

The President's Emergency Plan for AIDS Relief

Expenditure Analysis of PEPFAR Programs Guidance FY 2015

This guidance is designed to assist PEPFAR-implementing partner organizations collect and submit relevant program information and financial data for the PEPFAR Expenditure Analysis Initiative. The subsequent instructions and operational definitions refer to the data collection template provided by the PEPFAR Coordinator/Secretariat.



**PEPFAR FINANCE
AND ECONOMICS
WORK GROUP
(FEWG)**

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ACRONYMS AND ABBREVIATIONS

AOR	Agreement officer's representative
APR	Annual program results
ARVs	Antiretroviral drugs
ART	Antiretroviral therapy
BS	Blood safety
CBCTS	Community-based care, treatment, and support
CBTC	Community-based testing and counseling
CDC	United States Centers for Disease Control and Prevention
CHW	Community health worker
COAG	Cooperative agreement
COP	Country operational plan
COR	Contracting officer's representative
FEWG	Finance and Economics Work Group
FSW	Female sex worker
EA	Expenditure analysis
ECD	Early childhood development
FAQ	Frequently asked questions
FBCTS	Facility-based care, treatment, and support
FY	Fiscal year
GBV	Gender-based violence
GP	General population
HR	Human resources
HSS	Health system strengthening
HTC	HIV testing and counseling
HQ	Headquarters
IC	Infection control
IM	Implementing mechanism
INGO	International non-governmental organization
IP	Implementing partner
LAB	Laboratory
KP	Key populations
M&E	Monitoring and evaluation
MAT	Medication assisted therapy
MER	Monitoring, evaluation, and reporting
MSMTG	Men who have sex with men and transgendered individuals
NASA	National AIDS Spending Assessment
NHA	National Health Accounts
NGI	Next Generation Indicators
NGO	Non-governmental organization
OMB	The Office of Management and Budget
OST	Opioid substitution therapy

OVC	Orphans and vulnerable children
PC/S	PEPFAR Coordinator/Secretariat
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PIMS	Partnership information management system
PITC	Provider-initiated testing and counseling
PP	Priority Population
PROMIS	PEPFAR Records and Organization Management Information System
PM	Program management
PMTCT	Preventing mother-to-child transmission
PWID	Persons who inject drugs
ROP	Regional operational plan
QA/QI	Quality assurance/quality improvement
SAPR	Semi-annual program results
SHA	System of Health Accounts
SI	Strategic information
SNU	Sub-national unit
TA	Technical assistance
TBA	Traditional birth attendant
UGM	Umbrella grants manager
UNAIDS	The Joint United Nations Programme on HIV/AIDS
US	United States
USAID	United States Agency for International Development
USD	United States dollar
USG	United States Government
VCT	Voluntary counseling and testing
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

GETTING STARTED FOR IMPLEMENTING PARTNERS

1. Start early!

This exercise can take a significant amount of time, so start early to reduce stress as the deadline of November 13th, 2015 approaches.

2. Assemble a team

Inputs from accountants, program staff, and management are required to accurately report to EA.

3. Review EA background materials

Get familiar with the definitions and methods of reporting to EA in this guidance and the Excel data collection template

4. Verify which funds must be reported to EA

All PEPFAR COP programmed funds spent during the US government fiscal year 2015 (October 1, 2014 – September 30, 2015)

4. Contact sub-grantees and notify them of EA

Prime partners are responsible for reporting data from sub-grantees to EA. Contact subs early to notify and request financial data.

5. Gather financial reports and program data (S/APR)

Begin compiling required data. Determine which program areas you contribute to and if you work at the site-level and/or above site-level.

6. Again, Start early!

You may begin filling out the Excel data collection template early even if the US government fiscal year quarter has not closed yet. Just add 4th quarter expenses prior to finalizing the template!

1.0 SUMMARY

The United States Government (USG) is conducting an Expenditure Analysis (EA) of PEPFAR programs for fiscal year (FY) 2015, 01 October 2014–30 September 2015. The goal of this interagency exercise is to better understand the costs the USG incurs to provide a broad range of HIV services and support and subsequently use this information to improve program planning. Your organization is being asked to report program information and total expenditures for FY 2015 by program area, cost category (as defined by PEPFAR) and geography. Data should be collected and submitted using the PEPFAR Records and Organization Management Information System (PROMIS) or other specified data system. This guidance provides instructions for accessing the PROMIS website; downloading, completing, uploading, and submitting the Excel-based data collection template; and requesting technical assistance (TA). Further, this guidance provides operational definitions for PEPFAR program areas and cost categories, and recommended methods for categorizing and allocating expenditures. After data collection and the cleaning is complete, your organization will receive a summary report of the analyzed data.

1.1 TIMELINE

Data collection will commence on 01 October 2015. Your organization is requested to complete and submit the data collection template via PROMIS (or other specified data system) no later than 13 November 2015. New data will not be accepted beyond this date.

The EA initiative is an ongoing PEPFAR activity and is being institutionalized as part of routine PEPFAR reporting. If your organization continues to be a PEPFAR implementing partner in future fiscal years, your organization will be asked to report on PEPFAR expenditures in a similar format in each fiscal year in which you spend PEPFAR funds.

1.2 CONFIDENTIALITY

Identifiable mechanism-specific program and expenditure information you submit will be shared with your USG project manager (i.e., AOR, COR, Activity Manager, Project Officer) and USG country teams. In addition, the USG Expenditure Analysis Advisor for the country, the USG Expenditure Analysis headquarters coordination team, the contracted Technical Assistance Provider for your country, and the PROMIS development team will have access to your identifiable, mechanism-specific data for purposes of providing technical assistance, IT troubleshooting, and data analysis to generate results reports.

Data may be shared with other USG agency staff at headquarters and other stakeholders (e.g., host country governments, UNAIDS) as appropriate.

1.3 NOT AN AUDIT

Validating FY 2015 budgets with EA data is not an objective of this activity. Instead, the goal of this exercise is to better understand all of the actual USG costs associated with providing HIV services to beneficiaries in order to improve program planning. Understanding that PEPFAR budget codes do not align directly to EA program area categories and that disbursement are often delayed from the fiscal year in which funds are obligated.

It is understood that completion of the EA data collection template may involve estimation of how funds were spent for which explicit documentation is not available, although it is highly recommended that all estimation procedures should be explained and justified in the comments section of the data collection template, especially if they differ from the recommended guidance.

1.4 FEEDBACK

Your feedback on the data collection template and process is highly valued. You will have several opportunities to share your experience and provide feedback so that in the future, this process minimizes burden and maximizes the usefulness of results, both for your organization and USG agencies. You are encouraged to provide feedback to your country's USG EA Advisor or PEPFAR Coordinator/Secretariat, which will be shared with the FEWG.

1.5 REQUESTED DATA

You are requested to provide EA-specific program information and comprehensive expenditure data on your PEPFAR-supported programs for FY 2015. Some standard categories and descriptions for program outputs and expenditures are listed below; however, some data may be requested that are unique to each program area.

FUNDING SOURCES TO BE REPORTED

1. Only PEPFAR funds should be reported to EA.

Your organization may receive funding from sources other than PEPFAR, including other non-PEPFAR USG funds for other health areas such as family planning, malaria, tuberculosis, or nutrition. Any non-PEPFAR expenditures should NOT be reported to EA. Even if the non-PEPFAR funds are received under the same Cooperative Agreement or contract as PEPFAR funds, you must report only the PEPFAR funds spent to EA. If you are not sure which of the funds that your organization receives are from PEPFAR, please immediately contact your USG project manager (AOR/COR/Activity Manager/Project Officer) to clarify this before completing your EA template.

2. PEPFAR funds programmed in a Country Operational Plan (COP) or Regional Operational Plan (ROP) that were spent during FY 2015 should be reported to the 2015 EA. Funds programmed in any COP or ROP year can be reported to the 2015 EA so long as the funds were actually expended between 01 October 2014 and 30 September 2015.

The most common category of PEPFAR funding for an implementing partner are funds that originate from the Country Operational Plan (COP) or Regional Operational Plan (ROP) process, which serves as the annual basis for U.S. Congressional notification, allocation, and tracking of budgets and targets. Funds budgeted through this process are affiliated with a prime implementing partner (organization), and an implementing mechanism (agreement) with an affiliated "Mechanism ID" that is recorded in the U.S. State Department's FACTSInfo system of record. Spending associated with funds budgeted for your organization in any year's COP/ROP that were spent during FY 2015 are required to be reported to EA 2015. This includes COP/ROP funds that are used to "buy in" to a centrally-held Cooperative Agreement or contract that is managed out of USG agency headquarters.

3. Beginning in EA 2015, Central initiatives, "plus-up" funds, and other special initiative funding that is not programmed in a COP/ROP should also be reported

A second and less common method of allocating PEPFAR funding to organizations is through central initiatives, "plus-up funds", or other special initiative funding. These are often one time disbursements and are intended to fill critical programmatic gaps as determined by PEPFAR leadership and host-national governments, including but not limited to the Key Populations Challenge Fund; VMMC Reserves; Accelerating Children's HIV/AIDS Treatment (ACT); and Determined, Resilient, Empowered AIDS-free, Mentored, and Safe (DREAMS) women.

Beginning in EA 2015, spending associated with funds budgeted to your organization through these special initiatives SHOULD be reported in this exercise. “Central initiatives” here refers to the source of the funding (i.e., not from a COP/ROP) and not the location of the Cooperative Agreement or contract (as in #2 above, COP funds that are used to “buy in” to centrally-held Cooperative Agreements and contracts should be reported to EA.)

If you are not sure if your PEPFAR funds are from a COP/ROP, or from a central or special initiative, please immediately contact your USG project manager (AOR/COR/Activity Manager/Project Officer) to clarify this before completing your EA template.

4. Eligible funds spent during FY15 must be reported to EA by implementing mechanism, based on the implementing mechanism number recorded in the FACTSInfo system of record.

When PEPFAR country teams submit their COPs/ROPs, they record an implementing mechanism number, name, and prime partner in a USG system called FACTSInfo. This PEPFAR implementing mechanism usually corresponds to a specific Cooperative Agreement or contract; however, the implementing mechanism number and name as entered in FACTSInfo may be different from the Cooperative Agreement or contract number and name, or the informal project name used in country. The implementing mechanism is the unit of analysis in EA and therefore data must be submitted separately for each implementing mechanism.

If your organization is a prime partner for more than one implementing mechanism, your organization is required to submit EA data for each mechanism individually (i.e. one Excel template per COP-funded implementing mechanism that spent funds in FY 2015). This includes situations where your organization is implementing a project that is extended under a new implementing mechanism number; even if it is the same project from an implementation perspective, the spending must be reported by mechanism as programmed in the COP/ROP and recorded in FACTSInfo.

If your organization receives both COP/ROP and central initiative funding via the same mechanism, please record all expenditures for together in one template.

If you are not sure what your implementing mechanism number is, please immediately contact your USG project manager (AOR/COR/Activity Manager/Project Officer) to clarify this before completing your EA template. If you do not have a mechanism ID, please contact your EA advisor along with EA global coordinators Ramona Godbole (rgodbole@usaid.gov) and Jeffrey Bale (wol3@cdc.gov)

5. Headquarters Operational Plan (HOP) and country-level Management and Operations funds should not be reported to EA 2015.

If you have questions regarding categorizing your organization’s PEPFAR funding per the above guidance, please contact your USG Contracting Officer or Activity Manager for more information.

PROGRAM INFORMATION

Most program information used for EA will be taken directly from indicator data routinely supplied to PEPFAR through the Semi-annual and Annual Program Results (S/APR), and will be obtained from DATIM. You are requested to report some program information required for the analysis is requested that has not already been supplied to PEPFAR (see Table 3).

EXPENDITURES

Your organization is requested to report total PEPFAR expenditures (as defined above under “Funding Sources to be Reported” section) for FY 2015 by implementing mechanism, program area, cost-category, point-of-service, and geography. Expenditures are first classified as those that occur at the point of service delivery or site-level (e.g., in facilities or communities) or those that occur

above site-level (e.g., support the broader program or health system). Expenditures at the site-level are categorized first by geography, next by point-of-service category, then the relevant program area, and lastly by common cost categories associated with each program area (e.g., vehicles, personnel, office equipment, etc.). PEPFAR expenditures incurred above site-level for *program management (PM)*, *strategic information (SI)*, and *surveillance* are categorized first by geography, then by cost category, and lastly by program area (using a percentage estimate of level of effort). Health systems strengthening (HSS) is first categorized by geography, cost category, functional area, and program area.

The goal in reporting expenditure information is to account for every COP/ROP-funded and Central/Special Initiative-funded PEPFAR dollar spent over the fiscal year. Expenditures should not be reported by PEPFAR budget code, but according to how PEPFAR dollars were actually spent to deliver services and/or support. Any site-level expenditures should be classified by geography, program area, and reported according to the appropriate cost category (e.g., vehicles, personnel, office equipment, etc.). For some program areas (e.g., community-based care, treatment, and support), additional disaggregation of expenditures or program effort may be needed as appropriate to enhance interpretation and usability of results. Any expenditure that did not originate at the site or the point of service should be recorded as program management (PM), strategic information (SI), surveillance, or health system strengthening expenditure (HSS). Full descriptions of each expenditure category can be found in sections 2.2–2.5. If an implementing mechanism reports indicators to PEPFAR, it is expected that expenditures are allocated to the associated program areas.

CURRENCY CONVERSION

Please report all expenditures in United States dollars (USD). If your accounting software does not already track your transactions in USD, please use the average exchange rates listed in Appendix A to convert your local currency to USD.

SHARED EXPENDITURES

Some common types of expenditures may be shared across program areas, such as personnel who work on both care and treatment and HIV testing and counseling activities; while others may be shared across geography, such as a vehicle used across a country. Shared expenditures such as these must be allocated to the appropriate program area and geography in order to accurately estimate expenditures for specific HIV services and target populations. This guidance provides some general illustrative examples of methods for allocating shared expenditures in section 3.0. Each organization is different and there is no single method for allocation that will accurately define the program for all organizations supplying data. Technical assistance (TA) will be available in-person and remotely to help your organization work through specific challenges pertaining to allocation. Information on requesting TA can be found in section 4.2.

ACCOUNTING METHOD

For the purposes of this analysis we ask your organization to use the cash basis of accounting and recognize disbursements as expenditures. This means record all COP/ROP-funded PEPFAR dollars as they were spent during the last fiscal year. Hence, "financial expenditures" are cash disbursements from the perspective of the prime contractor or awardee.

Examples of transactions that would be considered a financial expenditure for this analysis:

- Cash paid for an asset (e.g., vehicle, equipment, etc.), regardless of the asset's useful life
- Prepayment for rent, supplies, or utilities

Transactions that would not be considered a financial expenditure for this analysis:

- An asset purchased and received, for which payment has yet to be made
- Expenditures accrued but not yet paid
- Issuance of a note or other promise to pay cash at a time in the future

EXPENDITURE ANALYSIS RULE OF THUMB FOR REPORTING EXPENDITURES BY GEOGRAPHY

For the purposes of reporting expenditures by geography, there is a rule of thumb in EA which states: **“report the expenditures at the location where they are consumed”**. In short, regardless of where a transaction occurs, the expense should be reported where the resource is consumed. The exception to this rule is training, please see section 3.6 for a detailed explanation of how to report training expenditures.

Example: A vehicle is purchased in the capital city, which will be utilized to provide services and support in another province. The dollars were consumed in the capital city but the resource on which the dollars were spent – the vehicle – will be consumed, i.e., used, in the province. Therefore, although the transaction occurred in the capital, the full expenditure on the vehicle should be reported in the province in which it will be utilized.

Example: A foreign consultant is hired to conduct a national-level evaluation in the country. The consultant spends 50% of her time outside the country for study preparation and report writing and 50% of her time in the country for data collection. The consultant is paid via wire transfer to her bank outside the country. The dollars were consumed outside the country but the resource on which the dollars were spent – the consultant’s time – was consumed 50% outside the country and 50% in the country. Therefore, the expenditure on the consultant should be reported as 50% above national and 50% national.

Special note for Department of Defense Partners: For Department of Defense partners that provide military-to-military services, expenditure analysis data is not required to be disaggregated to sub-national units within a country due to special considerations around confidentiality. A separate template has been created for these partners and can be accessed by contacting <mailto:Brittney.n.shook.ctr@mail.mil> or Catherine.ramirez4.ctr@mail.mil.

FUNDS DISBURSED TO SUB-GRANTEES

Some organizations may have funds they disbursed to sub-grantee partners over FY 2015. The prime implementing partner is responsible for capturing expenditure data attributable to each sub-grantee organization and including those data in the prime partner’s EA template submission.

Special note for Umbrella Grants Managers (UGMs) reporting in South Africa: For UGMs, prime implementing partners may help their sub-partners collect the requested data, but unlike traditional prime/sub-prime arrangements, each UGM sub-partner should report data as an individual unit. In other words, funds disbursed through UGM subs should not be included in the UGM submission, but should be reported as individual, separate mechanisms. The UGM prime partner should therefore only report expenditures by their own organization, such as program management and any technical assistance or systems strengthening expenditures for managing sub-recipients.

1.6 DEFINITIONS OF PROGRAM AREAS AND COST CATEGORIES

Throughout this guidance and the Excel EA data collection template there will be references to EA program areas and cost categories. The definitions of those terms can be found in Table 1 and 2 respectively. These program areas and cost categories in EA are exhaustive and exclusive encompassing the nature of PEPFAR support and therefore it is intended that each dollar is able to fit in the associated category.

Please note that the definitions for EA program areas differ from the PEPFAR budget codes used to program funds to your organization through the COP/ROP process.

Table 1. EA Program Areas and Descriptions

Program Area	Description
Facility-based care, treatment, and support (FBCTS)	Clinical care, support, and antiretroviral therapy (ART) provided in a health facility. Effort related to supportive supervision and mentoring of healthcare workers providing care and treatment services in a health facility as well as patient-directed TB services in a health facility should be reported under this program area. This program area also includes nutrition support, psychological and other supportive interventions, linkage and retention activities ¹ , and quality improvement measures that occur within a health facility.
Community-based care, treatment, and support (CBCTS)	Care, support, and ART provided in a community setting, outside of a traditional health facility. This includes any clinical care provided outside health facilities, as well as nutrition support, psychological, social, or spiritual care, and economic strengthening activities. Effort related to supportive supervision and mentoring of healthcare workers providing care and treatment services in a community or home-based setting should be reported under this program area. This program area also includes linkage and retention activities ¹ and quality improvement measures that occur within a community or home-based setting.
Prevention of mother-to-child transmission (PMTCT)	Services for pregnant women and exposed infants which include HIV testing and results; access to care, ART and prophylaxis for those found positive; and information on ways to protect themselves if negative. Note that classifying expenditures reported for supporting Option B+ will depend on your country-specific implementation of Option B+. Specifically, effort expended to support women who are on treatment (currently pregnant or not) who are still counted as receiving Option B+ should be reported as PMTCT. When your organization continues to support those women on lifelong treatment beyond their being considered an Option B+ beneficiary, those expenditures should be classified as FBCTS.
HIV testing and counseling (HTC)	Services providing HIV testing and results to individuals as well as counseling on how to remain negative for those who test negative and information on seeking care, treatment, and prevention services for those who test positive. Note: HIV testing done in a laboratory setting should be recorded under the LAB program area.
Voluntary medical male circumcision (VMMC)	The provision of surgical circumcision and support services. Expenditures related to the provision of HTC services which often accompany VMMC procedures should be reported under the VMMC program area rather than the HTC program area.
Post-exposure prophylaxis (PEP)	Services providing prophylaxis for both occupational and non-occupational exposure to HIV.
Blood safety (BS)	Services and support for the collection and testing of blood units to ensure a safe and adequate blood supply.

¹ Linkage and retention activities may include such innovations as using a buddy system, drug drop-offs and pick-up points, m-health (text, follow-up calls), transport help, mobile service schemes, and other facilitation actions that retain clients in the continuum of services.

Infection control (IC)	Investments in renovating facilities and training health care workers to reduce the spread of infectious disease. This includes renovations and training for TB-HIV mitigation, however, patient-directed TB services should be recorded under FBCTS.
Laboratory (LAB)	Provisions of diagnostic services related to HIV clinical interventions (e.g., lab-based HIV testing, CD4 counts, viral load, hematology, chemistry, and tuberculosis testing), early infant diagnosis, quality improvement/quality assurance, safety and employee infection control, and site-level system development support efforts to maintain, renovate, train, and otherwise expand laboratory capacity and quality.
Orphans and vulnerable children (OVC)	Services that target OVC needs in the areas of medical care (not facility-based), educational support, spiritual care, psychological care, social care and food and nutrition.
General population prevention (GP-PREV)	Behavioral prevention and structural prevention interventions targeted to the general population rather than specific key-populations or other vulnerable populations.
Key population prevention-persons who inject drugs (KP-PWID)	Behavioral prevention and structural prevention interventions targeted to persons who inject drugs including harm reduction services, needle exchange and condom distribution. Expenditures related to the provision of medication, such as methadone, to PWIDs should be estimated and reported under the Medication Assisted Therapy (MAT) program area.
Key population prevention- female sex workers (KP-FSW)	Behavioral prevention and structural prevention interventions targeted to female sex workers.
Key population prevention- men who have sex with men and transgender (KP-MSMTG)	Behavioral prevention and structural prevention interventions targeted to men who have sex with men and transgender populations.
Priority Population Prevention (PP-PREV)	Behavioral prevention and structural prevention interventions targeted to other vulnerable populations which are not PWID, FSW, or MSMTG specifically. Depending on the country context, this may include but not be limited to: miners, migrant workers, truck drivers, fisher folks, mobile men with money, or enlisted military.
Medication Assisted Therapy (MAT)	Provision of opiates such as methadone for PWIDs. Expenditures related to outreach, mobilization, and other ancillary services provided to opioid substitution therapy (OST) clients should be estimated and reported under the SORP-PWID program area.

In the site level sheet of the data collection template, there are fifteen cost categories common to each of the program areas. In the PM, SI, and HSS sheets of the data collection template, the cost categories are streamlined into four common categories (five in the case of HSS). Definitions for these cost categories can be found in Table 2.

Table 2. EA Cost Categories and Descriptions

Cost Category	Description
Investment expenditures: Site-level program expenditures, both human and capital, that have a useful life of more than one year	
Training (in-service)	Expenditures in this category should include all expenditures related to training, such as materials, per diem, travel, facilitators and venue. In-service training supports the capacity development of existing health workers and program staff <i>at the site level</i> . Training that supports the creation of new health workers or supports the capacity development for government employees at the national level should be entered on the HSS worksheet. Training is also the exception to the EA rule of thumb: “report expenditures based on the location in which they are consumed”. A complete description of how to classify training expenditures is provided in section 3.6.
Construction and renovation	Site-level expenditures for construction and renovation of health facilities or program offices. Construction and renovation that benefits multiple program areas will need to be allocated across the different program area columns.
Vehicles	Expenditures for the purchase of vehicles only. Fuel and maintenance expenditures should be recorded as recurrent expenditures under travel/transport.
Equipment and furniture	Site-level expenditures for the purchase of clinical and office equipment and furniture, including computers. Office supplies that are purchased and used up within a year should be recorded as recurrent expenditures.
Other investment expenditures	Site-level investment expenditures otherwise not categorized. Explanations are required in the comments section of the template for this category to complete the submission.
Recurrent expenditures: Site-level program expenditures that are consumed as part of normal routine program operations	
Personnel	All expenditures related to above site-level personnel. This includes salary, fringe benefits, top-up salary, stipends, and reimbursement for overtime.
Antiretroviral drugs (ARVs)	Expenditures for the purchase of ARVs. Only report in this category if <u>your</u> organization procured ARVs with PEPFAR funds over the EA timeframe.
Non-ARV drugs and reagents	Expenditures for the purchase of any drugs not classified as ARVs and the purchase of reagents for laboratory diagnostics.
HIV test kits	Expenditures for the purchase of rapid HIV test kits

Condoms	Expenditures for the purchase of condoms
Other supplies	Expenditures related to the purchase of any commodities or supplies that are otherwise not classified
Food supplements	Expenditures for the purchase of food supplements
Building rental and Utilities	Expenditures for the renting of building space and any utility including electricity, internet, cellular data and cellular talk time.
Travel and transport	This category includes all travel-related expenditures such as airfare, bus fare, per diem, and vehicle fuel and maintenance. The <i>purchase</i> of mobile equipment, such as vehicles, should be categorized as investment expenditures.
Other recurrent expenditures	Site-level recurrent expenditures otherwise not categorized. Explanations are required in the comments section of the template for this category to complete the submission
Program management, strategic information, surveillance, and health system strengthening cost categories	
Personnel	All expenditures related to personnel that support the program but do not work in sites. This includes salary, fringe benefits, top-up salary, and reimbursement for overtime.
Consultants (external)	All expenditures related to contracted services and consultant services (external to your organization).
Construction and renovation (for HSS only)	Expenditures related to the construction and renovation of non-service delivery structures owned by the host-national government, such as the renovation of a Ministry of Health Headquarters building.
Transport/travel	This category includes all travel related expenditures for above site-level personnel, such as airfare, bus fare, per diem, and vehicle fuel and maintenance.
Other general and administrative	This category includes all above-site-level expenditures not otherwise categorized as personnel, consultants, or transport/travel.

Within certain program areas some additional information is required on further disaggregation of expenditures or program effort. Explanations for these categories and their affiliated EA program areas are provided below in Table 3.

Table 3. EA Program Areas with Additional Information Requested

Facility-Based Care, Treatment & Support

The additional information on programmatic service delivery for beneficiary populations receiving facility-based care, treatment and support services is used by the EA team to allocate expenditures between care and treatment patient types. This data was formerly located on the Program Information sheet, but now is at the end of the FBCTS section on the Expenditures Site-Level sheet.

In general, if your organization has or will report on the clinical care and treatment indicators (number of people currently receiving a care service or currently on ART) in APR 2014, S/APR 2015, or APR 2015: you are required to fill this sheet out; otherwise, you are asked not to report into this section. Please only complete data entry fields that pertain to your organization’s programs and operations. If you are unsure if a specific category pertains to your organization, please request TA (section 4.2).

Clinic Visits: Estimate the average number of times over the year each patient-type received a clinic visit

Adult pre-ART patients (15+ years)	For each patient type supported with FBCTS, please indicate the average number of times each patient received a clinic visit over the course of the year. Fractions are acceptable. Estimate using clinical records or program staff input on actual service delivery, not just guidelines. For example, consider an average pre-ART patient who you support in a facility, on average how frequently did this patient come in for a clinical exam during FY 2015. <u>Please do not enter the actual number of individuals you support in this section.</u> The purpose of this information is to allocate resources between the patient types so that more accurate and specific unit expenditure estimates can be generated.
Pediatric pre-ART patients (< 15 years)	
Current adult ART patients (15+ years)	
Current pediatric ART patients (<15 years)	

Lab Tests: Estimate the average number of times over the year each patient-type received a lab test, including CD4 tests, biochemical panels, hematology tests, and viral load assessments.

Adult pre-ART patients (15+ years)	For each patient type supported with FBCTS, please indicate the average number of times each patient received a lab test over the course of the year. This estimate should include all lab tests received and each test should be counted separately, even if the tests resulted from the same specimen or clinic visit. Fractions are acceptable. Estimate using clinical records or program staff input on actual service delivery, not just guidelines. For example, consider an average pre-ART patient who you support in a facility, on average how many lab tests (of any kind) did this patient receive during FY 2015. <u>Please do not enter the actual number of individuals you support in this section.</u> The purpose of this information is to allocate resources between the patient types so that more accurate and specific unit expenditure estimates can be generated.
Pediatric pre-ART patients (< 15 years)	
Current adult ART patients (15+ years)	
Current pediatric ART patients (<15 years)	

Community-Based Care, Treatment & Support

Medical Care (not-facility based)	The amount of site-level expenditures for Community-Based Care, Treatment & Support which can be allocated to each of these service categories. The sum of these amounts must equal the sum of investment and recurrent expenditures for Community-Based Care, Treatment & Support. A brief description of each of the service categories is listed below:
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Economic Strengthening	<ul style="list-style-type: none"> • Medical Care (not-facility based): May include community-based services such as: linkage and retention activities to connect and keep patients in care and treatment; referral of patients for care or treatment in a health facility; home-based monitoring of PLHIV; community-based distribution of ART; management of TB; coordination with malaria prevention activities; safe water, sanitation, and hygiene (WASH) services to reduce diarrheal illness in PLHIV’ mental health services; pain and symptom management; and end-of-life-care • Economic Strengthening: May include community-based services such as income-generating activities and livelihood support activities. • Social, Psychological & Spiritual Care: May include community-based services such as support groups for PLHIV, counseling, prevention for PLHIV/Positive Health, Dignity, and Prevention (PHDP) services, mental health services, and legal services. • Nutrition & Food Security: May include community-based nutritional assessment, counseling, and support (NACS) services, including nutrition assessment and referral to clinical care and referral to economic strengthening and livelihood services and support to improve food security and household resilience.
Social, Psychological & Spiritual Care	
Nutrition & Food Security	

Preventing Mother-to-Child Transmission

Percent Effort for HIV Testing of Pregnant Women	The percentage of staff time and program effort that is used to support each of these PMTCT services. This is a best estimate of how shared expenditures, such as personnel, building rental & utilities, and travel/transport are used to support these activities. Percent effort must sum to 100%
Percent Effort for HIV Testing of Exposed Infants	
Percent Effort for Prevention and Care for Pregnant Women (Option A, B or B+ Services)	
Percent Effort for Prevention and Care for Exposed Infants	
Test Kits for Pregnant Women	Disaggregation of the HIV Test Kit Cost Category. The sum of expenditures for test kits for pregnant women and infants should equal the value for HIV Test Kits for PMTCT.
Test Kits for Exposed Infants	
ARVs for Pregnant Women	Disaggregation of the ARV Cost Category. The sum of expenditures for ARVs for pregnant women and infants should equal the value for ARVs for PMTCT.
ARVs for Exposed Infants	

HIV Testing & Counseling

Provider-Initiated Testing & Counseling	The amount of site-level expenditures for HIV Testing & Counseling which can be allocated to each of these testing modalities. The sum of these amounts must equal the sum of investment and recurrent expenditures for HIV Testing & Counseling.
Voluntary Testing & Counseling	
Community-Based Testing & Counseling	

Laboratory

Percent Effort for ART Lab Services	The percentage of staff time and program effort that is used to support each of these Lab services. This is a best estimate of how shared expenditures, such as personnel, building rental & utilities, and travel/transport are used to support these activities. ART Lab Services includes lab-based HIV testing, CD4, viral load, hematology, and biochemical panels. Percent effort must
Percent Effort for TB Diagnostics	
Percent Effort for Early Infant Diagnosis	

Percent Effort for Quality Assurance/Improvement	sum to 100%.
Non-ARV Drugs & Reagents for ART Lab Services	Disaggregation of the Non-ARV Drugs & Reagents Cost Category. The sum of expenditures for Non-ARV Drugs & Reagents for these 4 services should equal the value for Non-ARV Drugs & Reagents overall for Lab.
Non-ARV Drugs & Reagents for TB Diagnostics	
Non-ARV Drugs & Reagents for Early Infant Diagnosis	
Non-ARV Drugs & Reagents for Quality Assurance/Improvement	
Supplies for ART Lab Services	Disaggregation of the Other Supplies Cost Category. The sum of expenditures for Supplies for these 4 services should equal the value for Other Supplies for Lab.
Supplies for TB Diagnostics	
Supplies for Early Infant Diagnosis	
Supplies for Quality Assurance/Improvement	
Orphans & Vulnerable Children	
Health Access & Health Promotion	The amount of site-level expenditures for Orphans & Vulnerable Children which can be allocated to each of these service categories. The sum of these amounts must equal the sum of investment and recurrent expenditures for Orphans & Vulnerable Children.
Educational Support and Early Childhood Development (ECD)	<p>A brief description of each of the service categories is listed below:</p> <ul style="list-style-type: none"> • Health Access & Health Promotion: Interventions to monitor holistic health outcomes, build health knowledge and skills in caregivers, and facilitate access to key health services including HIV testing, care and treatment and services for OVC. Direct HIV care and treatment services should be recorded under FBCTS. • Educational Support & ECD: Support to children and adolescents affected by and vulnerable to HIV to overcome barriers to accessing education including enrollment, attendance and progression. This category also includes interventions to improve the safety of children and adolescents at home and at school. Also includes activities related to ECD, defined as the physical, cognitive, social, and emotional maturation of human beings from conception to eight years but which impacts a lifetime. • Economic Strengthening: Economic strengthening (including social protection) interventions that reduce economic instability in adolescents and families affected by and vulnerable to HIV • Psychosocial Support: Services and interventions that support psychosocial and mental well-being for children and families affected by HIV • Nutrition & Food Security: Services and interventions related to nutrition screening and referral, building health and nutrition knowledge and skills in caregivers, and incorporating the community aspects of nutrition assessment, counseling, and support • Child Protection: Services and interventions that OVC programs support to prevent and mitigate maltreatment of children and adolescents including gender-based violence. • Case Management: Case management activities which ensure children, adolescents and families have access to a continuum of prevention, mitigation, care and treatment
Economic Strengthening	
Psychosocial Support	
Nutrition & Food Security	
Child Protection	
Case Management	

2.0 DATA COLLECTION

Data will be captured using an Excel based data collection template which will be uploaded into PROMIS, a web-based data management system. Please use the following link to access the website, download data collection templates, and submit data:

<https://pepfarpromis.net/promisea/ea>

The data collection template is in Excel 2007 format (with “.xlsx” file extension). Please note, if the template is opened and saved using an earlier version of Excel, PROMIS will not accept that file format, and data will need to be re-keyed into a new template for a successful submission. If you have any difficulties with Excel versioning, please contact your TA provider for assistance (see section 4.2 for requesting TA).

Information on each worksheet in the data collection template is provided below. Please complete each worksheet and data field that pertains to your organization. If data entry cells are left blank, the default value will be zero. Please do not adjust the structure of the template/worksheets or adjust any formula, this will result in a failed PROMIS upload.

DATA COLLECTION TEMPLATE OVERVIEW

TIP: Please open the Excel template while reviewing this section for ease of understanding.

For each data entry row on the site-level, PM, SI, and HSS sheets, select the geographic location² from the pre-populated drop down list in column D that corresponds to the expenditures you are reporting. For countries with many SNUs, there may be a preliminary dropdown in column C with the SNU level above the reporting SNU level. If this is the case, select the SNU which contains the desired reporting SNU in column C and then select the reporting SNU in column D. There should be a separate row for each geographic location in which your organization provides services and support. Note that all figures entered on a row will be analyzed as occurring in the location identified in column D. Also note that the buttons in column A do not in any way correspond with data entered on those rows, they are only intended to be used as navigation buttons between program areas on the same sheet. Any figure entered into a cell without a corresponding geography in column D will be rejected upon upload to PROMIS.

Each worksheet also contains buttons to fields for entering comments that may help explain your submission. Your organization should use these text fields to further explain the data, especially for expenditures classified under an “Other” cost category, or if an equation was used to allocate shared expenditures that differs from the recommended method.

You may utilize another Excel file as a working document for calculations, or various source files, to generate the figures which will be entered into the EA data collection template. In doing so, you will need to enter that data into the EA data collection template. Take great care in doing so. There are many hidden columns and rows in the EA template, and pasting data into the file can have the unintended result of populating hidden cells. Keep your eye on the column labeling of the EA file and take note of places where the column names skip over letters (e.g., In the site-level sheet the columns jump from HV to IA, where columns HW-HZ are hidden) and

² **Special note for Department of Defense Partners:** For Department of Defense partners that provide military-to-military services, expenditure analysis data is not required to be disaggregated to sub-national units within a country due to special considerations around confidentiality. A separate template has been created for these partners and can be accessed by contacting <mailto:Brittney.n.shook.ctr@mail.mil> or Catherine.ramirez4.ctr@mail.mil.

paste your data in appropriately. Also be sure to avoid pasting equations or other non-numerical values into the EA Excel file (i.e., \$, %, -, etc.).

Sections 2.1–2.5 provide detailed descriptions of the requested data for each worksheet in the data collection template. Should your organization have specific questions, please request TA (section 4.2).

TIP: Enter expenditure data on the site-level worksheet first. This will help provide the information needed to accurately allocate expenditures on other worksheets.

2.1 INSTRUCTIONS

The Instructions worksheet provides information on naming the data collection template, as well as the submission process. Please refer to this guidance for assistance with entering the requested data, including operational definitions and allocation methods. The Partner Info worksheet requests your organization’s name, contact information, and mechanism. Please ensure each partner information field is complete. If you do not know your mechanism ID, please contact your USG A/COR to retrieve the number. If you do not have a mechanism ID, please contact EA coordinators Ramona Godbole (rgodbole@usaid.gov) and Jeffrey Bale (wol3@cdc.gov)

2.2 EXPENDITURES—SITE-LEVEL

You should complete this worksheet if your organization uses any PEPFAR funding to provide services or support at the facility/site/implementation-level. Expenditures reported on this sheet may support a wide range of services across different program areas, with the similarity that they occur at the facility/site/implementation-level.

Site-level expenditures must be tied to a sub-national geographic unit in your country (note that there is no “National” or “Above National” option on this sheet). For EA 2015, you may be required to input site-level data at a lower sub-national unit than in previous years. The pre-populated drop down list found in column D is comprehensive of the locations which you can select, and deviation from this list (i.e., pasting a location over it) will result in a failed upload to PROMIS. Expenditures reported on this sheet are also required to be linked to a program area (see table 1), cost category (see table 2), and point-of-service type (see table 4).

Please contact your EA advisor if you have questions regarding the decision of which geographic level being used in your country.

When entering site-level data into the ‘Expenditures—Site-level’ worksheet:

- Select the sub-national unit where the expenditures occurred in column C and sub-sub-national unit in column D (if applicable/available)
- Select the point-of-service type in column E
- Enter the expenditure data in the appropriate cost category and program area column.

Examples of activities that would be recorded on the site-level sheet include:

- Purchase of HIV rapid test kits to be used at a stand-alone clinic would be categorized in the “HTC” program area, under the “HIV test kits” cost category in the sub-national unit the clinic is in.
- A computer purchased to perform accounting activities of a hospital providing treatment services would be categorized in the “FBCTS” program area, under the “equipment and furniture” cost category in the sub-national unit the hospital is in.
- Training costs for an individual who enters routine M&E data at an antenatal care (ANC) site would be categorized in the “PMTCT” program area, under the “in-service training” cost category in the sub-national unit the ANC site is in.
- Salaries for staff that provide supportive supervision and mentoring to health care workers providing anti-retroviral treatment (ART) in facilities would be categorized in the “FBCTS” program area, under the “personnel” cost category in the sub-national unit the ANC site is in.

POINT-OF-SERVICE CLASSIFICATION

PEPFAR implementers provide services and support through a variety of service delivery outlets. It is required that all site-level expenditures reported in EA must be tagged to a “point-of-service” as defined below based on the points-of-service your organization is active in. The intent of this additional classification of expenditures is to better understand the consumption of PEPFAR resources to improve strategic planning with host-national governments and other donors. This level of detail will enable PEPFAR to better align with other commonly implemented HIV and health resource tracking activities such as the UNAIDS National AIDS Spending Assessments (NASA) and the WHO National Health Accounts/System of Health Accounts (NHA/SHA). As such, the definitions below are based upon those already developed in the [NASA](#) and [NHA/SHA](#) guidance documents.

Determine which points-of-service types are applicable to your organization’s site-level work and classify your expenditures as such by selecting from the dropdown selection in column D of the site-level worksheet. It is possible to support more than one point-of-service type within a sub-national unit, and in these cases it will be necessary to allocate your organization’s expenditures within a single sub-national unit across those points-of-service. This estimation should be based upon program staff input on level of effort. To enter data for more than one point-of-service for a single sub-national unit, you will generate two or more lines of data by selecting the same sub-national unit twice from the dropdown menu in column D on two lines. Then select the appropriate point-of-service from the dropdown menu in column E.

See section 3.3 for more information on allocating effort across points-of-service.

Table 4. Point-of-service Classifications for EA

Point-of-service type	Description
Government hospital	Licensed establishments which are government owned (central, regional, local) which provide medical, diagnostic, and treatment goods and services primarily to inpatients . Hospitals may also provide outpatient services and lab diagnostics, but their principal activity is to provide inpatient care.
Not-for-profit hospital	Licensed establishments which are privately owned that invest surplus revenues into the organization’s cause . These facilities provide medical, diagnostic, and treatment goods and services primarily to inpatients . Hospitals may also provide outpatient services and lab diagnostics, but their principal activity is to provide inpatient care.
Private, for-profit hospital	Licensed establishments which are privately owned with the intention to generate profits to be distributed as dividends . These facilities provide medical, diagnostic, and treatment goods and services primarily to inpatients . Hospitals may also provide outpatient services and lab diagnostics, but their principal activity is to provide inpatient care.

Government outpatient site	Government owned establishments (central, regional, local) which provide health care services primarily to outpatients .
Not-for-profit outpatient site	Establishments which are privately owned that invest surplus revenues into the organization's cause and provide health care services primarily to outpatients .
Private, for-profit outpatient site	Establishments which are privately owned with the intention to generate profits to be distributed as dividends . These establishments provide health care services primarily to outpatients .
Government laboratory	Government owned facilities which primarily perform diagnoses of illness, monitor disease progress of individuals, or otherwise inform care and treatment decisions of health care providers via analytics on biological samples or imaging techniques (e.g. x-rays).
Not-for-profit laboratory	Facilities which are privately owned that invest surplus revenues into the organization's cause . These facilities primarily perform diagnoses of illness, monitor disease progress of individuals, or otherwise inform care and treatment decisions of health care providers via analytics on biological samples or imaging techniques (e.g. x-rays).
Private, for-profit laboratory	Facilities which are privately owned with the intention to generate profits to be distributed as dividends . These facilities primarily perform diagnoses of illness, monitor disease progress of individuals, or otherwise inform care and treatment decisions of health care providers via analytics on biological samples or imaging techniques (e.g. x-rays).
Outside of health facility	Locations where health care services and goods are provided outside of a designated health care facility . These locations may include schools, universities, orphanages, community centers, stadiums, and residences.

2.3 EXPENDITURES—STRATEGIC INFORMATION AND SURVEILLANCE

You should only complete this worksheet if your organization provides support for strategic information (SI) and/or surveillance activities above the site-level. SI activities are generally those that support routine M&E, operations research, and other biomedical, clinical, epidemiological, and social research related to HIV. Surveillance activities generally support either HIV drug resistance or serologic studies (i.e., epidemiological or disease specific surveillance, incidence studies, disease-specific surveys, etc.). If you have questions regarding whether or not your activities qualify as either SI or Surveillance, please request TA (section 4.2).

Like site-level expenditures, SI and Surveillance expenditures are first classified by location: sub-national level, national level, or above national-level. Expenditure data must also be recorded by cost category. There are four cost categories for SI and Surveillance expenditures: personnel, consultants (external), transport/travel, and other general/administrative. Definitions for each can be found in Table 2.

Finally, for each location and associated SI expenditure recorded, indicate what percentage of the expenditure is linked to each PEPFAR-defined program area (note that Surveillance expenditures do not require a program area allocation). The recommended allocation method for SI expenditures can be found in section 3.4. If the recommended method is not used, please provide an

explanation of the allocation method chosen and the motivation for using the alternate method in the comments section of the data collection template.

When entering SI and/or Surveillance above site-level data into the 'Expenditures—SI' worksheet:

- Select the location in which the SI or surveillance expenditures occurred: sub-national, national, or above national in column D
- Enter the expenditure data in the appropriate cost category in columns H:K (for SI) or column AD:AG (for surveillance).
- Allocate the percentage of expenditures supporting each PEPFAR program area into columns L:AB (SI only). The allocation percentages must total 100 by row, and not doing so will result in a failed upload to PROMIS.

Examples of activities that would be recorded above site-level for SI and Surveillance include:

- Payment for a consultant who lives in New York City and performed an analysis of data collected in a cohort study investigating adherence to ART would be categorized as SI "Above National", as the "Consultants (External)" cost category, and 100% would be allocated to the "FBCTS" program area.
- Salary for an M&E officer who sits in the capital city and oversees your organization's OVC M&E programs would be categorized as SI "National", as the "Personnel" cost category, and 100% allocated to the "OVC" program area.
- A computer and software purchased to compile and analyze data collected in a national incidence survey would be categorized as Surveillance "National", as the "Other General/Administrative" cost category (there is no need to allocate to program areas for Surveillance activities).
- Salary for a staff member who sits in your headquarters office in country and is responsible for tracking the progress and post-graduation activities of PEPFAR supported pre-service trainees would be reported as SI "National", as the "Personnel" cost category, and would be 100% allocated to the "HSS" program area.

2.4 EXPENDITURES—HEALTH SYSTEMS STRENGTHENING

You should only complete this worksheet if your organization provides support for Health System Strengthening (HSS). Above site-level HSS activities are greatly varied as they benefit many aspects of a health system. In general terms, activities classified as HSS would be those that provide technical assistance and capacity building support to the individuals, organizations, and processes in the host-national government's health system. More specifically, activities categorized as HSS should be focused on supporting the building blocks which the World Health Organization has deemed core to health systems: services, workforce, health information, essential medicines, health financing, and governance. In fact, these categories were the basis by which the EA HSS functional area categories were developed (see table 5 for a listing and description). If you have questions regarding whether or not your activities qualify as HSS in EA, please request TA (section 4.2).

After deeming expenditures to be affiliated with an above site-level HSS activity, you will classify the expenditures by location: sub-national level (e.g., province or region), national-level, or above national-level. Expenditure data must also be recorded by cost category. There are five cost categories for HSS above site-level expenditures: personnel, consultants (external), transport/travel, construction and renovation (unique to HSS), and other general/administrative. Definitions for each can be found in Table 2.

Once you have reported your expenditures by cost category, you are asked to report the same HSS expenditures by functional area. Table 6 provides a list of functional areas and definitions for HSS. On the HSS worksheet, the sum of columns H–L should equal the sum of columns N–Y for each row. It is possible and likely that some activities will cover multiple functional areas. In these cases, please allocate expenditures between functional areas (see section 3.4). Please request TA (section 4.2) if you are unsure of how to distribute HSS expenditures to functional areas.

Finally, for each location and associated expenditure recorded, indicate what percentage is linked to each PEPFAR-defined program area. As HSS activities typically benefit the system as a whole rather than specific program areas, you may find this portion challenging. This is still required, and though not exact, this will help the PEPFAR team understand how investments in HSS may

benefit particular programs and locations (see section 3.4). If you have questions on how you should allocate your HSS efforts to the program areas, please request TA (section 4.2).

When entering above site-level HSS data into the ‘Expenditures—HSS’ worksheet:

- Select the location in which HSS expenditures occurred: sub-national, national, or above national in columns D
- Enter the expenditure data in the appropriate cost category in columns H:L.
- Allocate the total HSS expenditures entered in the cost categories (columns H-L) into the functional area categories (columns N-Y). The allocation to cost categories must equal the allocation to functional areas, and not doing so will result in a failed upload to PROMIS.
- Allocate the percentage of expenditures supporting to each PEPFAR program area in columns Z:AP. The allocation percentages must total 100 by row, and not doing so will result in a failed upload to PROMIS.

Examples of activities that would be recorded as above site-level HSS include:

- Salary for staff who are providing technical assistance and support to the host-national government in developing national guidelines for implementing Option B+ would be reported as HSS “National”, as the “Personnel” cost category, under the “Technical area specific guidelines, tools, and policy” functional area, and 100% allocated to the “PMTCT” program area.
- International travel costs for a Ministry of Health staff member who is presenting results of a HTC costing study at a conference would be reported as HSS “Above National”, as the “Transport/Travel” cost category, under the “Institutional & Organizational Development for Government” functional area, and 100% allocated to the “HTC” program area.
- Payment to consultants based in London who developed an electronic medical record system would be reported as HSS “Above National”, as the “Consultants (External)” cost category, under the “Health Information Systems” functional area, and 100% allocated to the “SI” program area.
- Payment to personnel in the capital city office to pilot test a recently upgraded/expanded electronic medical record system would be reported as SI “National”, as the “Personnel” cost category, and 100% allocated to the “HSS” program area.
- Purchase of lab equipment and reagents that will be utilized by a national reference laboratory to aid in improving quality of field lab results would be reported as HSS “National”, as the “Other General/Administrative” cost category, under the “Lab Strengthening” functional area, and 100% allocated to the “Lab” program area.

Table 5. Health System Strengthening (HSS) Functional Areas and Descriptions

HSS Functional Area	Description
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Human Resources (HR)

Pre-service training	Support for the basic education required for an individual to provide core clinical and preventive services as a member of a particular cadre (e.g., doctors, nurses, midwives, laboratorians, pharmacists, CHWs, social workers, social service staff, paraprofessionals)
In-service training systems support & institutionalization	Support for institutions and systems which provide training for health care or social workers who have already completed the basic education for their field to improve the delivery of quality services. This category does not include implementation of program-specific (e.g. FBCTS, PMTCT) in-service training events which are captured on the Expenditures Site-Level under the Training (in-service) cost category (Section XX).
HRH performance support/quality	Support for the policies and systems which enable individual health care workers to perform their duties efficiently and provide quality care according to the needs of the clients
HRH policy, planning, and management	Support for broader health workforce policies and systems to ensure sustainability, efficiency, and impact of HRH on health outcomes

Governance

Technical area specific guidelines, tools, and policy	Development and implementation of policy, advocacy, guidelines, and tools that are related to a specific technical area such as Treatment and Care, PMTCT, HTC, OVC, etc. Examples include advocacy efforts and development of circulars or guidelines on use of rapid test for HTC.
General policy and other governance	Development, implementation, and enforcement policies that affect the health system and are combined with effective oversight, coalition building, regulation, and attention to system design and accountability.

Finance

Finance	Activities that assist in raising, accumulating, and allocating adequate funding for the health sector. These activities should target the payers, providers and/or consumers of health services.
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Systems Development

Supply chain systems	A supply chain system incurs two types of costs: fixed costs and operational costs and both should be recorded in this category. Fixed costs include infrastructure such as warehouse, trucks, and computer systems that might need to be added or improved to develop the system. Operational costs include adding human resources; training a new cadre of employees or training on new skills; advocacy work and technical assistance for the system development (i.e. designing a new inventory system or holding a stakeholder meeting to get buy-in for the system). Operational costs also include the expendable supplies to run the system: fuel, electricity, internet, etc.
Health information systems (HIS)	The production, analysis, dissemination, and use of reliable, timely information on health determinants, health systems performance, and health systems.
Laboratory strengthening	Direct funding to and capacity building assistance, other than training, for quality assurance (QA) and quality improvement (QI). QA and QI are the practices to monitor and ensure the quality of services and outcomes using techniques and methods to introduce and implement changes or adjustments for better performance and

outcomes. This includes the development of indicators and guidelines, supervision, monitoring visits, coaching, and other related expenditures.

This category also includes direct funding to or capacity building assistance for all other laboratory strengthening activities above the site level, including all aspects of quality management and safety systems, accreditation activities (including accreditation preparedness activities), implementation of laboratory information systems, and technical assistance to assure or improve quality of laboratory services.

Institutional and Organizational Development

Civil society and non-governmental organizations (NGOs)

Direct funding and capacity building assistance to sustain local civil organizations and other non-governmental organizations, faith-based organizations, and community-based organizations. Examples include strengthening internal structures, administrative systems, and processes; program/project management, leadership, and governance; resource mobilization and overall staff capacity; mentoring, technical assistance and trainings to develop systems and standard operating procedures, documents or tools (e.g. leadership development and team building, financial management, internal business operations and procedures).

Government institutions

Direct funding and capacity building assistance to governmental organizations to strengthen the capacity of host country government institutions to plan, finance, manage, implement, and monitor public health programs. Examples include strengthening internal structures, administrative systems, and processes; program/project management, leadership, and governance; resource mobilization and overall staff capacity; mentoring, technical assistance and trainings to develop systems and standard operating procedures, documents or tools (e.g., leadership development and team building, financial management, internal business operations and procedures).

2.5 EXPENDITURES—PROGRAM MANAGEMENT

You should complete this worksheet to record your organization's expenditures attributed to program management (PM) that occur above the site-level. In general, it is expected that every organization that submits expenditure data will have program management expenditures; this is true even if your organization only provides system-level support³. Program management activities support administration of PEPFAR funding including grant management, human resources management, internal accounting and finance, host country support staff and offices, and indirect recovery rates. Note that expenditures related to the support of your in-country HQ offices should be reported at the "National" level, and not in the sub-national unit in which the capital sits. All expenditures related to the support of your HQ located outside of the host-national government should be reported at the "Above National" level.

The program management expenditures are first classified by location: sub-national level, national-level, and above national-level. Expenditure data must also be recorded by cost category. There are four cost categories for PM above site-level expenditures: personnel, consultants (external), transport/travel, and other general/administrative. Definitions for each can be found in Table 2.

Finally, for each location and associated expenditure recorded, indicate what percentage of the PM expenditure is linked to each PEPFAR-defined program area. The recommended allocation method for program management expenditures can be found in

³ Organizations which are not required to report PM expenditures include U.S. government agencies which implement programs such as Department of State, Department of Defense, and Peace Corps.

section 3.3. If the recommended method is not used, please provide an explanation of the allocation method chosen and the motivation for using the alternate method in the comments section of the data collection template.

When entering data into the 'Expenditures—PM' worksheet:

- Select the location in which the PM expenditures occurred: sub-national, national, or above national in column D
- Enter the expenditure data in the appropriate cost category in columns H:K.
- Allocate the percentage of expenditures supporting each PEPFAR program area in columns L:AD. The allocation percentages must total 100 by row, and not doing so will result in a failed upload to PROMIS.

Examples of activities that would be recorded as above site-level PM include:

- Your organization supports OVC activities and pays rent for office space for your headquarters in Washington D.C. to house your HR staff. This expense would be reported as PM "Above National", as the "Other General/Administrative" cost category, and 100% allocated to the "OVC" program area.
- Salary for accounting staff based in your HQ in the capital city of the host country in which you provide prevention services and support to female sex workers would be reported as PM "National", as the "Personnel" cost category, and 100% allocated to the "KP-FSW" program area.
- International travel expenses for HR staff who are attending an internal training to your organization which provides technical assistance to the Ministry of Health to develop a health insurance scheme. These expenses would be reported as PM "Above National", as the "Travel/Transport" cost category, and 100% allocated to the "HSS" program area.
- Salary of program manager based in the capital city office providing management oversight to activities in specific provinces would be reported as PM "Sub-national unit", as the "Personnel" cost category, and the percentage allocation will depend on which programs he/she is overseeing. If it is all programs, then use a proportionate allocate across all the program areas which your organization supports. The allocation across program areas should total to 100%.

Please note that there may be positions in your organization which are generally presumed to be "administrative" in nature; however, persons filling those roles often support a wide variety of activities. The level of effort expended by these individuals should be allocated appropriately into EA, and not lumped into the PM category.

Example: Your Chief of Party spends 50% of his/her time managing and administrating your organization's PEPFAR program, and the other 50% of his/her effort is spent assisting the ministry of health in his/her efforts to improve health workforce retention in ANC sites. In this case, 50% of his/her salary should be reported as above site-level PM, as the "Personnel" cost category, and 100% allocated to HSS. Meanwhile the other 50% of his/her salary should be reported as above site-level HSS, as the "Personnel" cost category, under the "HR Management and Retention" functional area, and 100% allocated to PMTCT.

Also note that allocation of PM expenditures to a program area indicates your organization's involvement in providing services or support to the program area. Therefore, allocation of PM expenditures to program areas where you have no other site-level or above site-level expenditures would be unexpected, and it is generally expected that your PM program area allocations should mirror the allocation of expenditures entered elsewhere in the workbook (see section 3.4).

For additional (and more complex) examples of site-level and above site-level activities and allocation methods, see sections 3.1-3.6. If you have any difficulties in classifying your activities as either site-level or above site-level, please request TA (section 4.2).

3.0 ALLOCATION METHODS FOR SHARED SITE-LEVEL AND ABOVE SITE-LEVEL EXPENDITURES

Many program expenditures are shared by multiple program areas or geographic locations. Below are some recommended methods for allocating shared expenditures. Throughout this section, the recommend methods often reference level of effort and other programmatic effort. These pieces of information may not be readily available or familiar to the accounting staff largely responsible for responding to the EA reporting requirement. It is encouraged that staff who are responsible for the EA reporting exercise engage with individuals in your organization that are familiar with the day to day program activities and can inform these allocation estimations. Also reference Appendix C to learn how EA program areas align with S/APR results reported to PEPFAR.

3.1 ALLOCATING SHARED EXPENDITURES ACROSS PROGRAM AREAS AT THE SITE-LEVEL

If your organization provides services to beneficiaries in multiple PEPFAR-defined program areas, you will need to allocate expenditures affiliated with these services appropriately. Choosing the appropriate method depends on the type of expenditure, the context of the implemented program, and available information on level of effort and utilization of services.

INVESTMENT EXPENDITURES

If your organization used PEPFAR resources to train staff, invest in construction or renovation, or procure clinical or office equipment that served multiple program areas over the period, you will need to estimate the proportion of the investment that should be recorded in each program area column. To do this, multiply the total amount spent for the investment by an estimate of use by program area.

Example: If your organization purchased computer equipment for \$1,000 that is used to support both a community outreach program for general population prevention and HTC activities in a government owned clinic, you should estimate how frequently the computer was used for each activity. In this example, a reasonable measure for allocating the expenditure may be the amount of time program staff devotes to community outreach versus HTC activities. If your program staff estimates that (on average over the year) community outreach activities accounted for 80% of time and HCT 20% of time, you would:

- Record \$800 (80%*\$1000) in the “equipment and furniture” cost category under the “GP-PREV” program area on of the *Expenditures—Site-level* worksheet (column HK) after selecting the sub-national unit the community is in from column D and selecting the ‘Outside of health facility’ point-of-service from column E.
- Record \$200 (20%*\$1000) in the “equipment and furniture” column under the HTC program area of the *Expenditures—Site-level* worksheet (column CT) after selecting the sub-national unit the HTC clinic is in from column D and selecting the ‘Government outpatient site’ from column E.

RECURRENT EXPENDITURES

If your organization used PEPFAR resources to support recurrent expenditures that served multiple program areas over the period, you will need to estimate the proportion of the recurrent expenditures that should be recorded in each program area column. To do this, multiply the total expense by an estimate of use by each program area.

Example: If a non-profit organization rents a private building that is used to support FBCTS and PMTCT outpatient services, you should estimate how much of the building expense was used for each activity. One method is to determine how much of the total building space is devoted to each activity. This method works well if each activity has a dedicated space. For example, a clinic may

have rooms devoted to ART and rooms devoted to PMTCT. In this case you may estimate the percentage of building space that is occupied by each activity and multiply this by the total expense to allocate across multiple program areas.

It is likely, however, that health facility building space is shared by activities, e.g. ART and PMTCT patients are seen in the same clinic rooms. In this example, allocating rent by dedicated building space will not work and another method is needed. One option is to allocate the shared building expense by patient volume. For example, if a health facility sees 55 ART patients per day and 45 PMTCT patients per day, you could allocate 55% of the total building rental and utilities to ART (column T) and 45% to PMTCT (column BN) while ensuring you have selected the 'Not-for-profit outpatient site' point-of-service in column E.

There may be some other method that is most suitable for your organization based on the service delivery model and program areas covered. If you allocate shared recurrent expenditures by another method, please describe it in the comments section in the data collection template.

3.2 ALLOCATING SHARED EXPENDITURES ACROSS SUB-NATIONAL UNITS AT THE SITE-LEVEL

For data collection, your organization is asked to enter expenditure data by geography. The key is to follow the EA rule of thumb and record expenditures based on where the resources were consumed. If your organization provides services to beneficiaries in multiple locations, you will need to allocate these expenditures appropriately. Choosing the appropriate method depends on the type of expenditure and available program data.

INVESTMENT EXPENDITURES

Most investment expenditures should be easily tied to a specific location. Notable exceptions may include the purchase of vehicles or mobile equipment. For investment expenditures that support multiple sub-national units, you will need to estimate the proportion of the investment to record for each sub-national unit on unique data entry rows. To do this, multiply the total amount spent for the investment by an estimate of use by each location.

Example: If your organization purchased a vehicle for \$50,000 that is used to support mobile male circumcision activities in three sub-national units, you should estimate how frequently the vehicle was used in each location. Program staff or drivers should be able to provide this information. If staff estimates the vehicle is used roughly equally across the three locations, you would

- Divide the \$50,000 by three.
- Select the locations in column D on three unique data entry rows of the site-level sheet and select 'Outside of Health Facility' in column E for each.
- Record \$16,667 ($\$50,000/3$) in the "vehicles" cost category under the "VMMC" program area in column CC.

RECURRENT EXPENDITURES

If your organization used PEPFAR resources to support recurrent expenditures that served multiple locations over the period, you will need to estimate the proportion of the recurrent expenditures that should be recorded on each unique data entry row.

Example: If your organization procured commodities, such as drugs for opportunistic infections to be used in government hospitals, over the period that were consumed in several sub-national units, you will need to allocate the expenditure to each location receiving the drugs and enter the data on a separate row corresponding to each location (in column D) where the resources were consumed and select the 'Government Hospitals' point-of-service (column E). It is expected that drugs and other commodities are tracked to the facilities they support, so there may not be a need to estimate allocations between locations.

Site-level personnel, however, may be shared by sites stretching across administrative boundaries, and the costs associated with these personnel will need to be allocated according to an estimate of time spent in each location.

Example: Your organization supports staff that travel to government laboratories where they provide technical assistance in the accreditation of lab services. The staff's travel records indicating they spent three months of the year supporting labs in one sub-national unit, and the remainder of the year supporting labs in another sub-national unit. You would then allocate 25% of their salary and travel expenses to the first sub-national unit (column D), as 'Government outpatient sites' point-of-service (column E), under the Laboratory program area "Personnel" (column EV) and "Travel/Transport" (column FD) cost categories on the site-level sheet, and the other 75% of the expenses to the 2nd sub-national unit, the same point-of-service, under the same cost categories. You would also allocate 100% of the effort to "QA/QI" for both lines of data entered.

3.3 ALLOCATING SITE-LEVEL EXPENDITURES ACROSS POINTS-OF-SERVICE

Accurate allocation of expenditures across points-of-service requires two critical pieces of data: 1) number of sites within each sub-national unit which your organization has activities in and, 2) classifying each site per the definitions in table 5. You can use this distribution of sites within each sub-national unit to allocate expenditures between points-of-service.

Example: Your organization provides site-level mentoring to doctors and nurses in 'sub-national unit A' and spent \$200,000 on salaries for mentors. You determine that the salaries should be reported as the 'Personnel' cost category in the 'FBCTS' program area. You are unsure how to classify the expenditures by point-of-service so you speak with the personnel who are mentors and they tell you they support twenty sites in total, but cannot accurately say how much time is spent at each site type. However, they tell you that of the twenty sites, five are government hospitals and the remaining fifteen are government outpatient sites given the definitions in table 5.

With the information above, you decide to allocate \$50,000 (25% of \$200,000) to the 'Government Hospitals' point-of-service, in sub-national unit A, as the 'Personnel' cost category, in the 'FBCTS' program area (column M). You then allocate the remaining \$150,000 (75% of \$200,000) on a second row of data to in sub-national unit A (column C), to the 'Government Outpatient Sites' point-of-service (column D), as the 'Personnel' cost category, in the 'FBCTS' program area (column M)

3.4 ALLOCATING ABOVE SITE-LEVEL EXPENDITURES ACROSS PROGRAM AREAS

Expenditures for program management (PM), strategic information (SI), and health systems strengthening (HSS) that occur above the site-level will need to be allocated to the program areas (in addition to locations they support). Frequently activities in these sections are cross cutting and may span multiple EA program areas. In these instances you will need to estimate the level of effort benefiting each program area.

The recommended (and simplest) method of allocating above site-level expenditures to the site-level program areas is to match the distribution of spending which you have entered into the site-level sheet.

PROGRAM MANAGEMENT

Program management activities differ from SI and HSS activities in that PM activities generally do no benefit one part of your program any more than another. Therefore, it is expected that PM distributions by program area would map to the distribution of your programmatic effort. As such, it would be extraordinarily rare for PM to be allocated evenly across all program areas, accurately representing your organization’s activity. See the examples below regarding the allocation of PM to program areas, and request TA (section 4.2) should you face any challenges in doing so.

Example: Assume an organization provides FBCTS and PMTCT services in two locations (A and B), maintains a HQ office in the country’s capital city, and has grant management staff supporting the organization from the U.S.; the following data are reported:

Location	Expenditures—Site-level		Expenditures—PM
	FBCTS	PMTCT	
Sub-National Unit A	\$500,000	\$200,000	\$100,000
Sub-National Unit B	\$200,000	\$100,000	\$ 50,000
National	--	--	\$400,000
Above national	--	--	\$100,000

The organization needs to allocate expenditures for PM in the last column to the program areas supported. For PM expenditures in the sub-national units, the allocation should match the distribution of site-level expenditures by program area. To calculate the allocations, add the total site-level expenditures and divide the expenditures for each program area by the total.

In the above example for Sub-National Unit A:

$$\text{Total Site-level Expenditures for SNU A} = \$500,000 + \$200,000 = \$700,000$$

$$\text{FBCTS} = \$500,000 / \$700,000 = 72\%$$

$$\text{PMTCT} = \$200,000 / \$700,000 = 28\%$$

Record the data on the *Expenditures—PM* worksheet as follows: Enter \$100,000 for program management in Sub-National Unit A. Enter 72 in the FBCTS column and 28 in the PMTCT column.

The same method should be used to determine the allocation for the \$50,000 PM expenditure in Sub-National Unit B:

$$\text{FBCTS} = \$200,000 / \$300,000 = 67\%$$

$$\text{PMTCT} = \$100,000 / \$300,000 = 33\%$$

Program management at the national and above national levels may be less easily tied to specific program areas. Using a similar method, PEPFAR IPs can approximate how these expenditures support actual delivery of services and support, which helps to fill a crucial data gap.

Example: Using data from the last example to calculate the allocations of PM to program area for the National and Above National level:

- Add the total site-level expenditure for the organization
 $\$500,000 + \$200,000 + \$200,000 + \$100,000 = \$1,000,000$
- Add the total expenditures for each program area across regions
FBCTS = $\$500,000 + \$200,000 = \$700,000$
PMTCT = $\$200,000 + \$100,000 = \$300,000$
- Calculate the distribution of total site-level resources used to support each program area
FBCTS = $\$700,000 / \$1,000,000 = 70\%$
PMTCT = $\$300,000 / \$1,000,000 = 30\%$
- Record the national and above national expenditures on two unique data entry rows in the *Expenditures—PM* worksheet. Enter 70 in the FBCTS column and 30 in the PMTCT column. The same allocation percentages calculated above will apply to both national and above national expenditures.

In addition to the standard EA program areas (PMTCT, HTC, etc.) you may allocate PM effort to above-site level activities such as strategic information, surveillance, and/or HSS (columns AC to AE). These columns should be utilized when your organization has both above site-level and site-level activities.

Example: Your organization provides training to community organizations that provide home based HIV care. You also support the host-national government in the development of guidelines and policies to improve the livelihood of OVC. You would report the site-level CBCTS expenditures in the sub-national unit the trainees are from, under the “In-service Training” cost category, and allocated to the “Medical Care (not facility-based)” service category. Then report the above site-level HSS expenditures, at the “National” level, under the “Technical area specific guidelines, tools, and policies” functional area, and 100% allocated to OVC. Finally, you would allocate your program management expenditures to CBCTS and HSS according to the distribution of your site-level CBCTS and above site-level HSS spending.

Many PEPFAR implementing partners have no site-level activities at all. In these cases, the prior mentioned methodology would not be appropriate. In these instances program management should be allocated to SI, surveillance, and/or HSS rather than any of the EA program areas.

Example: Your organization’s sole activity in the prior fiscal year was supporting an ARV resistance surveillance study. You should report all the expenditures associated with implementing this activity in the surveillance section of the above site-level SI worksheet. After entering your organization’s program management expenses, you allocate 100% to surveillance.

These allocation methods are intended to approximate how above site-level program expenditures support program achievements. You may use other methods if your organization believes there is a more accurate way of attributing these expenditures to locations and program areas; if you do use other methods you should provide a description and justification of the method used in the comments section of the Excel template.

STRATEGIC INFORMATION

Allocation of strategic information expenditures can follow the same methods as described above.

Example: Continuing from the example given in section 2.4, your organization pays the salary of an M&E officer who sits at the host-national government's capital and oversees the routine M&E implementation. Their salary would be reported at the "National" level, as the "Personnel" cost category, on the above site-level SI sheet. You then allocate 70% of the effort to FBCTS, and 30% to PMTCT (the distribution of spending by your site-level activities).

However, some strategic information activities may be more targeted than broad program management support activities, and thus you could utilize a more accurate method of allocating SI expenditures to the program areas based on their specific focus.

Example: Your organization also has a data analyst on staff in your HQ in Boston to support a clinical trial to determine the optimal ARV regimen for pregnant mothers for 3 months. Their payment would be reported at the "Above National" level, in the "Personnel" cost category and 100% allocated to PMTCT. This method would be more accurate than allocating 70% to FBCTS and 30% to PMTCT per the distribution of spending at the site-level.

Again, organizations which also support above site-level activities should allocate their SI support to those activities as well.

Example: Your organization hired a consultant based in Oslo, Norway to build a database to house the data collected in the pregnant mother ARV study mentioned above. They complete the task in two months, and are contracted further to do an evaluation of your supply chain strengthening support to the host-national government. You report their payment at the "Above National" level, in the "Consultants (External)" cost category of the above site-level SI worksheet, and 33% allocated to the "PMTCT" program area (per the proportion of time spent on the PMTCT database) and 67% to the "HSS" program area.

Like the suggested program management allocation methods in the prior section, these methods are intended to best approximate your program's support. If you lack the necessary information to use these methods, or feel that some other method is more appropriate, please mention your preferred allocation method in the comments section of the Excel template. Should you have any challenges in allocating SI effort to program areas, please request TA (section 4.2).

HEALTH SYSTEM STRENGTHENING

HSS expenditures can often be most challenging to attribute to a PEPFAR program area due to the fact that they typically benefit multiple program areas or the health system as a whole. As such, it is often necessary to estimate effort across program areas. Although challenging, this portion of the EA is still required, and not fully allocating your HSS expenditures to the EA program areas will result in a failed upload into PROMIS. See example below of appropriate and inappropriate methods of allocating HSS effort.

Example: Your organization supports individuals who are attending pre-service training institutions to become healthcare providers. You would report these expenses into the above site-level HSS worksheet, under the "Other General/Administrative" cost category, and in the "Pre-Service Training" functional area. Since you do not know what activities the trainees will support (care & treatment, PMTCT, VMMC, HTC, etc.) you are unsure of how to allocate effort to each of the program areas. Your first instinct is to take the total number of program areas, and allocate effort evenly across them. Please note that this is NOT an acceptable allocation methodology!

While you have incomplete information on what the graduates will do in the future, there are a couple reasonable assumptions which can be made: a) that each program area does not receive the same level of support and b) the level of support provided by the new healthcare workers should align with the programmatic priorities of the national HIV response.

Given these assumptions, you speak with your program staff who mention that the vast majority of trained healthcare workers go on to provide care & treatment services in facilities, while a much smaller percentage end up working in antenatal care sites providing PMTCT services. Based on this information, you allocate 85% of the effort to the "FBCTS" program area and 15% to the "PMTCT" program area.

3.5 ALLOCATING BETWEEN SITE-LEVEL AND ABOVE SITE-LEVEL ACTIVITIES

Your organization may have staff that supports both the administration of your PEPFAR portfolio as well as direct support to specific sites. For these staff, it is encouraged that you allocate a portion of their time and compensation to site-level activities and a portion to system support rather than lump the expenditures into one single category.

Example: A Chief Medical Officer for a PEPFAR-supported organization spends half of her/his time traveling between sites in the country to supervise site-based staff and half of her/his time managing the overall care and treatment program from the national office. The total expenditure recorded for her/his salary over the period could be allocated to at least 2 areas: *Expenditures—Site-level—Personnel* and *Expenditures—PM—Personnel*. Determining the right allocation between the relevant categories requires an estimate for the amount of time the Medical Officer is engaged in each activity over the period. In this example, 50% of her/his salary could be allocated to site-level personnel in locations in which she/he worked over the period, while the remaining 50% should be allocated to program management above the site-level.

You may also have employees that reside at HQ, who also support field activities a portion of the time. Again, this geographic and site-level/ above site-level distinction should be represented in the data submission.

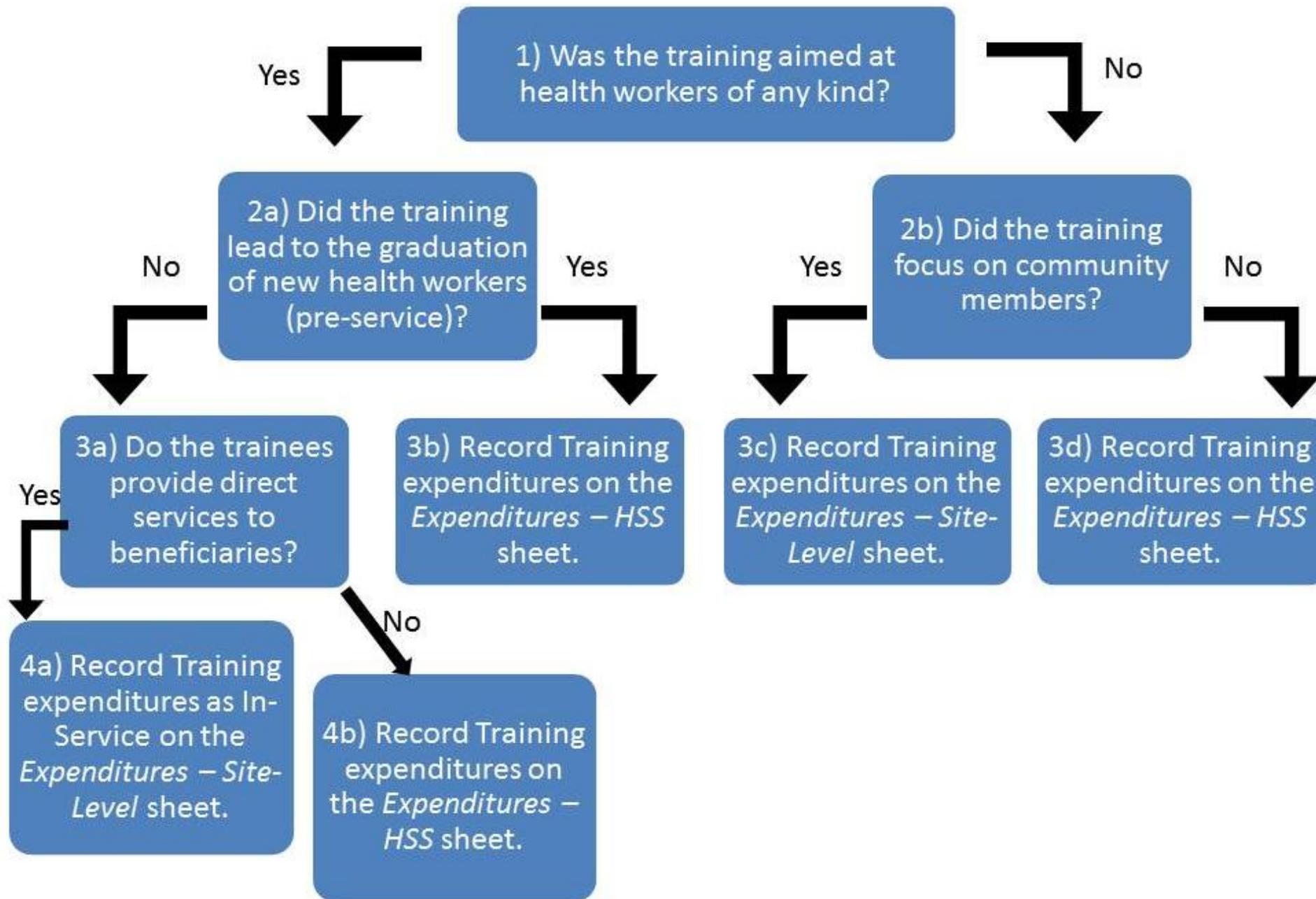
Example: An SI advisor sits at your HQ in San Francisco and oversees the day-to-day collection, management, and analysis of your routine M&E data collected on in country female sex worker prevention activities. However, they also make weeklong trips to the field quarterly to visit sites and ensure that data collected are of high quality. The eleven months out of the year (91.6%) spent at HQ, should be reported as above site-level SI, at the “Above National” level, under the “Personnel” cost category, and allocated to the “KP-FSW” program area. The remaining one month of the year (8.4%) should be reported at the site-level, in the sub-national unit visited by the SI advisor, under the “Personnel” cost category, and under the “KP-FSW” program area.

Special note for “district level” partners in South Africa: Expenditures associated with technical assistance provided at the district/sub-district level, such as the services provided by all hybrid district service partners, should be reported as above site-level HSS Expenditures, in the district the TA was provided in, as the “Institutional and Organizational Development for Government Institutions” functional area, and 100% allocated to Facility-Based Care, Treatment and Support. Expenditures associated with technical assistance for service delivery should be reported at the site-level and linked to FBCTS.

3.6 ALLOCATING TRAINING

Training is a unique category and expenditures for training can be recorded in more than one location in the data collection template. This guide will provide step-by-step instructions for assessing your organization’s training expenditures and how best to report them for EA. See the figure below and the accompanying instructions that follow.

Please note, if the activity in question was not implementation of a training event/program, but rather support for institutions and systems which provide training for health care or social workers who have already completed the basic education for their field to improve the delivery of quality services, please reported on the *Expenditure—HSS* worksheet and categorize as “in-service training systems support and institutionalization.”



- Step 1- Determine if the training focuses on Health Workers. If the training led to the creation or development of a health worker then go to step 2a. If the training was focused more broadly at the community level or at an institutional level then go to step 2b.
- Step 2a- Determine if the training for Health Workers is in-service or pre-service. If the training did not lead to the graduation of any new health workers, the training should be categorized as in-service [move to Step 3a]. If the training led to the graduation of new health workers (see specific definition in Table 6) then it should be classified as pre-service and reported on the *Expenditure—HSS* worksheet [move to Step 3b].
- Step 2b- Determine if the training for non-health workers is focused at the site level or above the site level. If the training is targeted towards individuals who are not health workers but work above the site level at the systems level (such as a training on how to develop curricula or training to government officials to improve policies for HIV affected individuals) then go to step 4b. If the training is aimed at individuals at a community level to improve awareness of HIV or otherwise inform the population of the risks of HIV, then go to step 3c.
- Step 3a- Determine if the in-service training should be classified as site-level or HSS expenditure.
 - If the participants (trainees) are health workers or otherwise engaged in the direct provision of HIV-related clinical or support services to beneficiaries, the training should be classified as *site-level* [move to Step 4a].
 - If the participants (trainees) are not involved in the direct provision of HIV-related services but support the system at a higher level, the training should be classified as *HSS* [move to Step 4B]
- Step 3b- Determine how to allocate the pre-service training expenditures. Record the expenditures for pre-service training under the *Expenditure – HSS* worksheet. Report the cost category according to the type of expenditures your organization records against pre-service activities. The functional area should always be *Pre-Service Training*. The most challenging element to categorize pre-service training by is program area. Because it is unknown how a pre-service trainee will go on to provide HIV support, it can be difficult to allocate to a program area. The HSS portion in Section 3.3 above details how to allocate pre-service training activities to program areas. See step 4a to determine which locations to tag your pre-service training expenses to.
- Step 3c- Determine how to allocate expenditures for trainings aimed at community members. These expenditures should be recorded on the *Expenditure – Site-Level* worksheet according to the type of support your organization is providing (cost category), the location of the community being trained, and the subject matter of the training (program area). For example, if you paid a staff member to provide a community with proper training and advocacy for condom use then you would report the expenditure as the personnel cost category, in the sub-national unit where the community exists, as the GP-PREV program area.
- Step 4a- Determine how to allocate training expenditures between locations and program areas. Training is the one exception to the EA rule of thumb, *record expenditures in the location where the resources are consumed*. Since so many trainings happen at the sub-national or national-level, it is important to understand how these trainings are benefitting specific locations and programs. There are two potential strategies for allocating expenditures between locations:
 - Record Based Method- If your organization keeps a record of the participants and which location they work in, you can allocate training expenditures in proportion to the origin of the participants. For example, your organization spent \$10,000 on training for 30 clinicians focusing on capacity building to improve ART adherence. The training was held in the capital city but participants came from five surrounding sub-national units. You can review your records to determine the distribution of attendees by location:

Sub-National Unit	Number of participants	Percent of total participants
1	10	33%
2	7	23%
3	5	17%
4	5	17%
5	3	10%
All	30	100%

The percentage of participants originating from each location can be calculated by dividing the number of participants from a given location by the total number of participants. You can then apply this distribution to the total expenditure for the training. For example, \$3,300 would go to Sub-national unit 1 (33% of \$10,000), \$2,300 would go to Sub-national unit 2 (23% of \$10,000), etc. When entering data in the template, a separate row should be started for each location represented and the expenditures recorded under *Expenditures—Site-level—Training (in-service)*.

- *Even Distribution Method*- If your organization does not track the origin location for each participant at the training, you will need to use an alternate method for allocating the expenditures between locations. Another, less specific method is to divide the total training expenditure equally by all locations represented. Therefore, in the above example, all five locations would have \$2,000 recorded under *Expenditures—Site-level—Training (in-service)*.

After allocating the training expenditure to the appropriate locations on the *Expenditures—Site-level* worksheet, you must also allocate expenditures between program areas according to the content of the training. In the above example, the training was directed for clinicians providing ART in facilities. As a result, all should be allocated to FBCTS. If trainings are focused on more than one program area, you will need to use some reasonable method to allocate expenditures between program areas and this should be explained in the notes. If you need assistance with this allocation, please request TA.

- *Step 4b*-There is not a cost category specifically for training on the HSS worksheet, so please categorize the costs according to the provided cost categories. For example, if an external trainer was contracted and the venue was paid by the organization, the expenditure for the trainer should be categorized as *Consultants (external)* and the expenditure for the venue should be categorized as *Other general/administrative*.

In addition to recording expenditures by cost category, you must categorize the expenditure for training by HSS functional area. Please choose the area that best describes the nature of the training (descriptions of functional areas in Table 6). For instance, if the training were for ministry officials on developing national Lab accreditation standards and plans, the functional area most appropriate for this training would be “Lab Strengthening”.

Finally, you will need to indicate how the HSS expenditure for training should be allocated to PEPFAR program areas. This percentage should be aligned with the topic of the training, and for those which are more cross-cutting in nature you may follow the methods in section 3.3 to produce a best estimate.

Initially, training expenditures may appear to be difficult to classify into EA; however, following the decision tree above should ensure that you are able to accurately capture your training efforts. While difficult to do, this is incredibly important as it comprises a large portion of PEPFAR effort overall, and incorrectly classifying a large training activity by location or program area could skew EA results. If you have any questions regarding the reporting of training into EA, please request TA.

4.0 DATA SUBMISSION AND TECHNICAL SUPPORT

4.1 ACCESSING PROMIS AND SUBMITTING DATA

To access PROMIS, you must create an account and request access to your organization and mechanisms for each country you will be reporting for. You may use the link provided below to create a new account, reset passwords, download data collection templates, request access to organizations, upload data, submit data to USG for review, and request technical assistance. For more detailed PROMIS guidance materials, please refer to the PowerPoint presentations located in the “Guidance” section of the website. If your country does not use PROMIS for collecting EA data, you will receive alternate training materials for your relevant reporting system.

Upon uploading your data collection template to PROMIS, your data will be evaluated against a series of “Data Quality Checks” (DQCs) which check for complete and logical data (e.g., percentages that sum to 100% and disaggregation which sum to their total). Some of these business rules are considered “Fatal” and by failing such a check your data collection template will not properly be processed by the system. You will receive a summary of these checks, and upon correcting them you will be able to re-upload successfully. For a complete listing of these DQCs, please see Appendix D. Other common barriers to having a successful data collection template upload include having a file type associated with pre-2007 versions of Excel (xls file type vs xlsx) and not tagging all expenditures to a location in the dropdown menu.

Completed data should be uploaded and submitted via the PROMIS website no later than 13 November 2015 at 8:00pm US/Eastern Standard Time (EST):

<https://pepfarpromis.net/promisea/>

Important note: Your most recent successful data upload will be considered for USG review and analysis after November 13th.

4.2 TECHNICAL ASSISTANCE

If you need technical assistance with completing the data collection template, classifying expenditures, allocating expenditures, accessing PROMIS, accessing your mechanism in PROMIS, uploading completed submissions, or other issues pertaining to EA, please submit a request on the PROMIS website in the “Help Desk” section. To create a new help desk ticket you will be required to provide the country your organization works in and the nature of your question to ensure the request is routed to the correct party. You should also provide a detailed explanation of your issue or question, and are encouraged to attach files or screenshots to the ticket to better illustrate the problem at hand.

Thank you for your support and diligence in providing the requested data. The results of this analysis will help to improve planning, transparency, and accountability of USG-supported HIV programs.

The methods and examples outlined in this document are intended to make the EA reporting requirement clearer and therefore the data you report more representative of your PEPFAR program. These examples do not comprehensively represent every possible PEPFAR activity, but should provide you with the basis to correctly classify your organization’s activities.

Upon reporting all of your organization’s expenses into the data collection template and uploading it into PROMIS, it is recommended that you use the “Reports” feature to generate summary statistics by program area and geography for your team to review. Ask yourselves: “Do these distributions accurately illustrate our organization’s accomplishments in this past fiscal year?” If not, identify the locations and/or program areas which appear unusual and make corrections before your final submission.

APPENDIX A: CURRENCY CONVERSION TABLE

Please utilize the table below to convert any transactions made in local currency to USD. Note that if your systems already track expenditures in USD, you are not required to re-convert any transaction using the values below.

To convert local currency using the rates in Table 6, use the following equation: $USD = \frac{\text{Local Currency Expenditure}}{\text{Conversion Rate}}$

Country (currency abbreviation)	Conversion Rate	Country (currency abbreviation)	Conversion Rate
Angola (AOA)	123.41	Kyrgyz Republic (KGS)	61.03
Antigua & Barbuda (XCD)	2.69	Laos (LAK)	8076.32
Bahamas (BSD)	0.99	Lesotho (LSL)	12.62
Barbados (BBD)	2.00	Malawi (MWK)	459.16
Belize (BZD)	1.97	Mozambique (MZN)	37.80
Botswana (BWP)	9.96	Namibia (NAD)	12.62
Burma (MYR)	3.81	Nicaragua (NIO)	26.49
Burundi (BIF)	1,558.36	Nigeria (NGN)	198.32
Cambodia (KHR)	4038.89	Panama (PAB)	1.00
Cameroon (XAF)	596.49	Papua New Guinea (PGK)	2.69
China (CNY)	6.13	Rwanda (RWF)	702.23
Costa Rica (CRC)	523.65	South Africa (ZAR)	12.62
Côte d'Ivoire (XOF)	596.49	South Sudan (SDG)	5.98
Dominica (XCD)	2.69	St. Kitts & Nevis (XCD)	2.69
Dominican Republic (DOP)	44.29	St. Lucia (XCD)	2.69
DRC (CDF)	912.08	St. Vincent (XCD)	2.69
El Salvador (SVC)	8.55	Suriname (SRD)	3.25
Ethiopia (ETB)	20.56	Swaziland (SZL)	12.62
Ghana (GHS)	3.56	Tajikistan (TJS)	6.26
Grenada (XCD)	2.69	Tanzania (TZS)	2053.45
Guatemala (GTQ)	7.49	Thailand (THB)	34.91
Guyana (GYD)	197.81	Trinidad & Tobago (TTD)	6.23
Haiti (HTG)	55.96	Turkmenistan (TMT)	3.12
Honduras (HNL)	21.36	Uganda (UGX)	3352.13
India (INR)	63.92	Ukraine (UAH)	21.49
Indonesia (IDR)	13415.40	Uzbekistan (UZS)	2555.86
Jamaica (JMD)	113.27	Vietnam (VND)	21495.40
Kazakhstan (KZT)	185.13	Zambia (ZMW)	7.57
Kenya (KES)	85.78	Zimbabwe (USD)	1.00

⁴ Weekly average exchange rate to USD from August 8th 2014 to August 8th 2015 pulled from www.oanda.com

APPENDIX B: FREQUENTLY ASKED QUESTIONS

Expenditure Analysis (EA) Initiative - general questions:

- 1) [Who is expected to provide data for this activity?](#)
- 2) [What expenditure data should be reported?](#)
- 3) [Will my organization be asked to provide this information in the future?](#)
- 4) [Why does the “Instructions” sheet in the data collection template indicate this activity should take 24 hours when it seems this could take much longer?](#)
- 5) [My financial reports are already in US Dollars but a different exchange rate or rates were used throughout the year than the one stated in the guidance; do I have to use the rate specified in the guidance?](#)
- 6) [How are EA categories different from PEPFAR budget codes?](#)
- 7) [Who are the most appropriate organizational staff to complete the EA template?](#)
- 8) [Who is the FEWG and what is their role?](#)
- 9) [I am receiving emails from several different people about EA; who are these different people and what are their roles?](#)
- 10) [We did not know that we would have to report expenditures by PEPFAR vs non-PEPFAR or COP vs non-COP funding and we have not kept our accounting records like this over the past year; what can we do to meet the EA requirement?](#)

Allocating expenditures and other expenditure - specific questions:

- 11) [What is the difference between “site-level” and “above site-level” expenditures?](#)
- 12) [My organization tracks expenditures by site; do I have to sum up the expenditures to record a single row for each sub-national unit, or is there some way to enter my expenditures in the template by site?](#)
- 13) [How should training-related expenditures be captured?](#)
- 14) [How do I categorize training expenditures geared towards non-health workers such as community health workers \(CHWs\), Par-social Workers, traditional birth attendants \(TBAs\), community counselors or general community members?](#)
- 15) [How should I classify training for Project Management, Monitoring and Evaluation \(M&E\) or HSS activities?](#)
- 16) [There is no program area for activities related to gender equality and gender-based violence \(GBV\). Where would I categorize those expenditures?](#)
- 17) [What is the difference between personnel and consultants?](#)
- 18) [Should expenditures by sub-grantees and sub-contractors be captured?](#)
- 19) [My organization paid a lump sum fee to a consulting firm for a set of activities and the consulting firm in turn spent funds on supplies, travel, and consultant time; however, I do not know how much the consultant spent on each of these. How should I proceed?](#)
- 20) [We provide integrated care and treatment services that have both a facility-based and community-based component; how should we divide our expenditures between these two program areas?](#)
- 21) [We provide integrated care and treatment services at several clinics including HIV testing and counseling, and PMTCT; how should we separate expenditures between FBCTS, HTC, and PMTCT?](#)
- 22) [How should expenditures for curriculum development and curriculum implementation be captured and how is this different?](#)
- 23) [How should I categorize testing expenditures for pregnant women or males reached through a VMMC program; would they fall under HTC their respective program areas?](#)
- 24) [Why is there a recurrent cost category for food supplements, and for the CBCTS and OVC program areas, a service category for nutrition and food support as well? Are these the same?](#)
- 25) [I’m not sure whether I should categorize my lab expenditures under the Site-level Lab section or the Laboratory Strengthening column in the HSS worksheet. What is the guidance on this?](#)
- 26) [I am unsure of whether I should categorize my Construction and Renovation expenditures in the Site-level tab or the HSS tab; what is the guidance on this?](#)
- 27) [How should program staff time be allocated between program management and program implementation?](#)
- 28) [Is Monitoring and Evaluation part of Program Management or Strategic Information \(SI\)?](#)
- 29) [Where do we include expenditures for personnel at the site level who are involved with data capture and reporting?](#)
- 30) [Should indirect costs be captured in the EA template, and if so, where?](#)
- 31) [Why are health systems strengthening expenditures allocated to functional areas and is this required?](#)
- 32) [The prevention expenditure categories do not reflect my program. Why are prevention activities categorized in this way for EA?](#)
- 33) [How should expenditures related to technical assistance \(TA\) be captured?](#)

- 34) [Our organization does not track our site-level expenditures \(e.g., ARVs\) at a sub-national level, can we simply report them as “National”?](#)
- 35) [How should PEPFAR expenditures consumed outside of the host country be captured?](#)
- 36) [How much time can an above-national level staff member spend in-country before part of his or her salary should be allocated to the national level or province visited?](#)
- 37) [How should other sources of funding \(i.e., non-PEPFAR\) be captured in the EA tool?](#)
- 38) [Is it ok to report expenditures for a region or program area if my organization does not report indicators?](#)
- 39) [Will EA results be compared to budgets?](#)
- 40) [How should I allocate pre-service training expenditures across program areas when I am unsure what types of health services the graduates will provide in the future?](#)
- 41) [I provide assistance at the Provincial level, but only districts are listed. How do I classify my expenditures?](#)

Questions on data use, timelines, support and deliverables:

- 42) [How will these EA data be used, both in the host country and in PEPFAR?](#)
- 43) [Will EA results be compared across countries?](#)
- 44) [Will EA results be compared across implementing partners within a country?](#)
- 45) [Are the EA data submission due dates flexible?](#)
- 46) [Will program results already submitted to PEPFAR need to be supplied again for EA?](#)
- 47) [Is there error checking when uploading files and if so, does it provide a detailed description of the problem?](#)
- 48) [For data cleaning, could you clarify the process/flow of information between HQ-USG field team-partners?](#)
- 49) [Will PEPFAR provide financial support to implementing partners to complete this data request?](#)
- 50) [What is the role of the A/COR/Activity Manager/Project Officer during data collection and cleaning?](#)
- 51) [How long will it take to complete the data request?](#)
- 52) [How will expenditures be captured for implementing partners that do not provide services directly?](#)
- 53) [How can I request technical assistance \(TA\) with this data request?](#)
- 54) [Will my organization be provided a summary of EA results and our data submission?](#)

Questions about the PROMIS website:

- 55) [What is PROMIS?](#)
- 56) [Who has access to PROMIS?](#)
- 57) [I am having issues logging into PROMIS or accessing the site in any way; what should I do?](#)
- 58) [I have a username but am having trouble logging in. Whom do I contact for assistance?](#)
- 59) [I can log in to PROMIS but cannot see all of my mechanisms; what do I do?](#)
- 60) [What privileges accompany PROMIS access?](#)
- 61) [I have corrupted my Excel template by manipulating the structure of the form and PROMIS will not accept my upload, what should I do?](#)
- 62) [My percentage allocations to program areas across PM, SI, and/or HSS sum to 100% in the Excel file, but PROMIS tells me I have a failed upload. Why might this be?](#)
- 63) [Is it possible to upload multiple files at once to ease our workload?](#)
- 64) [Is it possible to make changes to a data template after upload?](#)
- 65) [When does the PROMIS system come online to begin data collection?](#)
- 66) [When does the PROMIS system close for data collection? What time of the day?](#)
- 67) [How does the help-desk ticket system work?](#)

Expenditure Analysis (EA) Initiative - general questions:

- 1) Who is expected to provide data for this activity?

If your organization spent any PEPFAR dollars during the USG fiscal year 2015 (October 1, 2013 – September 30, 2015) you are asked to submit data for the EA using the standard template. If you have any questions about how this reporting relates to your agreement with your PEPFAR funding agency, please contact your A/COR at your PEPFAR agency for guidance.

- 2) What expenditure data should be reported?

PEPFAR dollars spent between October 1, 2013-September 30, 2015 which were programmed through the COP process and PEPFAR 'central initiative' or 'plus up' funding should be reported. Specifically:

- a) Did your organization spend COP funded PEPFAR dollars during the fiscal year 2015? If yes, then you must report against these expenses.
- b) Is your mechanism labeled as 'field support' or funded through a centrally-held contract or cooperative agreement (CoAg) (e.g., a country has "bought into" a USAID/Washington managed mechanism)? If yes, then you must report against these expenses.
- c) Is the source of the funds spent non-PEPFAR, such as USAID Health or other CDC funding? If yes, then do NOT report those expenditures in this exercise.

Refer to section 1.5 of the EA guidance for more details on funding sources which should be reported.

- 3) Will my organization be asked to provide this information in the future?

Yes. As part of a larger initiative in PEPFAR to improve efficiency and accountability, EA is being institutionalized as part of routine, annual PEPFAR reporting. In 2012, nine countries participated in the first phase of institutionalization. In the second phase in 2013, an additional ten countries for a total of nineteen participated, In 2014, all other PEPFAR countries were included in a third and final phase of institutionalization of EA. It would be beneficial for your organization to think about how these data could be provided in future years with less effort and standardized allocation methods. This data collection has been granted The Office of Management and Budget (OMB) approval (DS-4213, OMB No. 1405-0208)

- 4) Why does the "Instructions" sheet in the data collection template indicate this activity should take 24 hours when it seems this could take much longer?

The Office of Management and Budget (OMB), the USG authority responsible for approving data collection tools, requires an average estimate, not a range, be included in the data collection form, and the stated average is for one mechanism in a single country. Since this is an average, there are some partners who will only need a few hours to complete the activity while larger partners will require much more time to complete the template. Naturally, organizations with multiple mechanisms in multiple countries will require the greatest time commitment. Based on feedback from IPs, the average was increased to 24 hours during the public comment rounds during the approval process.

- 5) My financial reports are already in US Dollars but a different exchange rate or rates were used throughout the year than the one stated in the guidance; do I have to use the rate specified in the guidance?

No. If your expenditures are already in US Dollars, you do not have to adjust for the exchange rate in the guidance. However, if the expenditures are in local currency, please use the exchange rate provided in appendix A.

- 6) How are EA categories different from PEPFAR budget codes?

Some EA program areas align fairly directly with PEPFAR budget codes (for example, male circumcision, HIV testing and counseling, OVC) while other EA program areas cover multiple PEPFAR budget codes (for example, the EA program area of facility-based care, treatment, and support relates to the PEPFAR budget codes for HTXS, HDTX, HBHC, PDCS, PDTX, HVTB, and HLAB).

The EA activity is designed to capture data based on how programs are actually being implemented, rather than how money is programmed via PEPFAR budget codes. We recognize that in some cases money originating in one budget code may be used to support other/related activities to meet program objectives. The EA activity is not an audit and there will not be an effort to link budgets to actual expenditures. One major goal of EA is to understand how PEPFAR dollars are actually being used to support service delivery and provide program support on the ground. It will be important to appropriately associate expenditures to the sub-national unit where they are consumed (i.e., region, province, etc.) and allocate shared resources to appropriate program areas and cost categories. Guidance for allocating expenditures can be found in the EA guidance. Note: The EA guidance is also available on the PROMIS website.

7) Who are the most appropriate organizational staff to complete the EA template?

Program staff are well versed in service delivery and operations, while finance/accounting staff are well versed with the financial reporting of the organization. Therefore the EA team highly recommends that the EA template be completed with coordination from both the financial and program staff to accurately allocate expenditures to each appropriate program area and sub-national unit.

8) Who is the FEWG and what is their role?

The FEWG is the PEPFAR Finance and Economics Work Group which consists of an USG interagency team of individuals responsible for providing technical assistance and oversight of finance and economic activities at PEPFAR HQ and in the field. They are the primary implementers of EA at the HQ level in developing guidance, systems, materials, analyzing results, producing reports, and otherwise providing technical assistance on the reporting and usage of EA data.

9) I am receiving emails from several different people about EA; who are these different people and what are their roles?

- a) EA Advisor: The EA advisor is the designated HQ point of contact for liaising with a particular operating unit (country or region) which is to report in EA. Their role is to ensure that any and all critical information regarding EA reporting is communicated to the PEPFAR USG country team.
- b) TA provider: Each operating unit is assigned a TA provider who is contracted to be the primary point of contact in providing assistance to implementing partners on the classification of expenditures or otherwise fulfilling the EA reporting requirement.
- c) Help Desk emails: If you fill out a Help Desk ticket in PROMIS, you may receive email notifications regarding the responses given. The individuals responding to these emails can range from your EA advisor, TA provider, or even the PROMIS development team.

Your A/COR or designated staff from the PEPFAR funding agency may also reach out to you regarding the EA reporting.

10) We did not know that we would have to report expenditures by PEPFAR vs non-PEPFAR or COP vs non-COP funding and we have not kept our accounting records like this over the past year; what can we do to meet the EA requirement?

For this reporting cycle, you may choose to align each of your expenditures in aggregate to the EA program areas and cost categories. Upon doing so, you should apply a percentage to all expenses according to PEPFAR's overall contribution to your funding. For instance, you spent \$20,000 on Personnel from all donor sources, but PEPFAR makes up 75% of your total funding. You could apply that percentage and report \$15,000 (75% of \$20,000) as Personnel in EA. You may also use contextual information to assist in this process. For instance, if you received money from PEPFAR specifically to purchase HIV test kits, you may report the full amount report as HIV test kits in EA rather than reducing this amount. A similar methodology could be undertaken for non-COP/non-ROP funding which should be left out of EA. Determine a proportion of your total PEPFAR funding which is sourced from the COP/ROP, and apply that to your PEPFAR expenditures before reporting to EA.

It is strongly recommended that systems be adjusted to account for PEPFAR-specific funding in future years.

Allocating expenditures and other expenditure - specific questions:

11) What is the difference between “site-level” and “above site-level” expenditures?

Site-level expenditures are those which occur at the point of service at the facility/community level regardless of the nature of the support (e.g., payment for nurses’ salaries who provide care in a clinic and salary for a staff member who provides TA and mentoring to doctors in a hospital). Any expenditure that occurs above the facility/community level would be considered above site-level expenditures--e.g., program management (PM), strategic information (SI), health system strengthening (HSS). While information should be provided for all site-level and above site-level expenditures, it is not required to disaggregate these expenditures to individual sites. The EA guidance also provides details and a recommended method for allocating above-site level expenditures, including PM, SI and HSS.

12) My organization tracks expenditures by site; do I have to sum up the expenditures to record a single row for each sub-national unit, or is there some way to enter my expenditures in the template by site?

You may enter multiple rows of data with the same sub-national unit tag. Each row of data for the same sub-national unit may represent a specific site’s expenses which you are recording. Upon uploading an excel template with multiple sub-national unit rows, the data will be automatically aggregated by the system. HOWEVER, please do not paste or overwrite the sub-national unit names in the Excel template with a site or facility name, this will result in a failed upload to PROMIS and require you to re-enter your data in a new template.

13) How should training-related expenditures be captured?

Allocating training expenditures requires asking two primary questions: who is being trained? and where is the training being conducted?

Training expenditures are unique as these can occur at the site-level or above site-level (regional, national or above-national levels). These expenditures are an exception to the rule, *capture expenditures where resources are consumed*. Training expenditures are fully loaded, thus please include all related expenditures under training (Personnel, Consultants, Travel and Transport, Materials, Venue, etc). We have developed some operational definitions for training to help guide you in allocating these expenditures between regions and program areas. Full guidance can be found in section 3.6.

- a) In-service training: Training devoted to site-level service providers who are existing health workers. These expenditures are captured at the site-level for the respective program area and should be allocated between the sub-national units in which the trainees work. Detailed, step-by-step guidance can be found in section 3.6.
- b) Pre-service training: We use the PEPFAR APR definition of pre-service training. If such training is conducted at the central level (e.g., capital city) for individuals from different provinces, these expenditures should be captured in *HSS-Human Resources–Pre-Service Training* section at the national-level. If funds support pre-service training at a non-central institution where all or most of the students come from that region, you may record those expenses under the applicable location.

14) How do I categorize training expenditures geared towards non-health workers such as community health workers (CHWs), Para-social Workers, traditional birth attendants (TBAs), community counselors or general community members?

The main distinction is whether the individuals are being trained to perform specific tasks for a health organization. CHWs, community counselors, Para-social workers and other support staff should be treated as health workers. General members of the community who are not affiliated with a health care or support organization should not be classified as health workers and expenditures related to their training should be recorded at the site-level according to the cost category and program area they support (but NOT the In-Service Training category). For example, a training is conducted on community members on proper use of condoms and your organization contributes staff time and travel. This would be recorded on the Site-Level sheet, under the GP-PREV program area, recorded under the Personnel and Travel cost categories.

If the training is geared towards community members at large (for example, training on condom use or other prevention activities) the activity should be considered part of program operations and recorded as a site-level expenditure under the “Training” cost category according to the corresponding program area and region.

15) How should I classify training for Project Management, Monitoring and Evaluation (M&E) or HSS activities?

Where the individual being trained works will determine how these training expenses get classified.

If the trainee is an individual with your organization, who works above the site level providing support to your organization in program management, M&E, or HSS- the training expenses should all be classified as above site-level PM, SI or HSS respectively.

If the persons being trained are members of the host national government, community-based organizations, or otherwise critical to indigenous organizations providing HIV services and support, then the expenditures associated with training those individuals should be reported as above site-level HSS, and classified under the appropriate cost category, functional area, and program area, per the training’s content.

16) There is no program area for activities related to gender equality and gender-based violence (GBV). Where would I categorize those expenditures?

Programs addressing gender inequality and gender-based violence can be tagged in several different program areas, depending on the nature of the program. An activity raising awareness and seeking to prevent GBV should most likely be categorized as GP-PREV. If a program seeks to prevent GBV among key populations, such as female sex workers, such activities would fall under KP-FSW. PMTCT and OVC are other possible program areas that may be associated with GBV programs, depending on the nature of the activities. If you are unsure which program area best reflects your activities, please contact the PROMIS help desk for technical assistance.

17) What is the difference between personnel and consultants?

In the site-level sheet of the Excel template, there is no distinction made between personnel and consultants. For costs associated with either personnel or consultants at the site-level, please record as the “Personnel” cost category.

In the above site-level sheets (PM, SI, HSS), a distinction is made between personnel and consultants. Personnel are employees, full-time or part-time, of PEPFAR implementing partners’ payroll. Consultants are individuals contracted by the partner organization to carry out specific tasks, including provision of TA. Please report expenses associated with personnel and consultants according to this definition when filling out the above site-level sheets.

18) Should expenditures by sub-grantees and sub-contractors be captured?

PEPFAR prime implementing partners may work with other organizations through a sub-agreement. Similarly, a prime implementing partner may contract specific technical or administrative services with other external organizations. Prime implementing partners are required to collect and aggregate data from all sub-agreements and sub-contracted service providers for the EA activity.

19) My organization paid a lump sum fee to a consulting firm for a set of activities and the consulting firm in turn spent funds on supplies, travel, and consultant time; however, I do not know how much the consultant spent on each of these. How should I proceed?

The most accurate way to present this information would be under the specific cost categories. While the contractor has not provided you with this level of detail, it is more than likely that they track their expenses in a way similar to how the EA cost categories are defined. Time permitted, you should reach out to the contractor to get these sub-totals for entry into EA. If this is not possible, then you will be forced to record the expenditures into an ‘Other’ category. If you do so, please explain in the comments section.

20) We provide integrated care and treatment services that have both a facility-based and community-based component; how should we divide our expenditures between these two program areas?

Your expenditures will need to be allocated between the FBCTS and CBCTS program areas. The costs which should be allocated between the areas should be aligned with categories which can be shared between a facility and community setting. For example, costs related to travel, vehicles, personnel time, and supplies may be shared between settings, while costs on static equipment, rent, or construction may not. You may allocate expenditures like vehicles, travel and personnel based on perceived level of effort in the field (contact program staff for this information).

- 21) We provide integrated care and treatment services at several clinics including HIV testing and counseling, and PMTCT; how should we separate expenditures between FBCTS, HTC, and PMTCT?

You may choose to allocate expenditures between these program areas based on several pieces of data. One example may be utilization of services based on floor space. Another option is to allocate expenditures based off level of effort estimates from site-level workers (contact your program staff for this estimate). You can apply these estimates of effort to each of the costs incurred. See section 3.1 of this guidance for more details.

- 22) How should expenditures for institutionalization and support for training systems (e.g. curriculum development) and curriculum implementation be captured and how is this different?

These are two distinct activities. Expenditures related to the actual development of the curriculum materials or other support for institutionalization of in-service training should be captured in *HSS - Human Resources-In-service Training Systems Support & Institutionalization*. Expenditures related to the use of the developed materials for trainings, workshops, seminars, etc. should be considered as implementation and likely captured as training expenditures at the site level, recorded according to the geographic unit where the trainees will work, or as pre-service training under above site-level HSS if they are curricula for a degree program.

- 23) How should I categorize testing expenditures for pregnant women or males reached through a VMMC program; would they fall under HTC their respective program areas?

If your activities focus on counseling and testing but you happen to test pregnant women as well and refer them to PMTCT services, you do not have to separate the expenditures for testing the pregnant women. If your mechanism provides testing and counseling through a PMTCT site or program, the testing and counseling expenditures should be categorized as PMTCT.

If you provide medical male circumcision services, and also offer testing and counseling services to your clients, then report all expenditures related with those testing services under VMMC rather than HTC.

- 24) Why is there a recurrent cost category for food supplements, and for the CBCTS and OVC program areas, a service category for nutrition and food support as well? Are these the same?

The food supplements recurrent cost category should include only the expenditures for the purchase of food supplements. The nutrition and food support service category should include food supplements, but it should also include other expenses related to the implementation of nutrition and food support programs, such as personnel, other supplies, and any investment expenditures.

- 25) I'm not sure whether I should categorize my lab expenditures under the Site-level Lab section or the Laboratory Strengthening column in the HSS worksheet. What is the guidance on this?

The main distinction is whether the expenditures are tied to the provision of laboratory services at specific labs or sites, or whether the expenditures are for improving the laboratory system as a whole. Expenditures captured in the Site-Level Laboratory section should be directly related to the provision of laboratory services; if your mechanism pays for Lab technicians working in specific facilities or labs, for example, these personnel expenditures should be captured in the Site-Level Worksheet. However, if your staff works to strengthen the laboratory system in a country or region by providing technical assistance, mentorship or other support, their personnel expenses should be captured as above-site level, HSS Personnel expenditures. These should then be tied to Laboratory Strengthening under the HSS functional areas, and allocated to the Lab program area.

- 26) I am unsure of whether I should categorize my Construction and Renovation expenditures in the Site-level tab or the HSS tab; what is the guidance on this?

Construction and Renovation can occur for facilities that provide direct services to beneficiaries, as well as for facilities that are not used for direct services, such as Ministry of Health headquarters buildings. For facilities tied to specific services, construction and renovation expenditures should be categorized as site-level and allocated to the specific program areas for which the facility provides services. For facilities not involved in direct service, such as a building housing a division of the Ministry of Health, expenditures should be categorized as HSS- Construction and Renovation, then applied to the functional area(s) most applicable, and then allocated across the program area(s) supported.

27) How should program staff time be allocated between program management and program implementation?

There is always clarity needed as to where the expenditures for above site-level staff, typically based at the in-country head office (mostly capital city), should be captured. Often program managers are also involved in technical aspects of the program, including direct service provision and support to local government entities. It is acceptable and encouraged to allocate a manager's compensation between program management and other areas. If a manager travels half of the time to field sites to provide services or manage facility/community-level staff, you may allocate 50% of the manager's time to the provinces and program areas in which they worked (*Expenditures-Site-level* worksheet). If the manager also supports capacity development of the host country system or staff, you may allocate a portion of the manager's time to the appropriate locations and functional areas within health system strengthening (*Expenditures- HSS*).

28) Is Monitoring and Evaluation part of Program Management or Strategic Information (SI)?

You may have program managers that travel to the field sites to monitor the implementation of the program. We consider this Program Management. An M&E Advisor who goes to the field and ensures that the reporting is correct, that would be considered Strategic Information since that goes into the program monitoring and evaluation reporting system.

29) Where do we include expenditures for personnel at the site level who are involved with data capture and reporting?

Site level personnel should be considered part of service delivery and should be included as personnel expenditures under that program area. The same classification should be followed for individuals who are accountants, drivers, and persons providing technical assistance.

30) Should indirect costs be captured in the EA template, and if so, where?

Yes. Indirect costs (e.g., NICRA) should be reported on the worksheet, *Expenditures- PM*, under General and Administrative (G/A).

31) Why are health systems strengthening expenditures allocated to functional areas and is this required?

The data collection categories for health system strengthening (HSS) have been evolving since the inception of the EA pilots in 2009. Country teams have expressed a need to better account for PEPFAR support to broader system development and have sufficient detail to evaluate progress and allocation of HSS resources. HSS expenditures are requested to be reported in two ways: first, by cost category; second, by functional area.

The HSS functional areas are aligned with the WHO Six Building Blocks while also reflecting PEPFAR-specific activities. The sum of the HSS expenditures by cost category should equal the sum of HSS expenditures by functional area. Operational definitions have been provided in section 2.5 of this EA guidance.

32) The prevention expenditure categories do not reflect my program. Why are prevention activities categorized in this way for EA?

Defining prevention categories has been a challenge in EA as the intervention types are often interpreted differently in different countries and there can be a great deal of overlap between categories depending on interpretation. Country teams have generally wanted more detail in this program area to better understand how prevention dollars are being spent; however, some prevention technical working groups have indicated the sub-categories are not useful for program planning and recommended the instrument be adjusted to align with interventions for specific target populations instead of service categories. Additionally, IPs in several countries have indicated the sub-categories disaggregated by service types are not easily understood. It is beyond the scope of the EA activity to reduce prevention interventions into a narrow set of service categories with operational definitions that can be

compared across countries. However, to understand differences between prevention interventions for specific target populations, the disaggregation between general population and key populations has been maintained and is consistent with the standard PEPFAR indicators reported annually.

33) How should expenditures related to technical assistance (TA) be captured?

To properly record TA expenditures, it should first be determined if the TA is being provided at the site-level or above site-level (see question #12 above and sections 2.3, 2.4, 2.5, and 2.6 of the manual).

If the TA is determined to be site-level, then the expenditures should be reported on the site-level sheet, according to the cost categories applicable (usually personnel and travel/transport) and linked to the program area they are affiliated with.

If the TA is determined to be above site-level, then the expenditures should be reported on the above site-level HSS sheet.

34) Our organization does not track our site-level expenditures (e.g., ARVs) at a sub-national level, can we simply report them as “National”?

There is no option in the site-level worksheet to allocate site-level expenditures to the “National” level and all commodity procurements should be allocated to some sub-national unit. The study team understands that consumption or distribution data may not always be available if commodities or other products are procured to a national storage facility. However, we encourage you to use other sources of information, such as patient load or disease burden by geography to estimate usage. If you have any difficulties or concerns with this, please submit a help desk ticket for assistance.

35) How should PEPFAR expenditures consumed outside of the host country be captured?

This question is applicable typically for International NGOs who are PEPFAR implementing partners. If the INGO staff travels from the overseas location to the country (national-level), province (provincial-level) or the individual sites (site-level) for providing TA, conducting training, monitoring the program, such expenditures should be recorded in the appropriate section and according to location the resources were consumed.

On the other hand, if there is INGO staff conducting desktop analysis or grant management based in the overseas office only, then such expenditures would be captured as above-national expenditures.

36) How much time can an above-national level staff member spend in-country before part of his or her salary should be allocated to the national level or province visited?

The most accurate method for recording personnel expenditures is to use the EA rule of thumb: *allocate expenditures according to the location in which they are consumed*. If a manager resides in the US and travels to country over the course of the year to provide management support, you can multiply the percentage of time spent in country to their total compensation to determine what amount should be recorded at the national or regional level. If, for some reason, you are not able to determine an appropriate allocation, please use the “Add Comments” section extensively to explain how you classified the expenditure, or request TA (see section 4.2).

37) How should other sources of funding (i.e., non-PEPFAR) be captured in the EA tool?

The scope of this activity is to capture PEPFAR funds. The EA activity aims to capture expenditures during the EA timeframe made by partners in support of the PEPFAR program. Partners may receive funding from multiple sources, but non-PEPFAR funds should not be reported. The goal of the EA activity is to capture every PEPFAR dollar spent during the one year EA timeframe. Non-PEPFAR dollars should not be collected as part of this activity. Also see section 1.5 of the manual.

38) Is it ok to report expenditures for a region or program area if my organization does not report indicators?

The goal is to report every PEPFAR dollar expended. It is acceptable to have expenditures but no indicators if that is the nature of the program. However, it is not acceptable to have indicators but no expenditures reported for a program area. The EA activity expects that if partner reports site-level indicators that site-level expenditures be reported as well. In fact, one way to facilitate your

allocation of expenditures across program areas is to look at the indicators that you report, for example, if you report PMTCT beneficiaries, you should have site-level expenditures under the PMTCT program area.

If a partner is purely TA oriented and does not implement activities at the site-level, they may not have indicators to report but will have expenditures. We are limited to using indicator data captured in the APR.

39) Will EA results be compared to budgets?

It is not the intention of EA to conduct an audit. Partners should report expenditures based on actual service delivery and support and not account for obligations by budget codes.

EA results, however, will be used by the PEPFAR country teams to assist in creating work plans and budgeting for future years, including setting targets and implementing partner budgets. The higher the quality of EA data collected, the better information PEPFAR teams will have at their disposal to ensure maximal effectiveness and efficiency in meeting the needs of each country program.

40) How should I allocate pre-service training expenditures across program areas when I am unsure what types of health services the graduates will provide in the future?

Pre-service training is one of the most challenging activities to allocate across program areas in the Expenditure Analysis exercise. However, it is not appropriate to allocate this effort evenly across all program areas. Please see section [3.3 of the manual](#) for a detailed explanation of how to allocate this activity.

41) I provide assistance at the Provincial level, but only districts are listed. How do I classify my expenditures?

Activities which are carried out at the geographic level above the level provided in the template should be tagged as “National” expenditures. In this example, the assistance provided at the Provincial level would be tagged as “National”. Assistance provided above the site-level at a district level would be tagged to that district.

Questions on data use, timelines, support and deliverables:

42) How will these EA data be used, both in the host country and in PEPFAR?

At the country level, EA data will be one additional tool used to manage the PEPFAR portfolio and prepare budgets and targets using an evidence base that improves efficiency in operations and allocation of resources. EA data are useful at the global-level to assist with planning for required resources needed to sustain and continue to grow the PEPFAR program. Additionally, EA data assist PEPFAR in responding to US Congressional inquiries and demonstrating value and accountability in program operations.

43) Will EA results be compared across countries?

No. The FEWG is the PEPFAR in-house technical resource for financial and economic analysis, data and interpretation. The FEWG discourages any effort to compare EA results between countries, understanding that the cost inputs and social, political, and economic contexts are widely divergent. Country-specific data, however, is useful for constructing global budgets, modeling required resources and accounting for changes in cost structures as programs continue to grow and adapt to local influences.

44) Will EA results be compared across implementing partners within a country?

Partner-level data will be used for planning and targeting. The FEWG understands that contextual factors not captured by EA are equally relevant in the planning process and would not advocate setting budgets based solely on EA data (e.g., setting all partner budgets based on the “cheapest partner’s results”). However, the range of unit expenditures by partner and geographic location may help to identify potential efficiency gains, knowledge sharing of best practices, and overall improvement of output and outcomes given existing resources.

45) Are the EA data submission due dates flexible?

The due dates for the EA data submission are not flexible. Any data that has not been entered into the system by the date stated in this guidance will not be accepted and will not be included in the analysis and results reports.

46) Will program results already submitted to PEPFAR need to be supplied again for EA?

No. For most countries, no program results that have been submitted to PEPFAR via the Semi-annual and Annual Program Results will be asked for through the EA. These data will be used in the analysis and obtained through the country's PEPFAR Strategic Information USG team.

47) Is there error checking when uploading files and if so, does it provide a detailed description of the problem?

The data collection template has built-in data quality checks. Those using the template will see a sheet called "Data Quality Checks" in which there is a summary of errors (if any exist) in the template. The error is referenced by cell in the sheet and will explicitly explain the issue and the expected result. Your USG A/COR, Activity Manager, or Project Officer, during their review of the EA submission of the partner mechanism they manage, should be certain to check this sheet for any errors to help facilitate the data cleaning process.

Additionally, when data is submitted to the PROMIS system, the user will receive an electronic report detailing any errors made in the submission. These errors will need to be corrected for a submission to be accepted by the PROMIS system.

48) For data cleaning, could you clarify the process/flow of information between HQ-USG field team-partners?

The first step in the EA data analysis is to run the initial data submission through a quality check. After running this check, a set of flags for each partner will be generated, and the respective IPs will be contacted (as well as the associated A/COR) with an attachment detailing each issue and how the IP and/or A/COR should respond. Some issues may simply require an explanation or clarification, while other issues will require edits to the data collection template and a re-upload to PROMIS to have a successful submission.

49) Will PEPFAR provide financial support to implementing partners to complete this data request?

PEPFAR cannot provide additional funding to complete this request. Implementing partners should consider this activity as an extension of routine reporting. EA is now required as routine reporting and has been approved as such by the Office of Management and Budget (DS-4213, OMB No. 1405-0208). In order to assist partners with their submissions during the institutionalization phases, the FEWG is providing extensive technical assistance, through contracted firms with the appropriate skills, for support directly to field staff upon request. TA will be available in a combination of live and virtual TA throughout the data collection and cleaning process. While we know this is going to be intensive, the FEWG has conducted 9 pilots without any external TA and manual spreadsheets rather than a supported web-interface as is currently available, so the EA team is confident that adequate support can be provided to the country teams. The FEWG members and surge teams from the agencies are also available for assistance during the data collection/cleaning and for reviewing and using the data for program planning and COP/ROP preparation. The TA providers are fully funded by PEPFAR central funds. In addition, there is a contractor providing support for the data base/website that will be able to assist with technical difficulties that might arise with accessing the EA template and uploading/submitted completed data. All questions/requests for TA should be submitted by initiating a help-desk ticket in the PROMIS website.

50) What is the role of the A/COR/Activity Manager/Project Officer during data collection and cleaning?

A/CORs and activity managers will need to gain access to the PROMIS system. A/CORs will be provided a checklist and orientation to explain reviewing submissions, how to submit partner data as final, and how to request revisions. A/CORs will not be expected to answer technical questions pertaining to EA, but will be included on any correspondence with implementing partners during the data collection and cleaning process.

51) How long will it take to complete the data request?

The amount of time it takes to complete the EA template varies by partner, country and experience. Larger organizations/programs with wider scopes may require more time in planning, coordinating, and supplying data. Any partner who already tracks expenditures, maintains more sophisticated accounting software, or has dedicated accounting teams will have an easier time completing this request. The time required will likely depend on the size and complexity of the portfolio.

The average time required for 1 mechanism in 1 country is 3 full-time person days (24 hours), assuming adequate accounting systems and activities focused in a few program areas or geographic locations. Organizations with more program areas, more geographic coverage, limited accounting systems, multiple mechanisms, or mechanisms in multiple countries will likely require more time and should plan accordingly.

52) How will expenditures be captured for implementing partners that do not provide services directly?

It is important that all PEPFAR expenditures are captured through the EA and we are able to describe how USG funds support actual service delivery, as well as system support and capacity building. As PEPFAR moves away from direct service provision and more towards a technical assistance model in many countries, it is crucial we are able to demonstrate how above site-level and system support funds are contributing to building local capacity and improving the quality and quantity of services delivered. Though metrics are not always available for system strengthening activities, EA can provide greater detail on cost structure and how resources are allocated to various types of core areas within HSS.

53) How can I request technical assistance (TA) with this data request?

TA will be accessed by initiating a help desk ticket on the [PROMIS](https://pepfarpromis.net/promisea/) website (<https://pepfarpromis.net/promisea/>). After logging into PROMIS, use the *Help Desk* link to initiate a ticket. Please fill out all rows in the ticket request and provide a description of the problem you are having or the nature of your question/request. Your ticket will be routed to the appropriate authority and you will be contacted by the support teams.

54) Will my organization be provided a summary of EA results and our data submission?

Yes. Once data is cleaned and analyzed the country teams will receive a summary report, including total expenditures disaggregated by region, program area and cost category. Each implementing partner and associated A/COR will receive an implementing mechanism summary. This report will have a summary of your IM's total expenditure, unit expenditures and program area averages.

Questions about the PROMIS website:

55) What is PROMIS?

The acronym stands for PEPFAR Records Organization Management Information System. PROMIS is a 3rd party database system with an online user interface. For purposes of EA, PROMIS is used to download data entry templates, download EA guidance, request TA, and upload completed data entry templates.

56) Who has access to PROMIS?

Persons with access to PROMIS include the EA Country team, A/CORs, and selected individuals affiliated with IP's. Access is tiered with various levels of permissions. To gain access to PROMIS, individuals should create an account on the PROMIS website. Upon doing so, they will have no permissions or abilities to see or upload any data. At that point, you will need to request access to mechanisms you wish to report/review data for in specific countries. Upon being granted approval, you will then be able to upload and review results. Other than individuals in country, only the FEWG at HQ has access to PROMIS.

57) I am having issues logging into PROMIS or accessing the site in any way; what should I do?

First, ensure you are using either the Mozilla Firefox or Google Chrome web browsers, and NOT Internet Explorer. If you continue to have issues with the display of information in the website, please submit a help desk ticket. If you are unable to access the website at all, please contact your TA provider (section 4.0 of this guidance).

58) I have a username but am having trouble logging in. Whom do I contact for assistance?

Use the *'Forgot Username or Password'* link on the PROMIS homepage if you have difficulty with your login credentials. Follow the instructions and you will be able to retrieve your username and reset your password.

59) I can log in to PROMIS but cannot see all of my mechanisms; what do I do?

If your organization manages multiple PEPFAR mechanisms, please check with your colleagues if they have received access to the system; it may be that data for your missing mechanism is being submitted by someone else in your organization. If you know you are responsible for managing that mechanism's submission and have access to PROMIS, please request access to that mechanism via the *'Request Access'* button in PROMIS.

60) What privileges accompany PROMIS access?

Privileges vary by user affiliation. User's at the IP level have only access to their mechanisms, and have the ability to download and upload data tools. A/CORs have access only to the mechanisms which they oversee, and have the ability to accept or reject their mechanisms' uploads, as well as manually make changes to the upload. Users at the EA Country team level will have access to see all mechanisms supplying data.

61) I have corrupted my Excel template by manipulating the structure of the form and PROMIS will not accept my upload, what should I do?

Download a clean Excel template from the PROMIS website and re-enter your data (taking care not to corrupt the format of the file or mistakenly paste data into a hidden field).

62) My percentage allocations to program areas across PM, SI, and/or HSS sum to 100% in the Excel file, but PROMIS tells me I have a failed upload. Why might this be?

It is more than likely that you have pasted data into a hidden column in one of those sheets, resulting in the visible fields summing to 100% while the full range sums to greater than 100%. To resolve this you should send your template to your TA provider so they can remove the values from the hidden cells.

63) Is it possible to upload multiple files at once to ease our workload?

No, please ensure that only one Excel template at any point in time has been uploaded to PROMIS. If you have uploaded a template, and wish to revise and re-upload your data, you will need to first remove the old template before uploading the revision.

64) Is it possible to make changes to a data template after upload?

Yes, users may change data that has already been uploaded to the PROMIS system so long as the mechanism is not in a "locked" state (i.e., submitted for review by the A/COR). If data has been submitted to the A/COR for review, and is locked, you may request your A/COR to unlock the submission for editing.

Before uploading a revised template, ensure that any prior uploaded templates have been removed.

Again, since PROMIS cannot anticipate a user's intent, we strongly encourage you to always review your data summary reports in PROMIS to ensure that no values are inadvertently doubled, absent, or otherwise incorrect due to multiple uploads and web changes.

Please refer to the PROMIS manual for more detail on making changes to data.

65) When does the PROMIS system come online to begin data collection?

October 1st, 2015

66) When does the PROMIS system close for data collection? What time of the day?

November 13th, 2015. 8:00 PM US/EST.

67) How does the help-desk ticket system work?

Users will submit a help-desk ticket through PROMIS. There will be a form to fill out regarding the nature of the issue the user is having, this should be filled out thoroughly and accurately to ensure that the ticket is forwarded to the appropriate party and the issue is resolved quickly. (Please refer PROMIS User Guide presentation in the Guidance section of the PROMIS website.).

APPENDIX C: HOW S/APR RESULTS ALIGN TO EA PROGRAM AREAS

The EA program areas can be aligned to PEPFAR reported results to calculate unit expenditures (UE). This is the amount that PEPFAR spent per beneficiary being reached with a certain intervention. The PEPFAR unit expenditure does not represent the full cost of providing a service as all funding sources are not considered (e.g., host-national government, other donors, and non-PEPFAR USG support are not included) and investments from previous years outside of the EA reporting period are not included. Although not equal to the unit cost of the service, EA unit expenditures are still useful for internal PEPFAR planning purposes in estimating future USG resource requirements to reach particular targets.

When determining the program areas in which to report your organization’s expenditures, it is helpful to consider which indicator results your organization regularly reports in the S/APR. See table 8 below to learn how the EA HQ team aligns PEPFAR reported results with expenditure data to calculate unit expenditures in different EA program areas.

PEPFAR has institutionalized an M&E framework named “Monitoring, evaluation, and reporting” (MER) which replaced the PEPFAR Next Generation Indicators (NGI). The MER features a new type of disaggregation for indicators: Technical Assistance (TA) and Direct-service delivery (DSD). Please note that the EA 2015 analysis will not utilize the TA/DSD-disaggregated data.

Table 8. How EA program areas align with PEPFAR S/APR Results

EA Program Area	EA Indicator Description	MER Abbreviation Equivalent
Facility-based care, treatment and support (FBCTS)	Number of current Adult, Pre-ART patients in APR'14	[CARE_CURR - TX_CURR (>15 years old)]
	Number of current Pediatric, Pre-ART patients in APR'14	[CARE_CURR - TX_CURR (> 1 year but <15 years)]
	Number of current Adult, ART patients in APR'14	[TX_CURR (>15 years old) - PMTCT_ARV]
	Number of current Pediatric, ART patients in APR'14	TX_CURR (> 1 year but <15 years)
	Number of current Adult, Pre-ART patients in SAPR'15	[CARE_CURR - TX_CURR (>15 years old)]
	Number of current Pediatric, Pre-ART patients in SAPR'15	[CARE_CURR - TX_CURR (> 1 year but <15 years)]
	Number of current Adult, ART patients in SAPR'15	[TX_CURR (>15 years old) - PMTCT_ARV]
	Number of current Pediatric, ART patients in SAPR'15	TX_CURR (> 1 year but <15 years)
	Number of current Adult, Pre-ART patients in APR'15	[CARE_CURR - TX_CURR (>15 years old)]
	Number of current Pediatric, Pre-ART patients in APR'15	[CARE_CURR - TX_CURR (> 1 year but <15 years)]
Community-based care, treatment, and support (CBCTS)	Number of current Adult, ART patients in APR'15	[TX_CURR (>15 years old) - PMTCT_ARV]
	Number of current Pediatric, ART patients in APR'15	TX_CURR (> 1 year but <15 years)
	Number of community-based care, treatment & support beneficiaries (CBCTS)	CARE_COMM
	Number of CBCTS beneficiaries of medical care outside facilities	Optional, not MER Level 1 or 2
	Number of CBCTS beneficiaries of economic strengthening activities	Optional, not MER Level 1 or 2

	Number of CBCTS beneficiaries of psychological, social and spiritual care	Optional, not MER Level 1 or 2
	Number of CBCTS beneficiaries of nutrition and food support	Optional, not MER Level 1 or 2
Preventing mother-to-child transmission (PMTCT)	Number of pregnant women tested	PMTCT_STAT
	Number of pregnant women on care	PMTCT_ARV
	Number of infants tested	PMTCT_EID Numerator
	Number of infants on care	TX_CURR (<1 year old)
	Number of pregnant women tested positive	PMTCT_ARV denominator
	Number of infants tested positive	PMTCT_EID disaggregate
Voluntary medical male circumcision (VMMC)	Number of males medically circumcised	VMMC_CIRC
HIV Testing and counseling (HTC)	Number of persons tested and counseled	[HTC_TST - (PMTCT_STAT + PMTCT_EID numerator + VMMC_CIRC tested)]
	Number of persons receiving provider initiated testing and counseling (PITC)	HTC_TST Disaggregation (TB, STI, Outpatient, Inpatient, HIV care and treatment clinic)
	Number of persons receiving voluntary testing & counseling (VCT)	HTC_TST Disaggregation (VCT co-located, VCT standalone)
	Number of persons receiving community-based testing & counseling (CBTC)	HTC_TST Disaggregation (Mobile, Home-based)
	Number of persons tested and counseled who were found positive	[HTC_TSTPOS - (PMTCT_ARV denominator + PMTCT_EID disaggregate + VMMC_CIRC positive)]
	Number of persons who were found positive via PITC	HTC_TST Disaggregation (TB, STI, Outpatient, Inpatient, HIV care and treatment clinic) POS
	Number of persons who were found positive via VCT	HTC_TST Disaggregation (VCT co-located, VCT standalone) POS
	Number of persons who were found positive via CBTC	HTC_TST Disaggregation (Mobile, Home-based) POS
Post-exposure prophylaxis (PEP)	Number of post-exposure prophylaxis beneficiaries	Optional, not MER Level 1 or 2
Blood Safety (BS)	No unit expenditure calculated	None
Laboratory (Lab)	No unit expenditure calculated for lab services but linked to FBCTS & PMTCT	None
Infection Control (IC)	No unit expenditure calculated	None
Orphans and vulnerable children (OVC)	Number of orphan and vulnerable children beneficiaries	OVC_SERV
	Number of OVC beneficiaries of health access & health promotion	None
	Number of OVC beneficiaries of education support activities	None
	Number of OVC beneficiaries of economic strengthening activities	None
	Number of OVC beneficiaries of psychological support	None
	Number of OVC beneficiaries of nutrition and food support activities	None

	Number of OVC beneficiaries of child protection services	None
	Number of OVC beneficiaries of case management services	None
	Number of OVC beneficiaries of early childhood development (ECD)	None
General population prevention (GP-PREV)	Number of general population prevention beneficiaries	Optional, not MER Level 1 or 2
Persons who inject drugs (KP-PWID)	Number of KP-PWID prevention beneficiaries	KP_PREV disaggregation of PWID
Female sex workers (KP-FSW)	Number of KP-FSW prevention beneficiaries	KP_PREV disaggregation of FSW
Men who have sex with men and transgender (KP-MSMTG)	Number of KP-MSMTG prevention beneficiaries	KP_PREV disaggregation of MSMTG
Priority Population Prevention (PP-PREV)	Number of PP-PREV prevention beneficiaries	PP_PREV
Medication assisted therapy (MAT)	Number of beneficiaries receiving medication assisted therapy	KP_MAT

APPENDIX D: DATA QUALITY CHECKS

Table 8 below shows a list of Data Quality Checks (DQCs) which you could possibly have flagged in your excel template. Each DQC shows where in the excel template the error occurs and an explanation of each is given. Note that DQCs are deemed Tier 0, Tier 1, Tier 2, and Tier 3: with Tiers 0 & 1 being deemed “Fatal”, meaning they must be corrected to have a successful data upload and submission. Tiers 2 & 3 are clarifying checks which require review and verification, but may still be uploaded and submitted successfully.

Table 9: List of Possible Data Quality Checks in PEPFAR Expenditure Analysis							
Tier & DQC Type	ID	Program Area	Error ID Group	Sheet in Template	Column in template	Equation in template	Description
Tier-0 - Unable to upload template	1	All	1 - Location / Results identified	Site-level	F	C:E when H:LB > 0	Location and Point-of-Service identified on all rows with results?
Tier-0 - Unable to upload template	2	All	1 - Location / Results identified	Site-level	G	H:LB > 0 when C:E	Results identified on all rows with Location and Point-of-Service?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	3	FBCTS	3 - Other Expenditures <=20%	Site-level	H	$[L+V]/[H:V] \leq 0.2$	FBCTS Other Investment & Recurrent expenditures <= 20% of total FBCTS expenditures on row?
Tier-0 - Unable to upload template	4	FBCTS	6 - Non-negative percentages	Site-level	I	H:V >= 0	All FBCTS expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	5	FBCTS	10 - Average CL/LT	Site-level	J	X > 50	Average yearly clinic visits for Adult patients on Pre-ART less than or equal to 50 on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	6	FBCTS	10 - Average CL/LT	Site-level	K	Y > 50	Average yearly clinic visits for Pediatric patients on Pre-ART less than or equal to 50 on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	7	FBCTS	10 - Average CL/LT	Site-level	L	Z > 50	Average yearly clinic visits for Adult patients on ART less than or equal to 50 on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	8	FBCTS	10 - Average CL/LT	Site-level	M	AA > 50	Average yearly clinic visits for Pediatric patients on ART less than or equal to 50 on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	9	FBCTS	10 - Average CL/LT	Site-level	N	AB > 50	Average yearly lab tests for Adult patients on Pre-ART less than or equal to 50 on row?

Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	10	FBCTS	10 - Average CL/LT	Site-level	O	AC > 50	Average yearly lab tests for Pediatric patients on Pre-ART less than or equal to 50 on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	11	FBCTS	10 - Average CL/LT	Site-level	P	AD > 50	Average yearly lab tests for Adult patients on ART less than or equal to 50 on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	12	FBCTS	10 - Average CL/LT	Site-level	Q	AE > 50	Average yearly lab tests for Pediatric patients on ART less than or equal to 50 on row?
Tier-1 [Fatal] - Able to upload template, unable to submit	13	CBCTS	4 - Disaggregated Expenditures Equal Total	Site-level	R	AG:AU = AW:AZ	CBCTS expenditures equal disaggregated expenditures?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	14	CBCTS	3 - Other Expenditures <=20%	Site-level	S	[AK+AU]/[AG:AU] <= 0.2	CBCTS Other Investment & Recurrent expenditures <= 20% of total CBCTS expenditures on row?
Tier-0 - Unable to upload template	15	CBCTS	6 - Non-negative percentages	Site-level	T	AG:AU >= 0 and AW:AZ >= 0	All CBCTS expenditures non-negative?
Tier-1 [Fatal] - Able to upload template, unable to submit	16	PMTCT	4 - Disaggregated Expenditures Equal Total	Site-level	U	BH = BX:BY	PMTCT recurrent ARV expenditures equal disaggregated ARV expenditures for women & infants?
Tier-1 [Fatal] - Able to upload template, unable to submit	17	PMTCT	4 - Disaggregated Expenditures Equal Total	Site-level	V	BJ = BV:BW	PMTCT recurrent HIV Test Kit expenditures equal disaggregated HIV Test Kit expenditures for women & infants?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	18	PMTCT	3 - Other Expenditures <=20%	Site-level	W	[BF+BP]/[BB:BP] <= 0.2	PMTCT Other Investment & Recurrent expenditures <= 20% of total PMTCT expenditures on row?
Tier-0 - Unable to upload template	19	PMTCT	6 - Non-negative percentages	Site-level	X	BB:BP >= 0	All PMTCT expenditures non-negative?
Tier-1 [Fatal] - Able to upload template, unable to submit	20	PMTCT	5 - Distribution Equals 100%	Site-level	Y	BR:BU = 100	Distribution of PMTCT activities equals 100?
Tier-0 - Unable to upload template	21	PMTCT	6 - Non-negative percentages	Site-level	Z	BR:BU >= 0	All PMTCT percentages non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	22	VMMC	7 - Has ARV Expenditures	Site-level	AA	CG = 0	Recurrent ARV expenditures for VMMC on row?
Tier-2 [Non-fatal] - Able to upload template and	23	VMMC	3 - Other Expenditures	Site-level	AB	[CE+CO]/[CA:CO] <= 0.2	VMMC Other Investment & Recurrent expenditures <= 20% of total VMMC expenditures on row?

submit, requires post-processing			<=20%				
Tier-0 - Unable to upload template	24	VMMC	6 - Non-negative percentages	Site-level	AC	CA:CO >= 0	All VMMC expenditures non-negative?
Tier-1 [Fatal] - Able to upload template, unable to submit	25	HTC	4 - Disaggregated Expenditures Equal Total	Site-level	AD	CQ:DE = DG:DI	HTC expenditures equal disaggregated expenditures?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	26	HTC	7 - Has ARV Expenditures	Site-level	AE	CW = 0	Recurrent ARV expenditures for HTC on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	27	HTC	3 - Other Expenditures <=20%	Site-level	AF	[CU+DE]/[CQ:DE] <= 0.2	HTC Other Investment & Recurrent expenditures <= 20% of total HTC expenditures on row?
Tier-0 - Unable to upload template	28	HTC	6 - Non-negative percentages	Site-level	AG	CQ:DE + DG:DI >= 0	All HTC expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	29	PEP	3 - Other Expenditures <=20%	Site-level	AH	[DO+DY]/[DK:DY] <= 0.2	PEP Other Investment & Recurrent expenditures <= 20% of total PEP expenditures on row?
Tier-0 - Unable to upload template	30	PEP	6 - Non-negative percentages	Site-level	AI	DK:DY >= 0	All PEP expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	31	BS	7 - Has ARV Expenditures	Site-level	AJ	EG = 0	Recurrent ARV expenditures for Blood Safety (BS) on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	32	BS	3 - Other Expenditures <=20%	Site-level	AK	[EE+EO]/[EA:EO] <= 0.2	Blood Safety (BS) Other Investment & Recurrent expenditures <= 20% of total BS expenditures on row?
Tier-0 - Unable to upload template	33	BS	6 - Non-negative percentages	Site-level	AL	EA:EO >= 0	All Blood Safety expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	34	LAB	7 - Has ARV Expenditures	Site-level	AM	EW = 0	Recurrent ARV expenditures for LAB on row?
Tier-1 [Fatal] - Able to upload template, unable to submit	35	LAB	4 - Disaggregated Expenditures Equal Total	Site-level	AN	EX = FK:FN	LAB recurrent Non-ARV drugs and reagents expenditures equal disaggregated Non-ARV expenditures?
Tier-1 [Fatal] - Able to upload template, unable to submit	36	LAB	4 - Disaggregated Expenditures Equal Total	Site-level	AO	FA = FO:FR	LAB recurrent Other Supplies expenditures equal disaggregated Other Supplies expenditures?

Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	37	LAB	3 - Other Expenditures <=20%	Site-level	AP	$[EU+FE]/[EQ:FE] \leq 0.2$	LAB Other Investment & Recurrent expenditures <= 20% of total LAB expenditures on row?
Tier-0 - Unable to upload template	38	LAB	6 - Non-negative percentages	Site-level	AQ	$EQ:FE, FK:FR \geq 0$	All LAB expenditures non-negative?
Tier-1 [Fatal] - Able to upload template, unable to submit	39	LAB	5 - Distribution Equals 100%	Site-level	AR	$FG:FJ = 100$	Distribution of LAB activities equals 100?
Tier-0 - Unable to upload template	40	LAB	6 - Non-negative percentages	Site-level	AS	$FG:FJ \geq 0$	All LAB percentages non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	41	IC	7 - Has ARV Expenditures	Site-level	AT	$FZ = 0$	Recurrent ARV expenditures for IC on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	42	IC	3 - Other Expenditures <=20%	Site-level	AU	$[FX+GH]/[FT:GH] \leq 0.2$	IC Other Investment & Recurrent expenditures <= 20% of total IC expenditures on row?
Tier-0 - Unable to upload template	43	IC	6 - Non-negative percentages	Site-level	AV	$FT:GH \geq 0$	All IC expenditures non-negative?
Tier-1 [Fatal] - Able to upload template, unable to submit	44	OVC	4 - Disaggregated Expenditures Equal Total	Site-level	AW	$GJ:GX = GZ:HF$	OVC expenditures equal disaggregated expenditures?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	45	OVC	7 - Has ARV Expenditures	Site-level	AX	$GP = 0$	Recurrent ARV expenditures for OVC on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	46	OVC	3 - Other Expenditures <=20%	Site-level	AY	$[GN+GX]/[GJ:GX] \leq 0.2$	OVC Other Investment & Recurrent expenditures <= 20% of total OVC expenditures on row?
Tier-0 - Unable to upload template	47	OVC	6 - Non-negative percentages	Site-level	AZ	$GJ:GX, GZ:HF \geq 0$	All OVC expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	48	GP-PREV	7 - Has ARV Expenditures	Site-level	BB	$HN = 0$	Recurrent ARV expenditures for GP-PREV on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	49	GP-PREV	3 - Other Expenditures <=20%	Site-level	BC	$[HL+HV]/[HH:HV] \leq 0.2$	GP-PREV Other Investment & Recurrent expenditures <= 20% of total GP-PREV expenditures on row?
Tier-0 - Unable to upload template	50	GP-PREV	6 - Non-negative percentages	Site-level	BD	$HH:HV \geq 0$	All GP-PREV expenditures non-negative?

Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	51	KP-PWID	7 - Has ARV Expenditures	Site-level	BE	IH = 0	Recurrent ARV expenditures for KP-PWID on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	52	KP-PWID	3 - Other Expenditures <=20%	Site-level	BF	$[(IV+IP)/(IB:IP)] \leq 0.2$	KP-PWID Other Investment & Recurrent expenditures <= 20% of total KP-PWID expenditures on row?
Tier-0 - Unable to upload template	53	KP-PWID	6 - Non-negative percentages	Site-level	BG	IB:IP >= 0	All KP-PWID expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	54	KP-FSW	7 - Has ARV Expenditures	Site-level	BH	IX = 0	Recurrent ARV expenditures for KP-FSW on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	55	KP-FSW	3 - Other Expenditures <=20%	Site-level	BI	$[(IV+JF)/(IR:JF)] \leq 0.2$	KP-FSW Other Investment & Recurrent expenditures <= 20% of total KP-FSW expenditures on row?
Tier-0 - Unable to upload template	56	KP-FSW	6 - Non-negative percentages	Site-level	BJ	IR:JF >= 0	All KP-FSW expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	57	KP-MSMTG	7 - Has ARV Expenditures	Site-level	BK	JN = 0	Recurrent ARV expenditures for KP-MSMTG on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	58	KP-MSMTG	3 - Other Expenditures <=20%	Site-level	BL	$[(JL+JV)/(JH:JV)] \leq 0.2$	KP-MSMTG Other Investment & Recurrent expenditures <= 20% of total KP-MSMTG expenditures on row?
Tier-0 - Unable to upload template	59	KP-MSMTG	6 - Non-negative percentages	Site-level	BM	JH:JV >= 0	All KP_MSMTG expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	60	PP-PREV	7 - Has ARV Expenditures	Site-level	BN	KD = 0	Recurrent ARV expenditures for PP-PREV on row?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	61	PP-PREV	3 - Other Expenditures <=20%	Site-level	BO	$[(KB+KL)/(JX:KL)] \leq 0.2$	PP-PREV Other Investment & Recurrent expenditures <= 20% of total PP-PREV expenditures on row?
Tier-0 - Unable to upload template	62	PP-PREV	6 - Non-negative percentages	Site-level	BP	JX:KL >= 0	All PP-PREV expenditures non-negative?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	63	MAT	7 - Has ARV Expenditures	Site-level	BQ	KT = 0	Recurrent ARV expenditures for MAT on row?

Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	64	MAT	3 - Other Expenditures <=20%	Site-level	BR	[KR+LB]/[KN:LB] <= 0.2	MAT Other Investment & Recurrent expenditures <= 20% of total MAT expenditures on row?
Tier-0 - Unable to upload template	65	MAT	6 - Non-negative percentages	Site-level	BS	KN:LB >= 0	All MAT expenditures non-negative?
Tier-0 - Unable to upload template	66	PM	1 - Location / Results identified	Program Management	BY	C:D when H:AD > 0	Location identified on all rows with results?
Tier-0 - Unable to upload template	67	PM	1 - Location / Results identified	Program Management	BZ	H:AD > 0 when C:D	Results identified on all rows with Location?
Tier-1 [Fatal] - Able to upload template, unable to submit	68	PM	5 - Distribution Equals 100%	Program Management	CA	L:AD = 100	Distribution of PM expenditures by Program Area equals 100?
Tier-0 - Unable to upload template	69	PM	6 - Non-negative percentages	Program Management	CB	H:K >= 0	All PM expenditures non-negative?
Tier-0 - Unable to upload template	70	PM	6 - Non-negative percentages	Program Management	CC	L:AD >= 0	All PM percentages non-negative?
Tier-0 - Unable to upload template	71	SI	1 - Location / Results identified	Strategic Information	CG	C:D when H:AB and/or AD:AG > 0	Location identified on all rows with results?
Tier-0 - Unable to upload template	72	SI	1 - Location / Results identified	Strategic Information	CH	H:AB and/or AD:AG > 0 when C:D	Results identified on all rows with Location?
Tier-1 [Fatal] - Able to upload template, unable to submit	73	SI	5 - Distribution Equals 100%	Strategic Information	CI	L:AB = 100	Distribution of SI expenditures by Program Area equals 100?
Tier-0 - Unable to upload template	74	SI	6 - Non-negative percentages	Strategic Information	CJ	H:K >= 0	All SI expenditures non-negative?
Tier-0 - Unable to upload template	75	SI	6 - Non-negative percentages	Strategic Information	CK	AD:AG >= 0	All Surveillance expenditures non-negative?
Tier-0 - Unable to upload template	76	SI	6 - Non-negative percentages	Strategic Information	CL	L:AB >= 0	All SI percentages non-negative?
Tier-0 - Unable to upload template	77	HSS	1 - Location / Results identified	Health System Strengthening	CP	CD when H:AP > 0	Location identified on all rows with results?
Tier-0 - Unable to upload template	78	HSS	1 - Location / Results identified	Health System Strengthening	CQ	H:AP > 0 when C:D	Results identified on all rows with Location?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	79	HSS	9 - HSS C&R ANAT	Health System Strengthening	CR	No Above National in K	Construction & Renovation investment expense not reported for location 'Above National'?
Tier-1 [Fatal] - Able to upload template, unable to submit	80	HSS	5 - Distribution Equals 100%	Health System Strengthening	CS	H:L = N:Y	Distribution of HSS expenditures equals total of HSS expenditures?

Tier-1 [Fatal] - Able to upload template, unable to submit	81	HSS	4 - Disaggregated Expenditures Equal Total	Health System Strengthening	CT	Z:AP = 100	Distribution of HSS expenditures by Program Area equals 100?
Tier-0 - Unable to upload template	82	HSS	6 - Non-negative percentages	Health System Strengthening	CU	H:Y >= 0	All HSS expenditures non-negative?
Tier-0 - Unable to upload template	83	HSS	6 - Non-negative percentages	Health System Strengthening	CV	Z:AP >= 0	All HSS percentages non-negative?
Tier-0 - Unable to upload template	84	All	2 - Comments < 5,000	Expenditures - Comments	CZ	Program Area Comment <= 5000 characters	Comments <= 5,000 characters on Program Information - Comments tab per Program Area?
Tier-2 [Non-fatal] - Able to upload template and submit, requires post-processing	85	All	8 - Expenditures < \$10M	All	DB	Total expenditures less than USD \$10M?	Total expenditures less than USD \$10M?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	86	BS	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for BS and also has BS expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	87	CBCTS	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for CBCTS and also has CBCTS expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	88	FBCTS	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for FBCTS and also has FBCTS expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	89	GP-PREV	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for GP-PREV and also has GP-PREV expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	90	HTC	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for HTC and also has HTC expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	91	IC	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for IC and also has IC expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	92	KP-FSW	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for KP-FSW and also has KP-FSW expenditures?
Tier-3 [Non-fatal] - Able to upload and submit,	93	KP-MSMTG	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for KP-MSMTG and also has KP-MSMTG expenditures?

requires post-processing and indicator data							
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	94	KP-PWID	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for KP-PWID and also has KP-PWID expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	95	LAB	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for LAB and also has LAB expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	96	MAT	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for MAT and also has MAT expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	97	OVC	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for OVC and also has OVC expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	98	PP-PREV	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for PP-PREV and also has PP-PREV expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	99	PEP	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for PEP and also has PEP expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	100	PMTCT	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for PMTCT and also allocated PMTCT effort?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	101	PMTCT	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for PMTCT and also has PMTCT expenditures?
Tier-3 [Non-fatal] - Able to upload and submit, requires post-processing and indicator data	102	VMMC	11 - Indicators and Expenditures	Not in template	Not in template	Not in template	Reported indicators for VMMC and also has VMMC expenditures?