?

p120 Good that key pops are explicitly included on site-setting guidance, but the notes above about limits of data are important. Suggest that guidance explicitly suggest the collection of **qualitative data** from communities that can supplement the SIMS etc. Focus groups and conversations with community leaders can help map the areas of high concentration of key pops, which mapped against prevalence can help inform focus analysis and avoid leaving out key pops.

On sex worker programs: In several countries the anti-prostitution pledge is still interfering with meaningful efforts at a country level to engage sex workers in HIV prevention and treatment programming. Evidence suggests the interpretation of the pledge requirement, despite Supreme Court ruling, still varied significantly based on individual decisions made contract-by-contract and country-by-country. Guidance is insufficient to ensure the pledge does not undermine programmatic goals.

Defining the response needed to break the epidemic

Overall there is a need, as mentioned in the first section above, for teams to articulate the comprehensive response required to break the epidemic and then to identify the gaps left by PEPFAR funding, such that there is an accurate representation of the suite of strategies required to break the epidemic that can guide broader planning discussions and allocation of new or reprogrammed PEPFAR resources should they become available. This is essential to ensure that the full complement of requisite interventions is considered and that some are not de-prioritized by default based on a misreading of this guidance.

Section 3.1.3 While ART coverage and targets are supposed to be calculated based on SNU, the single line regarding targets for all other combination prevention appears to instruct country teams to use national or even regional data—completely moving away from a goal of achieving 80% coverage of, for example, VMMC in a key area. This single line lumps together a range of strategies, doesn't specify the coverage goal and doesn't assist with prioritization or emphasis decisions. A later statement, "teams should also calculate unmet need for VMMC and PMTCT" doesn't provide sufficient direction—especially about what do to with that information. There is a much better explanation of what to do with VMMC later on in the document – so remove this statement and clarify with where to look in subsequent detailed sections. Avoid all formulations that lump combination prevention interventions—which have manifestly different parameters for measurement, quantification of coverage, implementation and even definition (eg comprehensive prevention packages for key and priority populations)—and specify what should be done with each component and/or the steps for defining these packages in a rigorous and specific manner.

p 73-74 This is a very open-ended directive on an essential activity—especially given the statement on p 68 that there is no specific guidance applicable to all PEPFAR OUs on the most appropriate allocation of funds between combination prevention and support activities." There is a strong evidence base for bringing coverage of VMMC to scale—reflected elsewhere in the document; PrEP is now the subject of a UNAIDS target and adopted by the PEPFAR SAB. There is a line citing the WHO recommendation regarding PrEP that does not provide any context for readers of the guidance of the action that should be taken in the COPs. There should be far greater attention given to how this basic package is defined, targets set and implementation undertaken.

Civil Society Engagement

This section is significantly improved, though we note that guidance last year was also strong but teams did not follow the guidance as written (recognizing in large part due to time pressures) in a majority of countries. As such, we make a few specific suggestions below to make expectations more explicit.

A major problem with last year's COPs CS engagement process came when the actual draft SDSs were only shared *after* submission. This meant CS did not have opportunity to engage with much of the critical information, context, and decisions made in the SDS in country level conversations. This in turn pushed much of the most important feedback and intervention out of the country-level conversations and into the reviews—which upset PEPFAR country teams. It significantly undermined CSO meaningful engagement and has not been sufficiently dealt with in the guidance. Specifically on this point we suggest:

- p90, 101 Please consider revising these graphics to also include explicit steps of sharing the draft SDS w external + receive feedback + submission.
- p107 change MAY include to SHOULD include
- p107 Change to "draft Strategic Direction Summary for COP16"
- We urge addition of a simple explicit statement that says: "**Country teams should share the draft SDS with CS at least 2 weeks before it comments are due, which should be at least one week before submission to HQ to allow time for teams to review and incorporate feedback.**

p108-109 Many of the questions on this check list are not helpful or appropriate yes or no questions on CS engagement. Question such as:

- has ongoing contact established or maintained with a diverse group of civil society organizations and are plans in place for ongoing contact?
- Did civil society have an opportunity to provide the PEPFAR team with suggestions on goals, priorities, targets, and budgets before plans for COP 2016 were developed?
- Were draft goals, priorities, targets, and budgets for COP 2016 discussed?
- Were discussions held on the role of local civil society in the HIV/AIDS response?

can all be answered in the affirmative without adhering to the spirit of intention of the guidance.

Instead we suggest asking:

- On what date was the draft SDS shared?
- How many CSOs provided input?
- What portion of those CSOs are funded by PEPFAR?
- How many of those CSOs were activist or networks of PLWHA? Key Populations?

p.108 – Can a target date be provided for when civil society will be able to see the final approved COP? It is now November, and many civil society partners report they still have not received a copy of the final 2015 COP.

Human Rights & Advocacy

P36, Local small grants for Human Rights work are a good step. But they do not address the most fundamental needs of groups seeking to change government policy, watchdog implementation, and promote human rights—which is dedicated advocacy/policy staff. Most groups have none.

As such, we suggest this not be sidelined to just a small grants program, but instead be considered part of the core work of the SDS. Teams should explain how they are helping resource the accountability systems needed to address program scale up and sustainability—including resourcing groups to do the work of accountability. Civil Society activism and advocacy is often far more effective and cost effective than any TA provided by PEPFAR IPs in changing policy and practice. See, e.g. the stop stock outs work in several countries.

p33 This set of baseline documentation activities seems inadequate to advancing human rights. Health centres and NGOs have many approaches to documenting rights violations as part of routine services. Given the new "test and start" mandate as well as enduring unsolved issues with homophobia, sexism, anti-sex work and more—shouldn't there be a little more here?
There is a crucial need for the legal environment to be addressed as part of key populations programming yet it is not clear how or by what mechanism this priority recognized by PEPFAR should be conducted.

In addition we wonder why most of the HR activities are to be undertaken by PEPFAR staff rather than by supporting national human rights groups and activists?

p51 a much better articulation is needed as to how the elements catalogued in the SDI will actually change.

p34 AAAQ matrix is highly appreciated as a framework, but it lacks meaning here as it appears without indications about how to assess it in relation to PEPFAR and address deficiencies.
For both of these points, the history of AIDS tells us that simply documenting deficiencies in governance does not result in change. Instead, resources and efforts by Human Rights activists and civil society groups are needed and should be resourced rather than significant investment in "expert" TA assesmnets .

p.109 – For point "l", it would be useful to provide details on exactly what types of USG funding are available to civil society (e.g. Small Grants Program, sub-contracts with implementing partners, etc.)

Gender Analysis

p 53-53 This section briefly highlights a separate gender analysis that has to accompany next year's plans. The PEPFAR language on gender awareness is very inclusive—it addresses gender-non conforming individuals as well as cis-gendered men and women. Who is going to do this? Civil society engagement should be a must in this. How will it actually happen and what questions will be asked?

Geographic/Population/Expenditure Prioritization

p121 The 4 or fewer rule needs to be taken in a context of evaluating site effectiveness and population density as well as the current reality of data weakness/absence at the clinic level. Where low yield sites are near high yield sites this is especially suspicious and should be cross-checked with TA partners. As a hard and fast rule, this is especially worrisome in context of #3 consideration not to make decisions based on expected yield. This is a good rule, but only if combined with quality assessment. Assumption here seems to be ending support rather than fixing quality issues that may be driving low yield (e.g. #4). This could undermine the ultimate goal of epi control where small investments in quality could yield higher yield.

p83-Transition plans were largely lacking last year—COPs were largely vague on both process and content of transitioned programs and did not clarify how promises about maintenance would be implemented. No COP we know of had a plan to assess impact of transition to ensure people were *actually* maintained in care. Suggest that the guidance specifically what must be in a transition plan and make explicit that OUs need to do some sort of assessment in follow up to see if patents have been sustained.

p111-117 The guidance should better address the challenge of the handful of very high burden countries where 80/20 is not the most relevant factor. 20% may still represent out of control HIV. Greater attention could be given here to asking teams to justify their decisions and not apply 80/20 mechanically.

p64 Generally, but especially where focus areas are not an entire SNU, we are concerned that several COPS have not take into account mobility of populations, migration and work patterns, etc.

p55 The guidance says that EA-EPI analysis is "optional"—meaning countries wont necessarily have to run the hotspot numbers. Also, there is no mention of adolescent girls and young women as a population to run the numbers for EA EPI on—in spite of this group being a focus of the DREAMS initiative.

p58 The guidance advises field teams "to review previous decisions from COP 15 and make any required changes about which **locations** (sub-nationally) will be selected for scale-up to saturation or aggressive scale-up and which **populations** within those locations will be targeted." We are concerned that by first advising the prioritization of locations, there is a risk that key populations falling outside these prioritized locations will be abandoned for service provision. We would prefer that language here advise field teams to account for the possibility that key populations programming will still need to be provided even outside prioritized SNU locations.

As we note above, given the lack of KP data in many countries, these prioritization decisions should be taken only after consultation with KP organizations to gather local knowledge and qualitative evidence to inform understandings of additional sites in need of KP-targeted programming.

In addition, we suggest that the Guidance be more explicit about how countries should address

districts or facilities that are at the margins – particularly if newer data suggests that a district included as scale-up in COP2015 now would be classified as "sustained" or vice versa. Given the quality of the data being used for these decisions and the potential for vacillations at marginal cut-off points, we believe teams should be advised on how to proceed in such circumstances.

p54-57 The guidance requires country teams to develop charts of PEPFAR spending in each district per PLHIV and compare against the total PLHIV burden in the country. The problem with these charts is that they are open to misinterpretation without more information that is not required. For instance, a district may have very low spending per PLHIV and that could be because they are highly efficient or because only a limited amount of money is being spent in that district. Likewise a district with high spending per PLHIV may be because programs in that district are inefficient or because they have high levels of coverage for treatment.

We recommend either (A) that the Guidance also require a chart of the treatment coverage levels in each district to put the spending in context; or (B) simply evaluate the proportion of PEPFAR funds being spent in each district as against the percent of PLHIV in each district.

Health Systems & Sustainability Index

P51 Guidance notes the value of direct G2G programs and support of the public sector, but does little to encourage teams to critically consider the comparative small portion of funds invested in the public sector. We believe significant support to effective non-governmental IPs can be both appropriate and helpful. But over-reliance can starve the public sector on which most PLWHAs depend of the funds they need to successfully engage.
Suggest requiring

a. A simple total of funding direct to public sector institutions
b. What portion of services provided by IPs are provided at public sector facilities
c. A brief justification for why this portion is flowing through the public sector.

5.0 COP ELEMENTS p 138-160

Treatment

p140 We have a **significant problem** with this definition of direct support. We suggest that **"**Technical assistance for service delivery improvement support" is not direct treatment. Indeed in several countries it is clear that occasional visits to a clinic for TA largely substitute completely for purchase of commodities and support to front-line staffing. This is not direct treatment and needs to be revised.
In 2014 we were provided a definition of DSD support based on a two-prong test of the service being "critical" (e.g. commodities, staffing, operational costs) + frequent presence.
Has this definition changed? Why is it not included ehre?

Related: p186, where is the section that explicitly defines what constitutes direct treatment allocation?

p144-145 We welcome the requirements that all implementing mechanisms have an identified "agreement timeframe" as well as – if relevant – a "Legacy Mechanism ID". Both will be of assistance to stakeholders in understanding the evolution and future of PEPFAR programs.

P159 We note that new mechanisms are no longer required to include mechanism narratives and that these are being replaced with a required “Activity Table”. The format for the Activity Tables, however, are not available in the Guidance so we note some concern that PEPFAR ensure that the activity tables are sufficient to enable civil society organizations to clearly and fully understand what services implementing partners are being funded to provide. Activity Tables – if done properly – may be a substantial step forward over narratives or they may provide even less information if done improperly.

8.0 U.S. GOVERNMENT MANAGEMENT AND OPERATIONS (M&O) p195 - 221

We suggest there is a need to build out an existing budget code or create a new budget code specifically dedicated to Civil Society advocacy, monitoring, and human rights work.

APPENDICES p.224 -259

p230 We recommend adding a cross-cutting attribution related to funding for civil society advocacy, monitoring, human rights work and service evaluation. Funds attributed to this cross-cutting attribution should be used to fund civil society groups to engage in advocacy across a range of topics, but particularly toward monitoring of policy change, program implementation and program quality.

Health Systems & Sustainability Index

p230 HRH received insufficient attention throughout the document, but we are particularly concerned here that the bulk of HRH activities listed here are training. Partners are highly concerned that at this stage in the response training may actually be undermining the response as the many workshops and in-service trainings a) take up large budgets sufficient to hire many more health workers that are urgently needed and b) take health workers away from their jobs without measurably improving the level of service delivery. This should be addressed and a focus on supporting *more* health workers in the public sector - including salaries - should be emphasized. In addition PEPFAR should consider guidance limiting the number of trainings and workshops IPs conduct.

p231-232 – For both the MSM/TG and FSW budget attribution, we recommend adding an activity category for community mobilization, organizational capacity-building, and social support for MSM/TG.