PEPFAR Expenditure Analysis (EA) Initiative

Overview for PEPFAR Implementing Partners

PEPFAR Finance & Economics Work Group (FEWG)

Outline

- Introduction to EA
- EA Methods– The Basics
- EA Methods – Categorizing and Allocating Expenditures
- What's New for 2015
- EA Results & Analysis
- Data Use

Outline

- **Introduction to EA**
- EA Methods– The Basics
- EA Methods – Categorizing and Allocating Expenditures
- What's New for 2015
- EA Results & Analysis
- Data Use

What is Expenditure Analysis?

- **Routine financial monitoring of PEPFAR portfolio**
- **PEPFAR Implementing Partners provide annual data on expenditures by four elements: program area, cost category, point-of-service, and geography**
- **When available and applicable, expenditure data linked to routinely collected PEPFAR indicator data, allowing for a PEPFAR expenditure per output, or unit expenditure**

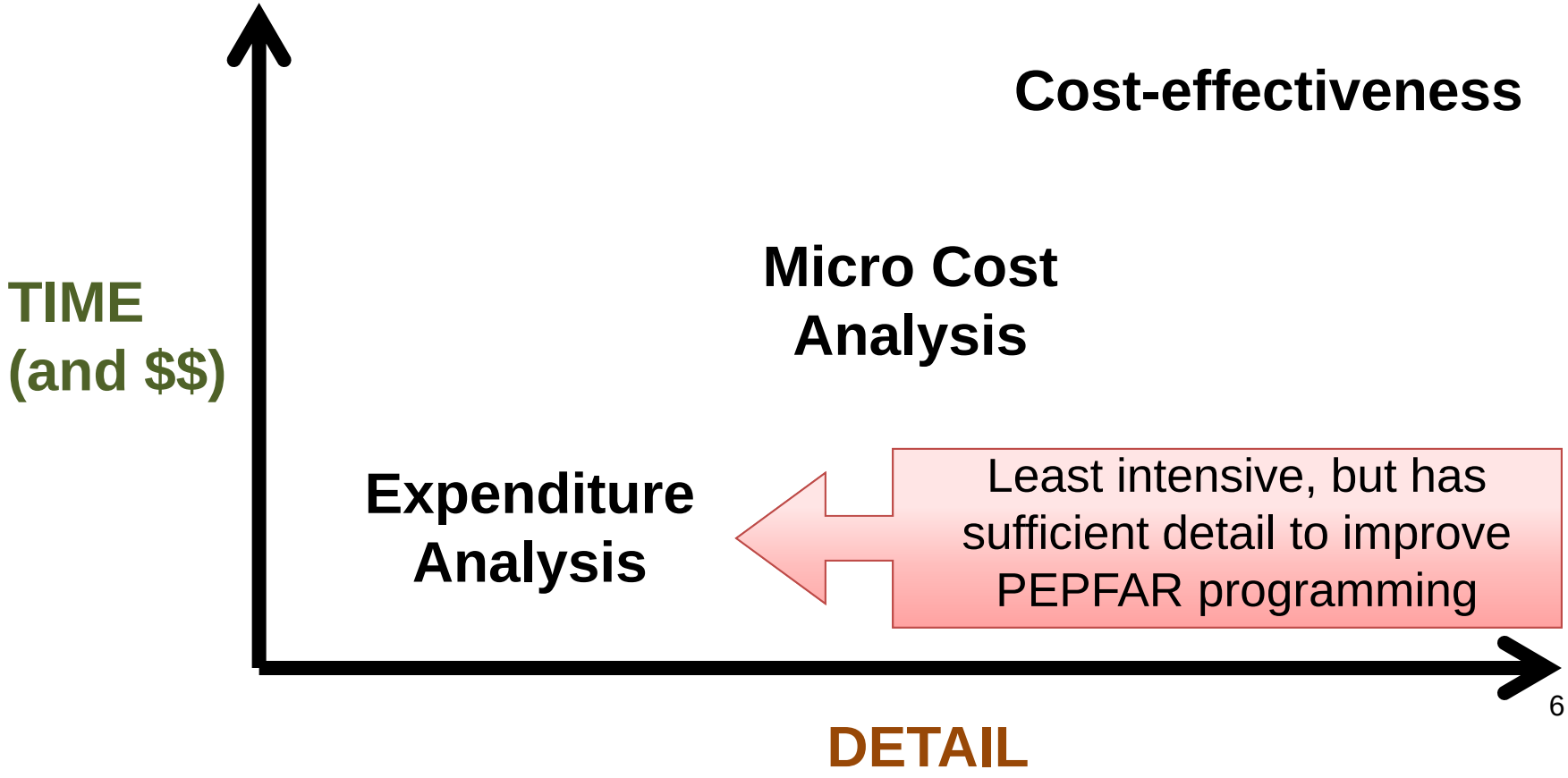
Purpose of Expenditure Analysis

- **To better understand the expenses USG incurs to provide a range of HIV services**
- **To improve accountability and oversight of PEPFAR efforts by tracking spending and accomplishments over time**
- **To improve transparency, collaboration, and strategic planning with other stakeholders**
- **To estimate the resources needed to support programs in future**

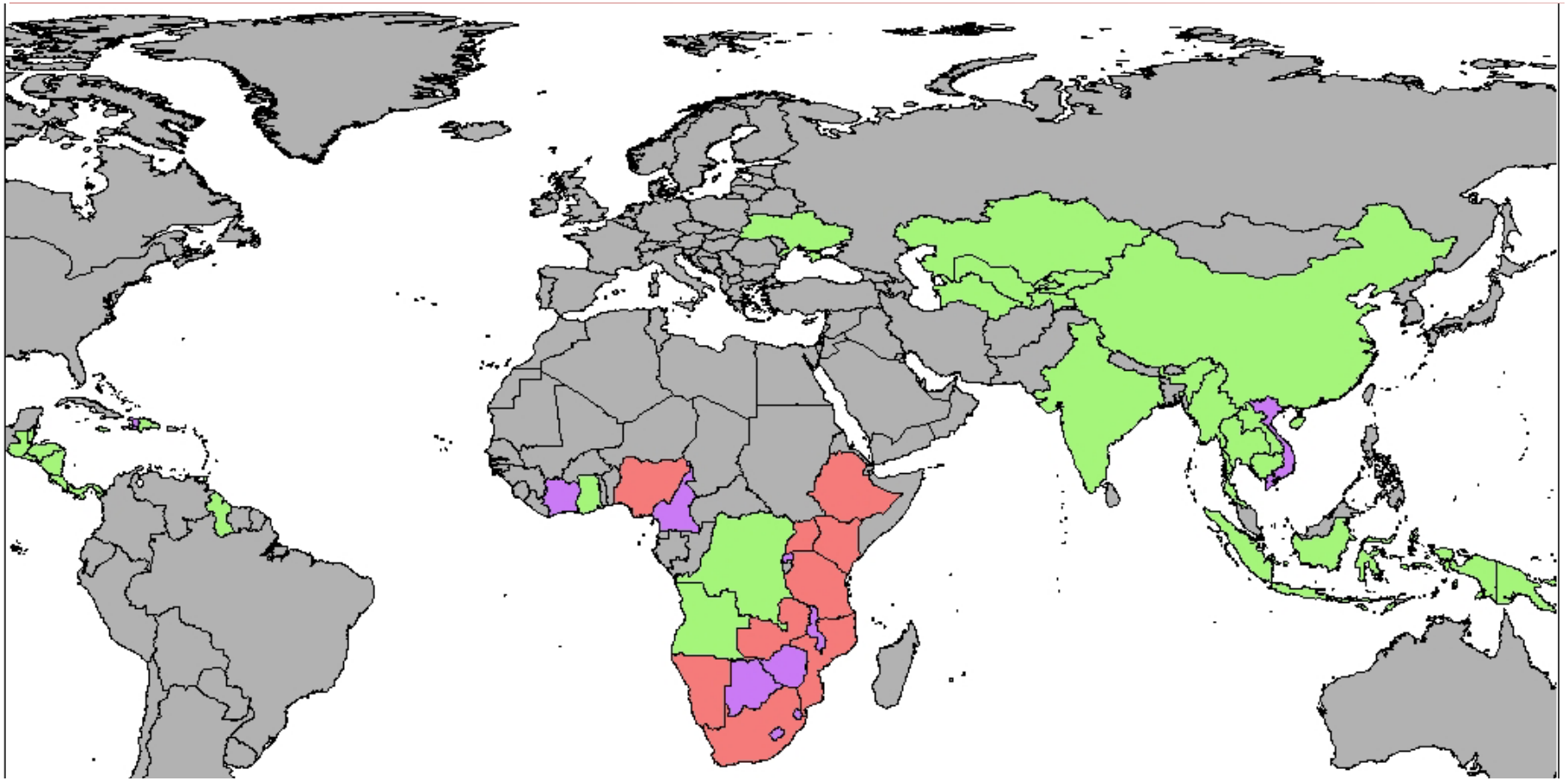
Why choose the EA methodology?

- **Cost-effectiveness Analysis**
- **Micro Cost Analysis**
- **Expenditure Analysis**

Other cost and financial studies are not replaced by EA, and still required to answer other program questions.



Extensive Piloting and Phased Institutionalization

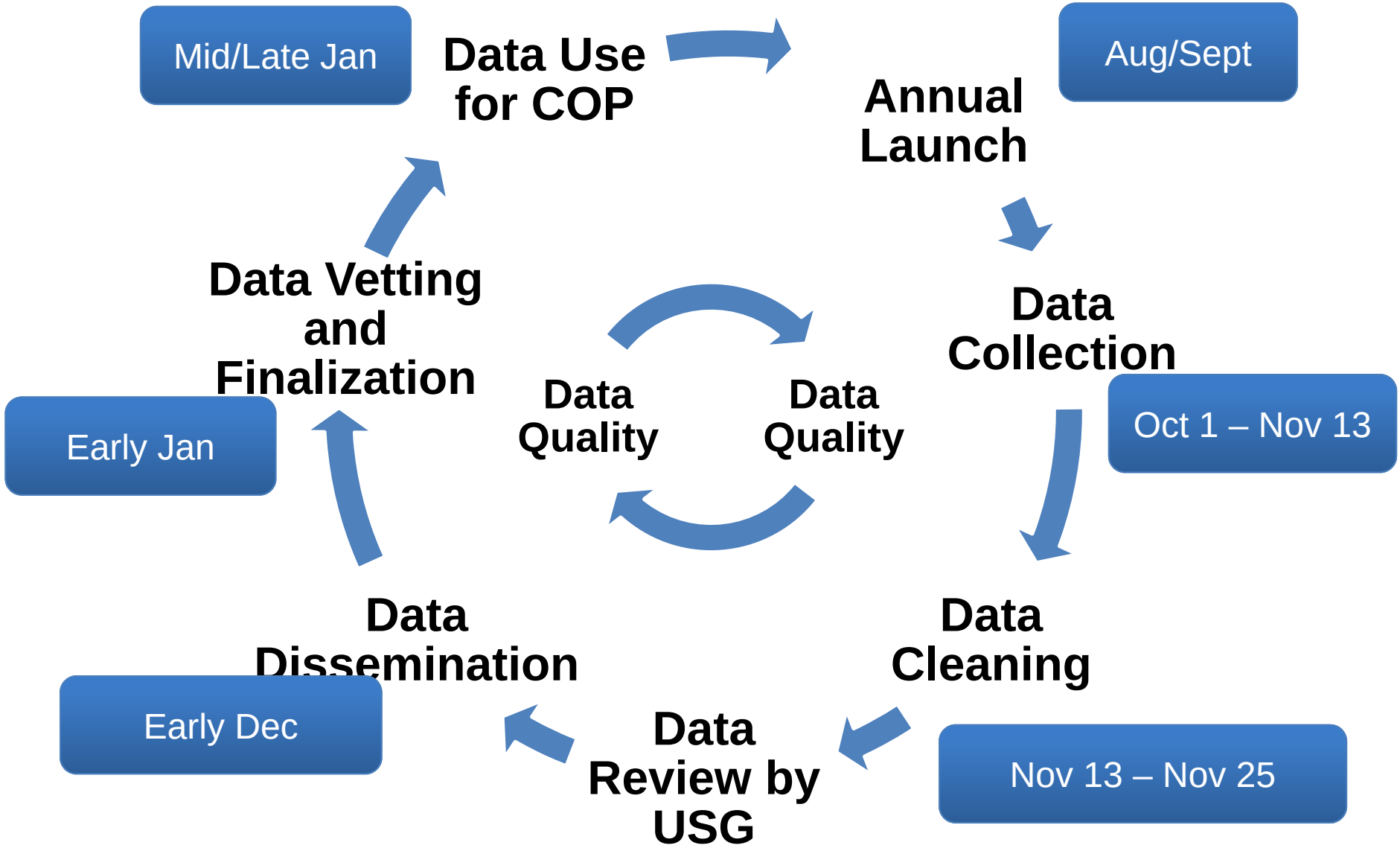


Phase 1: 9 OUs ~75% of PEPFAR Budget

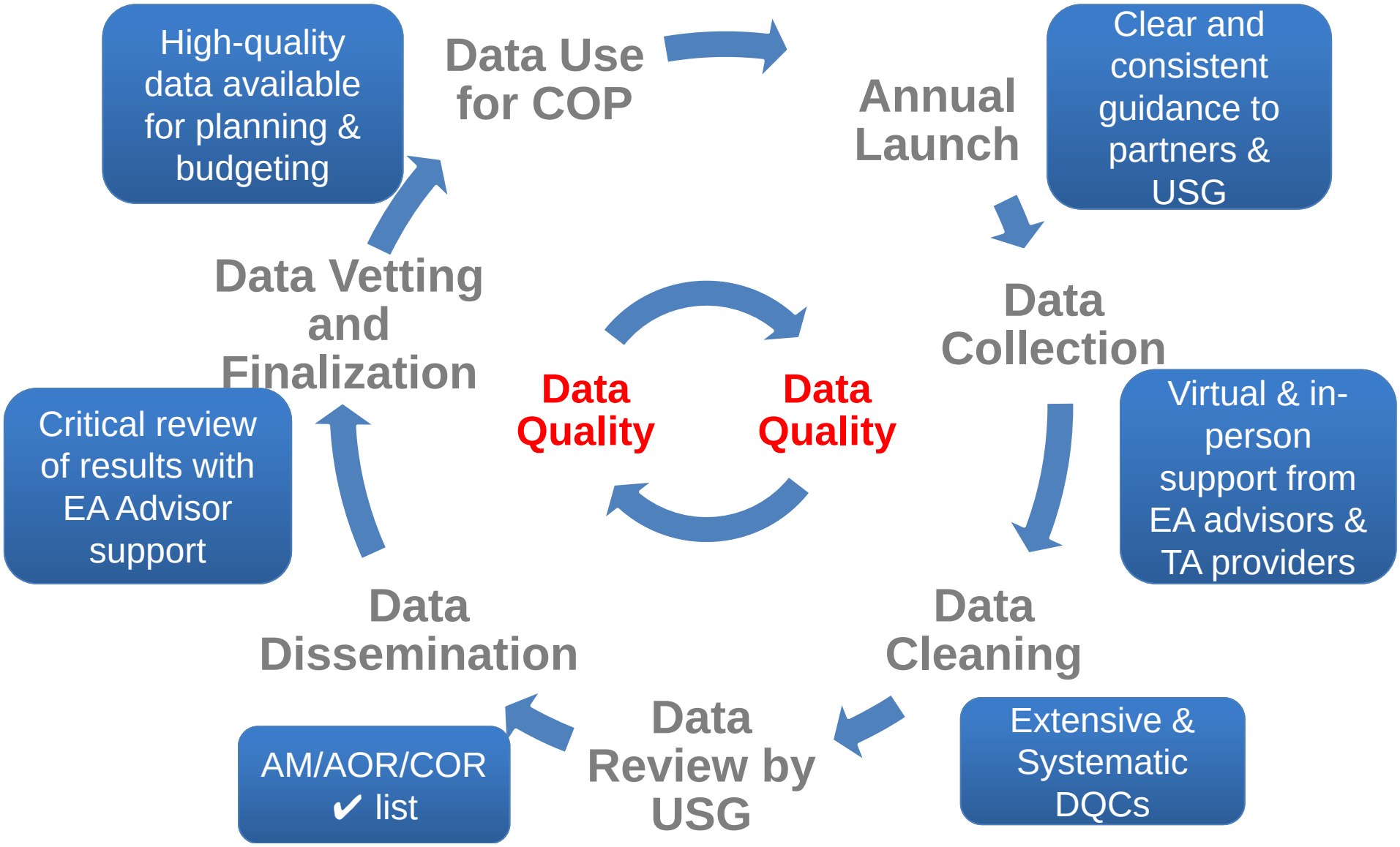
Phase 2: 19 OUs ~95% of PEPFAR Budget

Phase 3: 36 OUs 100% of PEPFAR Budget

The 2015 EA Process & Timeline



Ensuring Data Quality



Roles and Responsibilities

Implementing Partners

- Complete EA template and upload to PROMIS website by Nov 13, 2015
- Work with EA HQ team and AM/AOR/COR to correct any data quality issues by Nov 25, 2015
- Review previous years data alongside AM/AOR/COR

Roles and Responsibilities

EA Points-of-Contact

- Serve as primary liaison between the EA advisor and the country team
- Communicate EA updates and deadlines to IPs and USG team

USG AM/AOR/CORs

- Engage with partners throughout data collection process to ensure reporting
- Review their IP's data per a short checklist to ensure high quality data by Nov 25
- Review past year's data with partner

USG Technical Teams

- Critically review program area specific results immediately for data quality issues
- Use data for country operational planning and budgeting

Roles & Responsibilities

EA Advisors

- Manage data collection activities and data cleaning process
- Provide high-level technical assistance to IPs and USG during data collection/cleaning as needed
- Provide support to USG teams on use of EA data during COP

TA Providers

- Deliver in-person and/or technical assistance to partners on a day-to-day basis
- Ensure that data are accurate and complete prior to the submission
- Monitor PROMIS access, reporting status, and USG approval
- Assist USG to review and IPs address data quality concerns

Systems & Deadlines

- Data is entered by partners into an Excel template and then uploaded to the PROMIS website for submission
- Data collection will be run from Thursday, Oct 1 - Friday, November 13
- All EA guidance documents are available on the PROMIS website

www.promisea.pepfarpromis.net

PROMIS

- New users will need to register for PROMIS at www.promisea.pepfarpromis.net
- Users with a PROMIS account will not need to re-register, but WILL need to re-request access to mechanisms
- PROMIS website will be available and monitored beginning on October 1st
- PROMIS users guide available and to be distributed

Outline

- Introduction to EA
- **EA Methods– The Basics**
- EA Methods – Categorizing and Allocating Expenditures
- What's New for 2015
- EA Results & Analysis
- Data Use

Methodological Details

EA data should be submitted by each COP-funded mechanism in a country

Partners with multiple mechanisms, for example, would submit separate EA templates (and data is analyzed by mechanism)

Prime partners are responsible for compiling, categorizing, and submitting all relevant expenditure data

This includes expenditures incurred by their sub-grantees

Methodological Details

EA captures expenditures in a given fiscal year

For example, EA 2015 data includes all expenditures for a mechanism between Oct 1, 2014 through Sept 30, 2015

EA is not tied to COP cycles

EA is not concerned with WHEN or HOW funding was programmed. If spent within the FY, it doesn't matter what COP it came from or whether it was new or pipeline funding

Methodological Details

EA is not tied to PEPFAR budget codes

- EA program areas differ from PEPFAR budget codes used to fund country programs through the COP/ROP process
- Budget codes are *fungible* – and expenditures in EA should be recorded as they were actually spent

Methodological Details

Expenditures are reported in USD

Using standard exchange rates in the EA manual if tracked in local currency

EA captures PEPFAR expenditures only

Partners may receive funding from multiple sources, but 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.

Methodological Details

Included in EA

- **PEPFAR COP/ROP funding**
- **NEW for 2015! Special initiative funding**
- **This will include:**
  - **Central mechanisms "bought into" via COP/ROP)**
  - **PEPFAR dollars spent outside of country (int'l HQ costs, consultants, technical assistance, etc.)**
  - **NICRA**

Excluded in EA

- **HOP funding**
- **Agency M&O**
- **USAID Health, or other non-PEPFAR USG funds**
- **Global Fund, Host National Gov't funding, In-kind contributions**

Methodological Details

Expenditures are reported where they are consumed

- Regardless of where a transaction occurs, an expense should be reported where the resource is consumed*
- *Example*: In Zambia, a vehicle is purchased in FY15 by an implementing partner by their managing office in Lusaka Province. The vehicle will be used by a clinic located in Eastern Province. Where should the expense be categorized?

A.) Lusaka Province

B.) Eastern Province

C.) National Level

* Exception is expenditures related to training

Methodological Details

EA uses a cash basis of accounting

- EA recognizes “financial expenditures” as cash disbursements from the perspective of the prime contractor or awardee during the last fiscal year

- It doesn’t matter *when* the funding was programmed. EA “counts” any eligible dollar spent in that FY (for FY15, between Oct 1, 2014 – Sept. 30, 2015)

Methodological Details

EA uses a cash basis of accounting

- Financial expenditure for this analysis would include:
  - Cash paid for an asset regardless of the asset's useful life
  - Prepayment for rent, supplies, or utilities

- Financial expenditure for this analysis would not include:
  - 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

Methodological Details

EA is NOT an audit

- Validating FY 2015 budgets with EA data is not an objective of this activity.
- 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.
- Completion of the EA data collection template may involve estimation of how funds were spent for which explicit documentation is not available

Methodological Details

Partners should report expenditures in all program areas and/or SNUs where they report indicators,
but can also report expenditures in program areas and/or SNUs in which they DO NOT report indicators

Methodological Details

EA categories are comprehensive and mutually exclusive

- Each eligible dollar spent within a fiscal year should be captured, and
- Each eligible dollar can only be captured in a unique way so that there is no “double counting”

Expenditures captured in EA are categorized in a specific way

- As described in following section

Outline

- Introduction to EA
- EA Methods– The Basics
- **EA Methods – Categorizing and Allocating Expenditures**
- What's New for 2015
- EA Results & Unit Expenditures
- Use of EA Data and Tools for COP

Categorizing Expenditures in EA

Expenditures in EA are first categorized as either:

Site Level

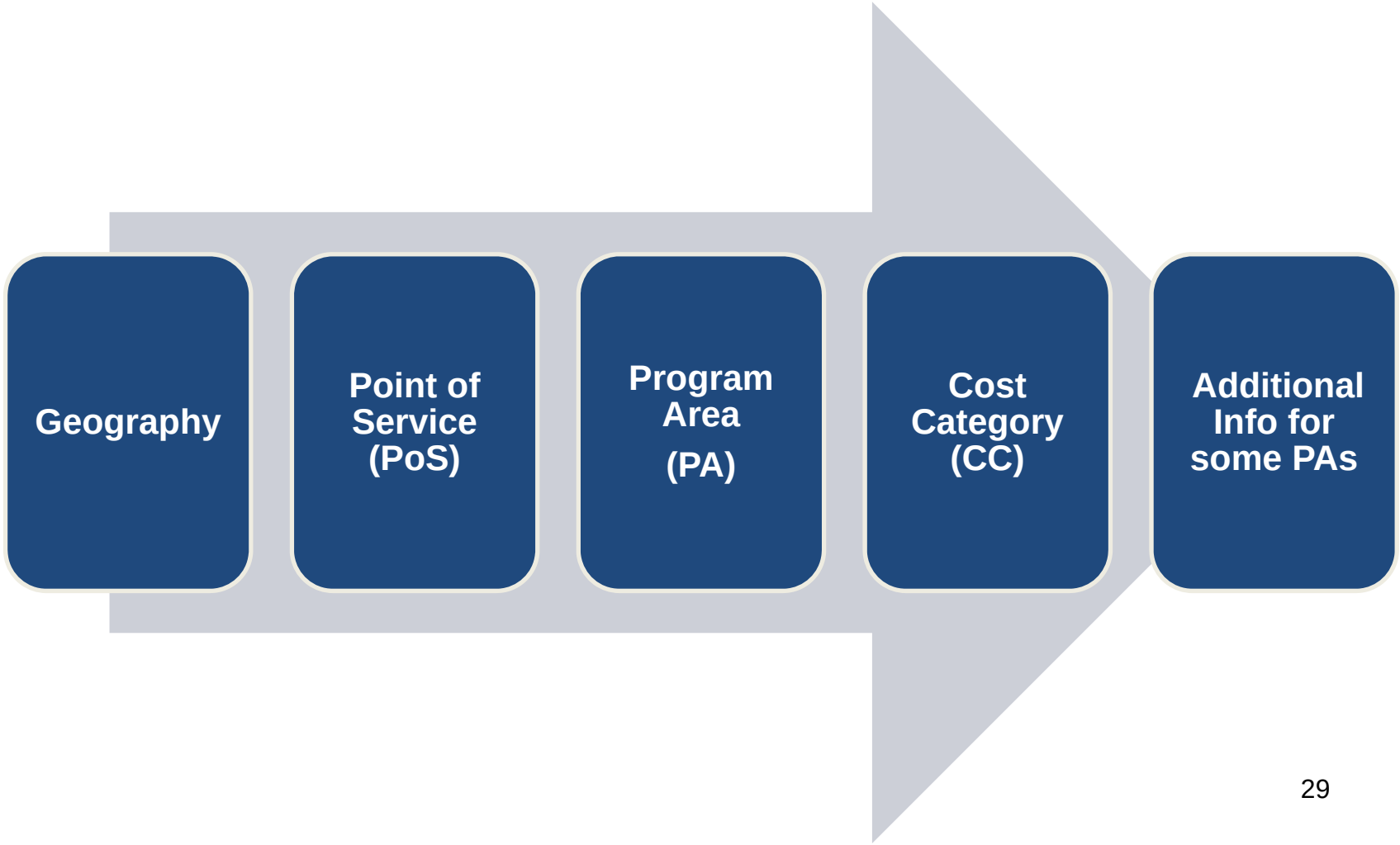
- Occur at point of service delivery or site-level and are categorized by implementation of treatment, care, and prevention activities in specific facilities or communities

Above Site-Level

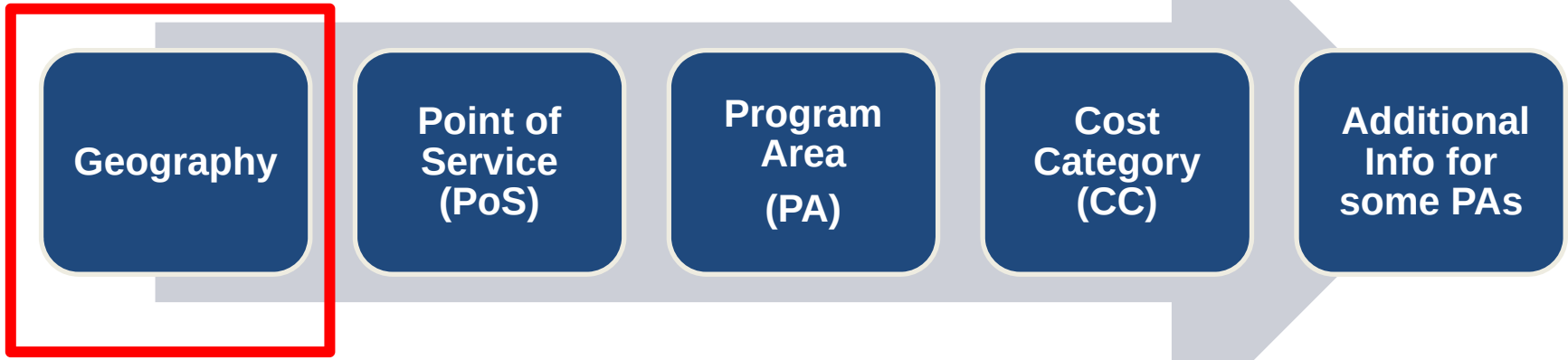
- Support the broader program or the health system including program management, strategic information and health systems strengthening

Site-Level Expenditures

Site-Level Expenditures are categorized by:

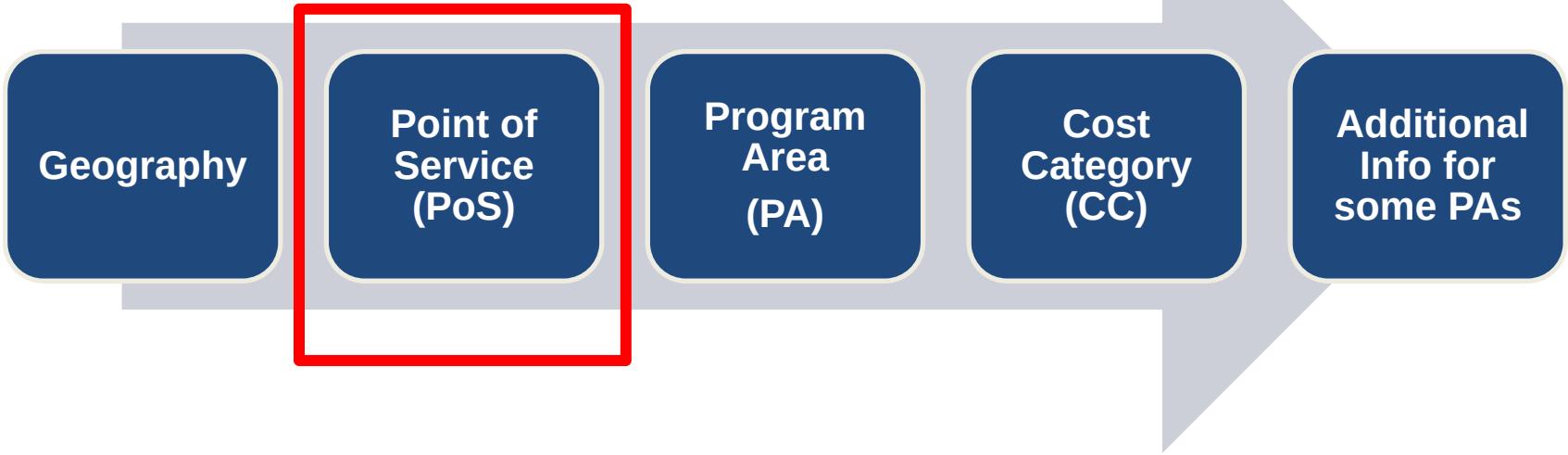


Categorizing Site Level Expenditures



- Site-level expenditures must be tied to a **sub-national geographic unit** (SNU) (e.g. province, state, district)
- In 2015, Caribbean will report at the District Level
- Site-level expenditures cannot be tied to the national or above-national level

Categorizing Site Level Expenditures



- IMs should determine which PoS types are applicable for each sub-national unit in which they work

- EA asks to classify by SNU and then by PoS, **but we do not require partners to report by site**

Point-of-Service Categories

- Government hospital
- Private, not-for-profit hospital
- Private, for-profit hospital
- Outside of health facility
- Government outpatient facility
- Private, not-for-profit outpatient facility
- Private, for-profit outpatient facility
- Government laboratory
- Private, not-for-profit laboratory
- Private, for-profit laboratory

Point-of-Service – Hospitals

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.

Point-of-Service – Outpatient Sites

Point-of-Service Type	Description
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**.

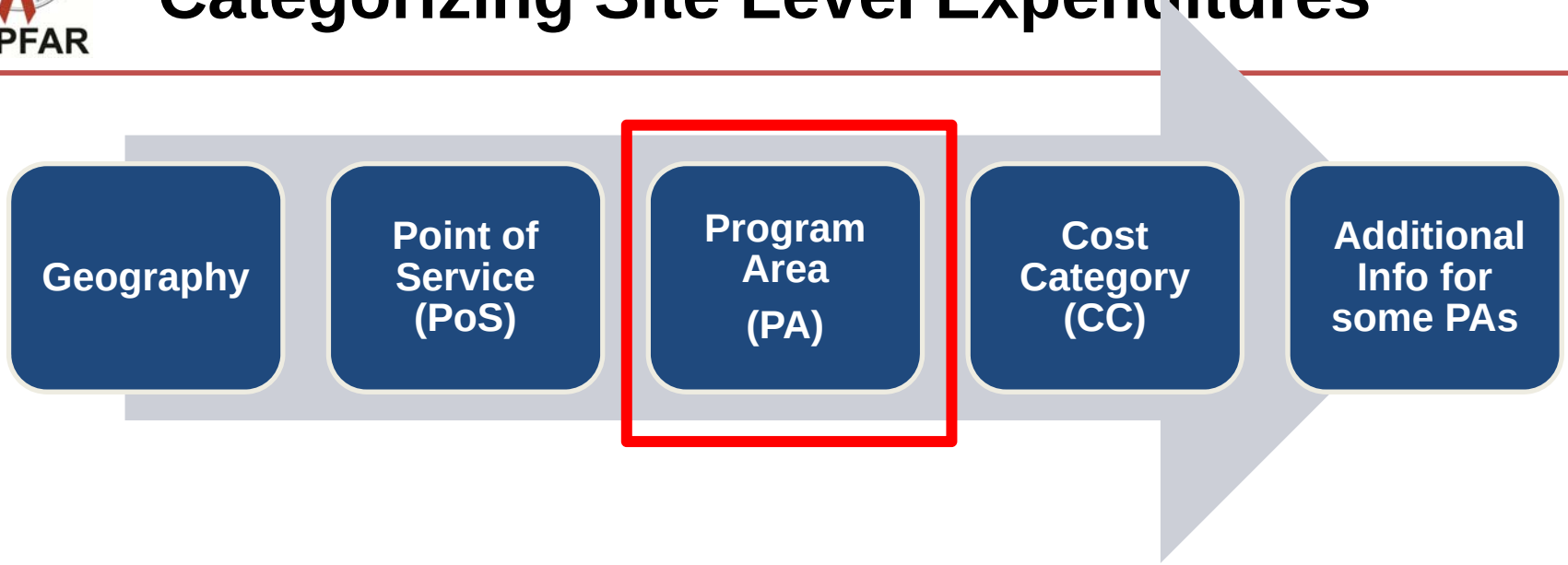
Point-of-Service – Laboratory

Point-of-Service Type	Description
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).

Point-of-Service – Outside Health Facility

Point-of-Service Type	Description
Outside 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.

Categorizing Site Level Expenditures



- Site level expenditures must be tied to one of 16 program areas which have defined inclusion and exclusion criteria

- **REMINDER:** definitions for EA program areas differ from the PEPFAR budget codes used to program funds through the COP/ROP process

Program Areas

- Facility-based care, treatment, and support (FBCTS)
- Community-based care, treatment, and support (CBCTS)
- Prevention of mother-to-child transmission (PMTCT)
- HIV testing and counseling (HTC)
- Voluntary medical male circumcision (VMMC)
- Post-exposure prophylaxis (PEP)
- Blood Safety (BS)
- Infection control (IC)
- Laboratory (LAB)
- Orphans and vulnerable children (OVC)
- General population prevention (GP-PREV)
- Key population prevention – persons who inject drugs (KP-PWID)
- Key population prevention – female sex workers (KP – FSW)
- Key population prevention – men who have sex with men and transgender (KP-MSMTG)
- Priority Population Prevention (PP-PREV)
- Medication Assisted Therapy (MAT)

Key EA Program Areas

Facility Based Care, Treatment, and Support (FBCTS)

- Clinical care, support, and antiretroviral therapy (ART) provided in a health facility.
- 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
- Nutrition support, psychological and other supportive interventions and quality improvement measures that occur within a health facility.
- Linkage and retention activities that occur within a health facility.

Key EA Program Areas

Community-Based Care, Treatment, and Support (CBCTS)

- Care, support, and ART provided in a community setting, outside of a traditional health facility.
- 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
- Linkage and retention activities and quality improvement measures that occur within a community or home-based setting.

Key EA Program Areas

Preventing 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.

Notes on Option B+:

•Classifying expenditures reported for supporting Option B+ will depend on your country-specific implementation

•$ 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.

•Lifelong treatment beyond their being considered an Option B+ beneficiary, those expenditures should be classified as FBCTS.

Key EA Program Areas

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.

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.

Key EA Program Areas

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.

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.

Key EA Program Areas

Laboratory (LAB)

Provisions of diagnostic services related to HIV clinical interventions (e.g., CD4 counts and tuberculosis testing), early infant diagnosis, quality improvement/quality assurance, and site-level system development support efforts to 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.

Key EA Program Areas

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 EA Program Areas

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.

Key EA Program Areas

Priority Population Prevention (PP-PREV)

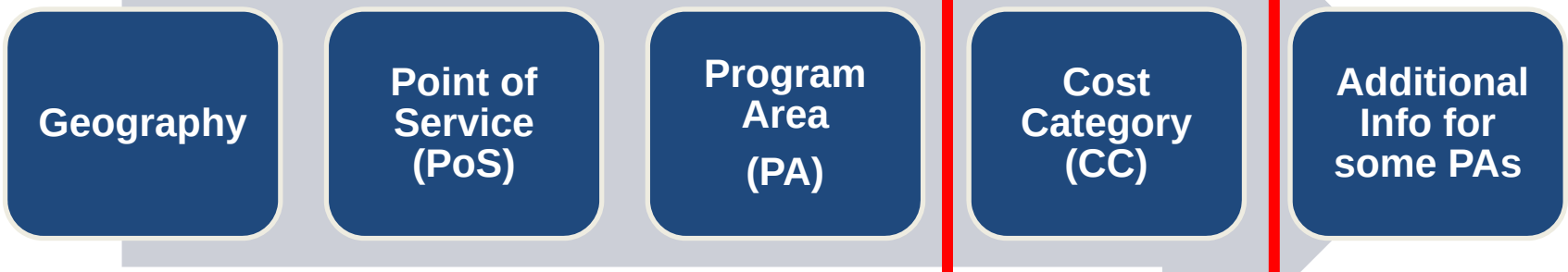
Behavioral prevention and structural prevention interventions targeted to other vulnerable populations which are not PWID, FSW, or MSMTG specifically.

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 KP-PWID program area.

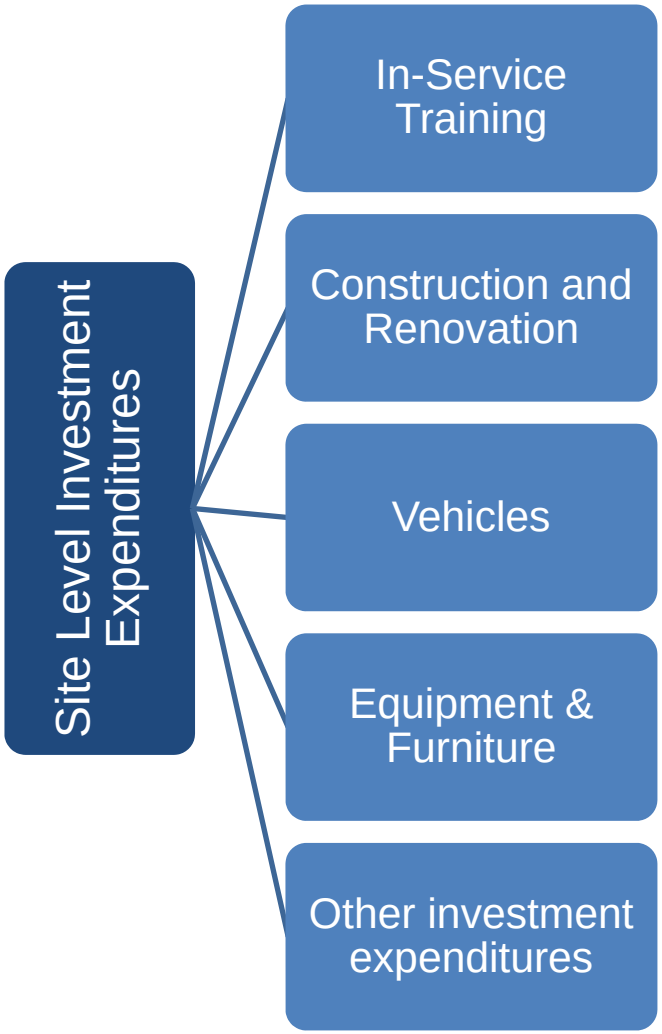
Categorizing Site Level Expenditures



Site-level cost categories are broadly grouped as either, with subcategories within each

Investment	OR	Recurrent
• Site-level program expenditures, both human and capital, that have a useful life of more than one year		• Site-level program expenditures that are consumed as part of normal, routine program operations

Investment Expenditures



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 *at the site level*.

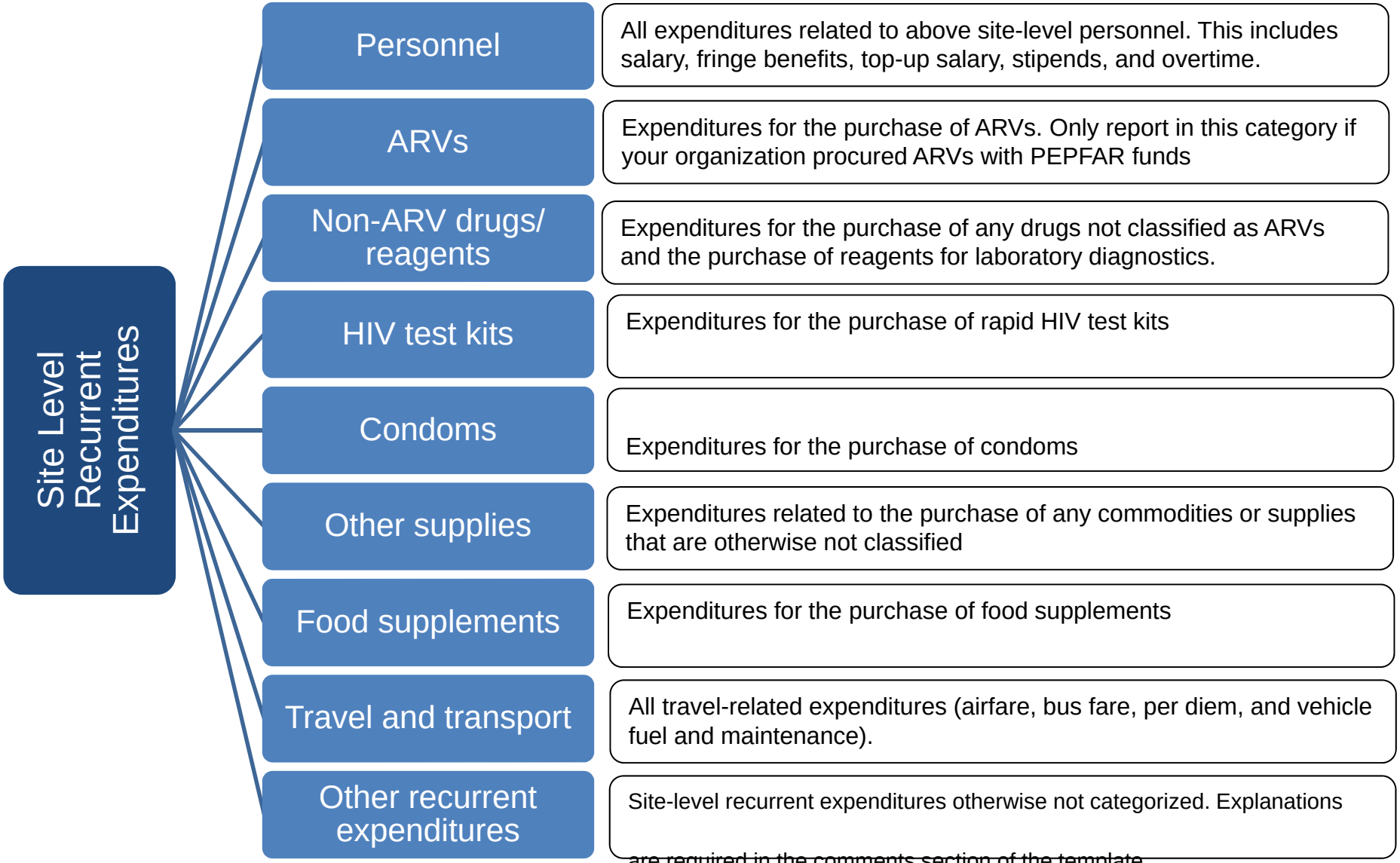
Site-level expenditures for construction and renovation of health facilities or program offices. Construction and renovation that benefits multiple program areas will need to be allocated across the different program area

Expenditures for the purchase of vehicles only.
Fuel and maintenance expenditures should be recorded as recurrent expenditures under travel/transport

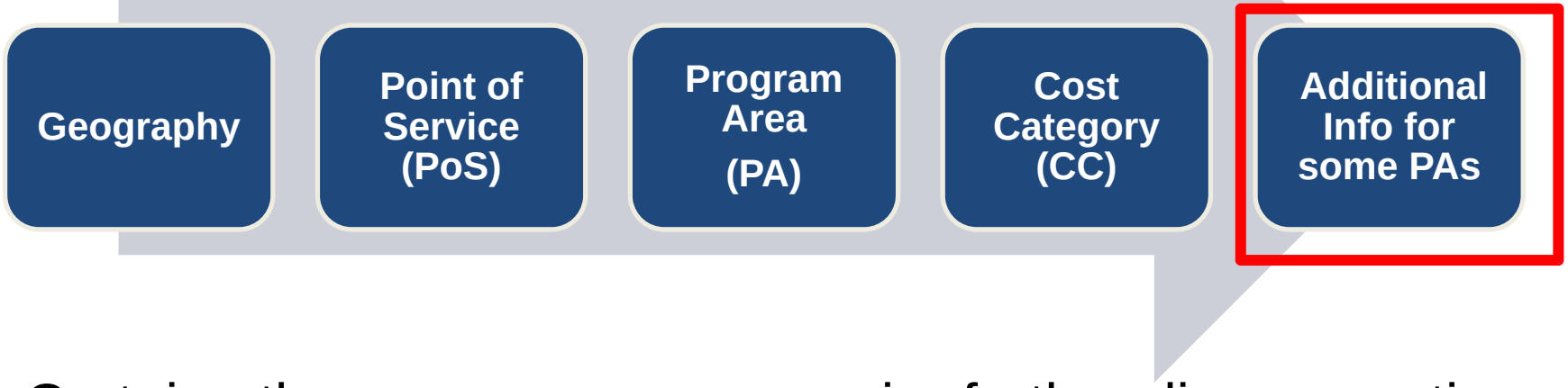
Site-level expenditures for the purchase of clinical and office equipment and furniture, including computers. Office supplies that are purchased and used up within a year should be recorded as recurrent expenditures

Site-level investment expenditures otherwise not categorized.
Explanations are required in the comments section of the template.

Recurrent Expenditures



Categorizing Site Level Expenditures



- Certain other program areas require further disaggregation of expenditure or program effort to assist with calculating total or unit expenditures by program area.
  - CBCTS
  - PMTCT
  - HTC
  - Lab
  - OVC

Additional Program Information - FBCTS

- Information on programmatic service delivery for beneficiary populations receiving facility-based care, treatment and support services required if and only if a partner reports the clinical care and treatment indicators in S/APR, they are required to fill this sheet out

- Used to allocate expenditures between care and treatment patient types.

- **NEW for 2015!**
  Enter this information on site-level expenditure tab (rather than separate Program Info tab)

Site vs. Above-Site Level

Expenditures in EA are first categorized as either:

Site Level

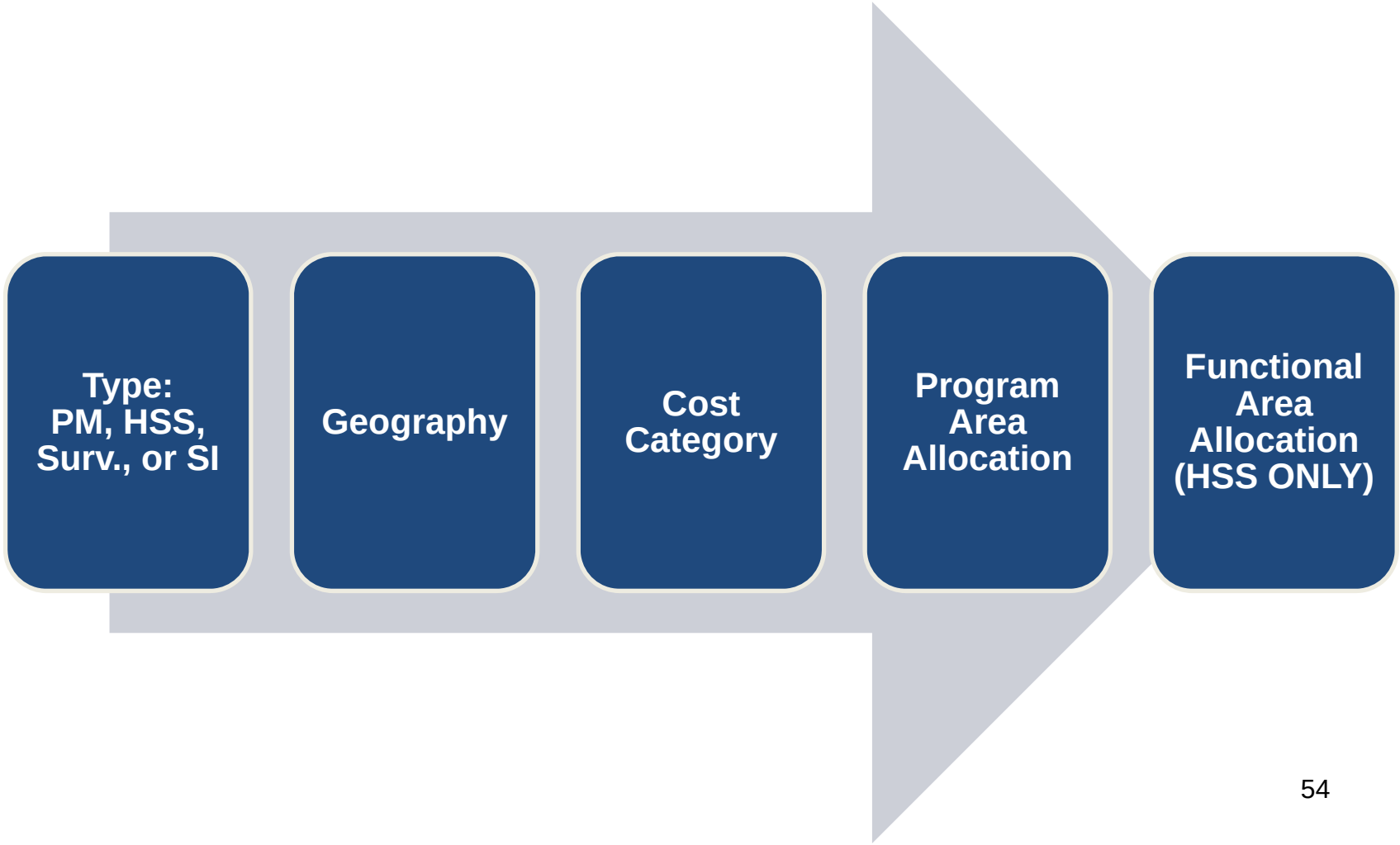
- Occur at point of service delivery or site-level and are categorized by implementation of treatment, care, and prevention activities in specific facilities or communities

Above Site-Level

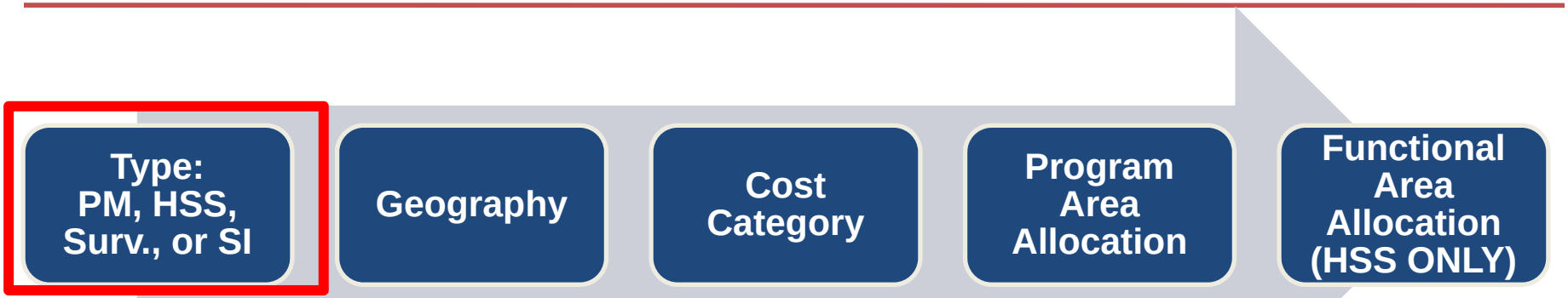
- Support the broader program or the health system including program management, strategic information, surveillance, and health systems strengthening

Above Site-Level Expenditures

Above Site-Level Expenditures are categorized by:

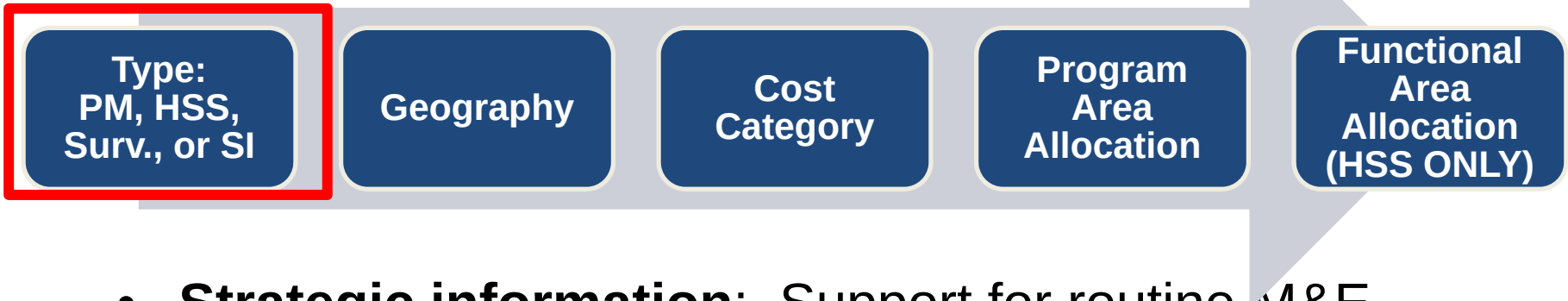


Classifying Above Site-Level Expenditures



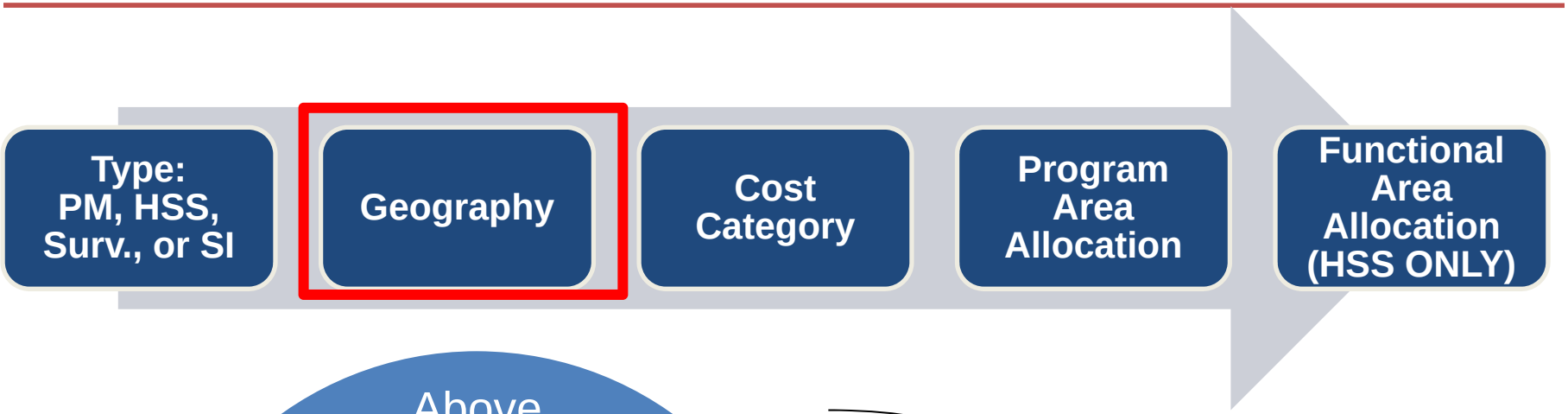
- **Program Management**: Administration support including grant management, human resources management, internal accounting and finance, host country support staff and offices, and indirect recovery rates
- **Health System Strengthening**: Technical assistance and capacity building support to the individuals, organizations, and processes in the host-national government's health system

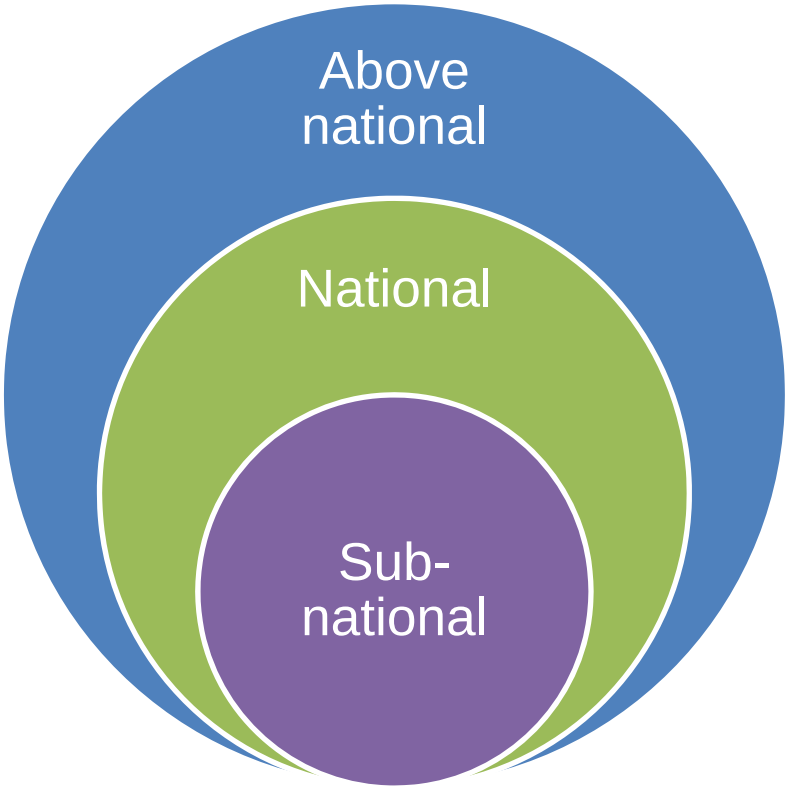
Strategic Information (SI) & Surveillance



- **Strategic information**: Support for routine M&E, operations research and other biomedical, clinical, epidemiological, social research related to HIV
- **Surveillance**: Specific HIV drug resistance or serologic studies (i.e. epidemiological or disease specific surveillance, incidence studies, disease-specific surveys, etc.)

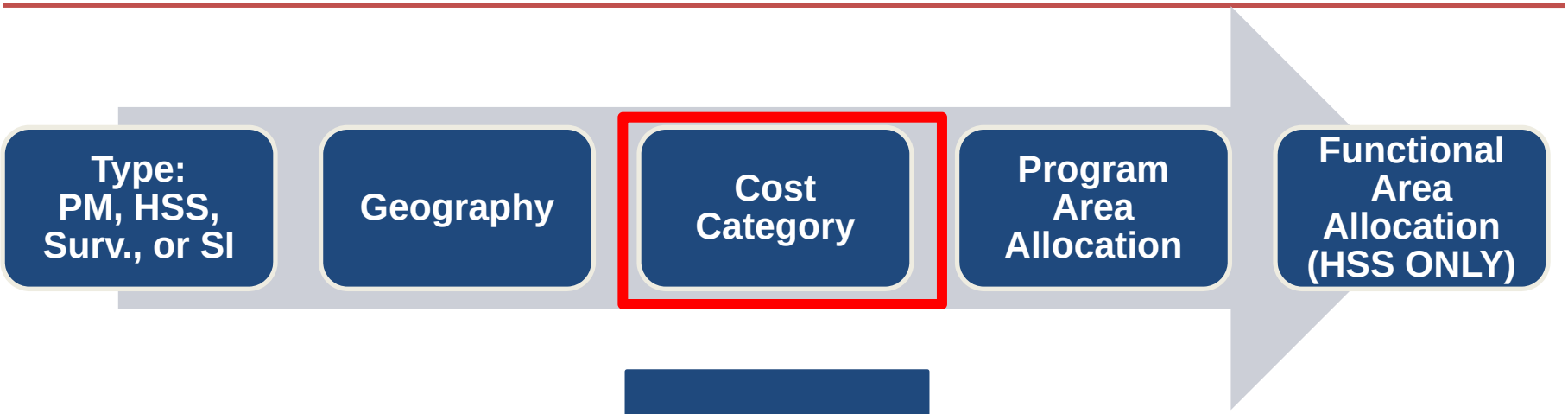
Classifying Above Site-Level Expenditures

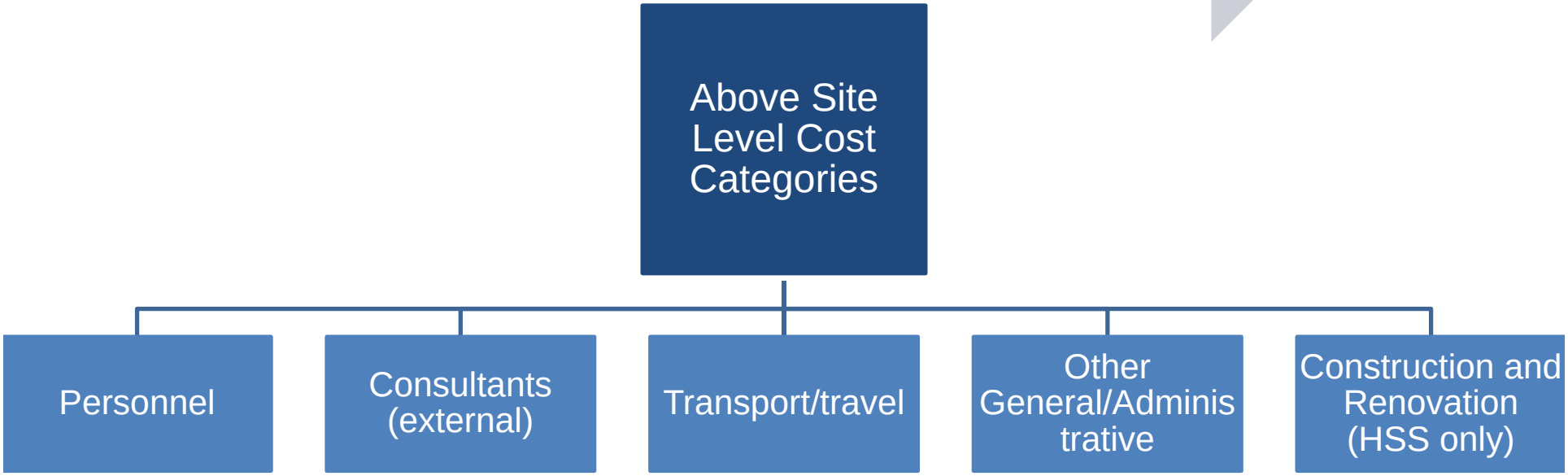




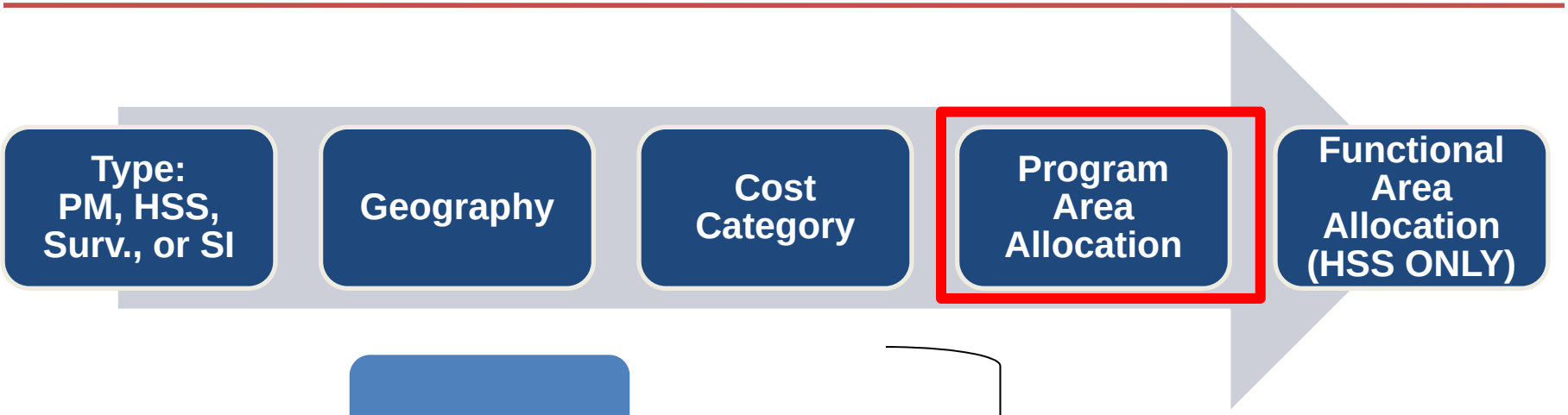
Above site-level expenditures can be classified as either SNU, national, or above national (i.e. outside of country, international).

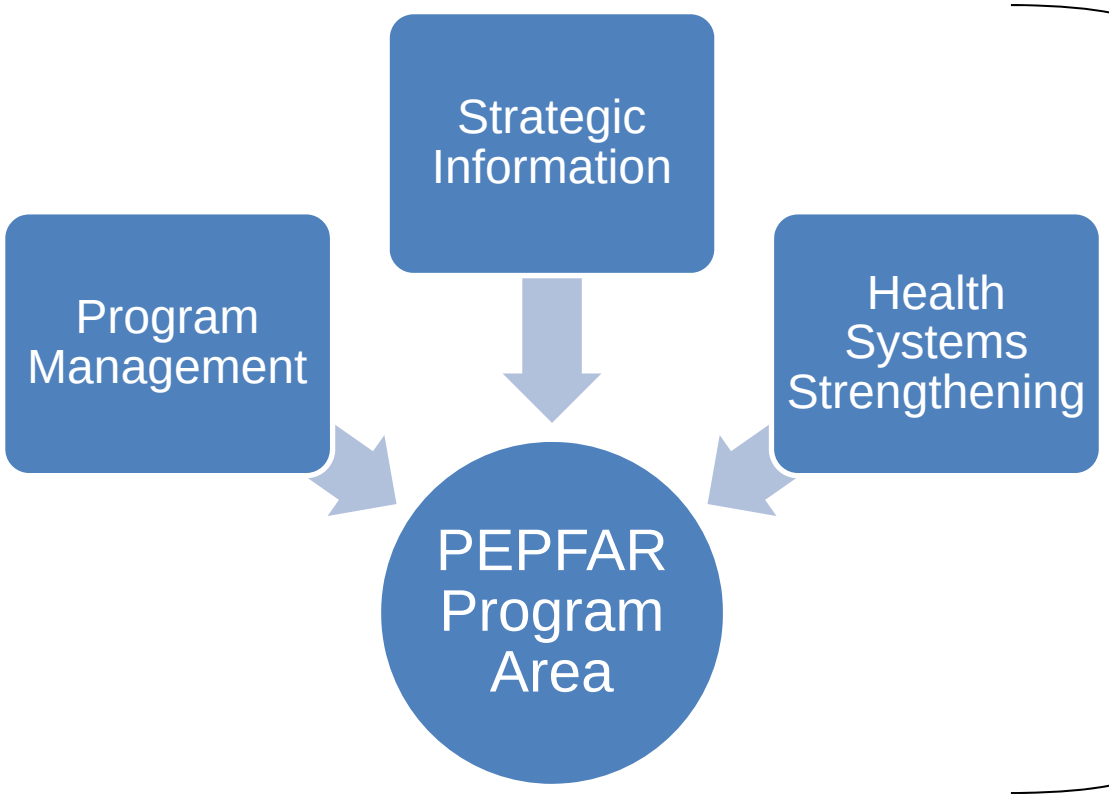
Classifying Above Site-Level Expenditures





Classifying Above Site-Level Expenditures by Program Area

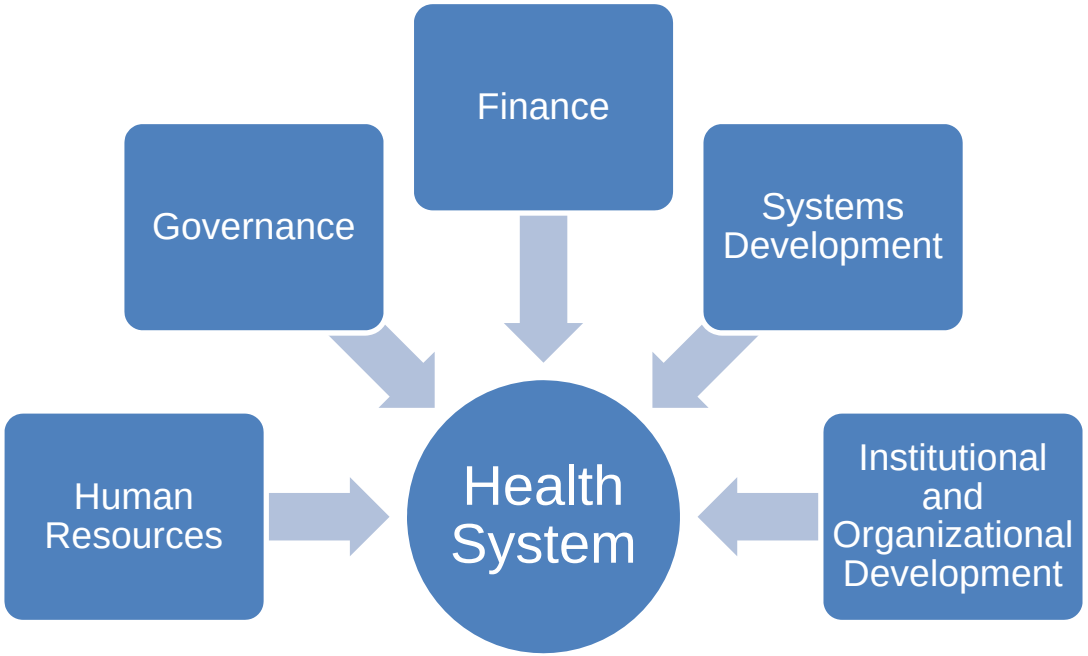




Above site-level expenditures need to be allocated as a percent to the appropriate program area benefiting from the activity.

Classifying Above Site-Level Expenditures

Type: PM, HSS, Surv., or SI → **Geography** → **Cost Category** → **Program Area Allocation** → **Functional Area Allocation (HSS ONLY)**



HSS expenditures by functional area is another way of categorizing the above site-level activity. It tells us the type of systems support PEPFAR is investing in to strengthen the broader health system

Allocating Shared Expenditures

In reality, some common types of expenditures may be **shared** across program areas, points-of-service, and/or geography, functional areas, or between site-level and above site-level

Examples:

- Physician who works to support treatment of people living with HIV and does medical circumcisions to prevent HIV
- A vehicle that is purchased to support sites in 3 different provinces or regions in a country
- Chief of Party spends time supporting program management and supporting policy documents for MOH
- Data manager spends time supporting the entire program as well as individual sites in districts

Allocating Shared Expenditures

Shared expenditures must be allocated to the appropriate level (site vs above-site), program area, point-of-service, & geography in order to accurately estimate expenditures for specific HIV services and target populations

Allocating Shared Expenditures

- Each organization is different and there is no single method for allocation that will accurately define the program for all organizations supplying data.
- Allocation method should be the most accurate and reasonable for that mechanism
- Appropriate methodology will depend on type of expenditure, context of the implemented program, and availability of program data
- Allocation strategies include:
  - Estimate of use
  - Staff level-of-effort
  - Building/facility space
  - Patient volume
  - Other program information or data

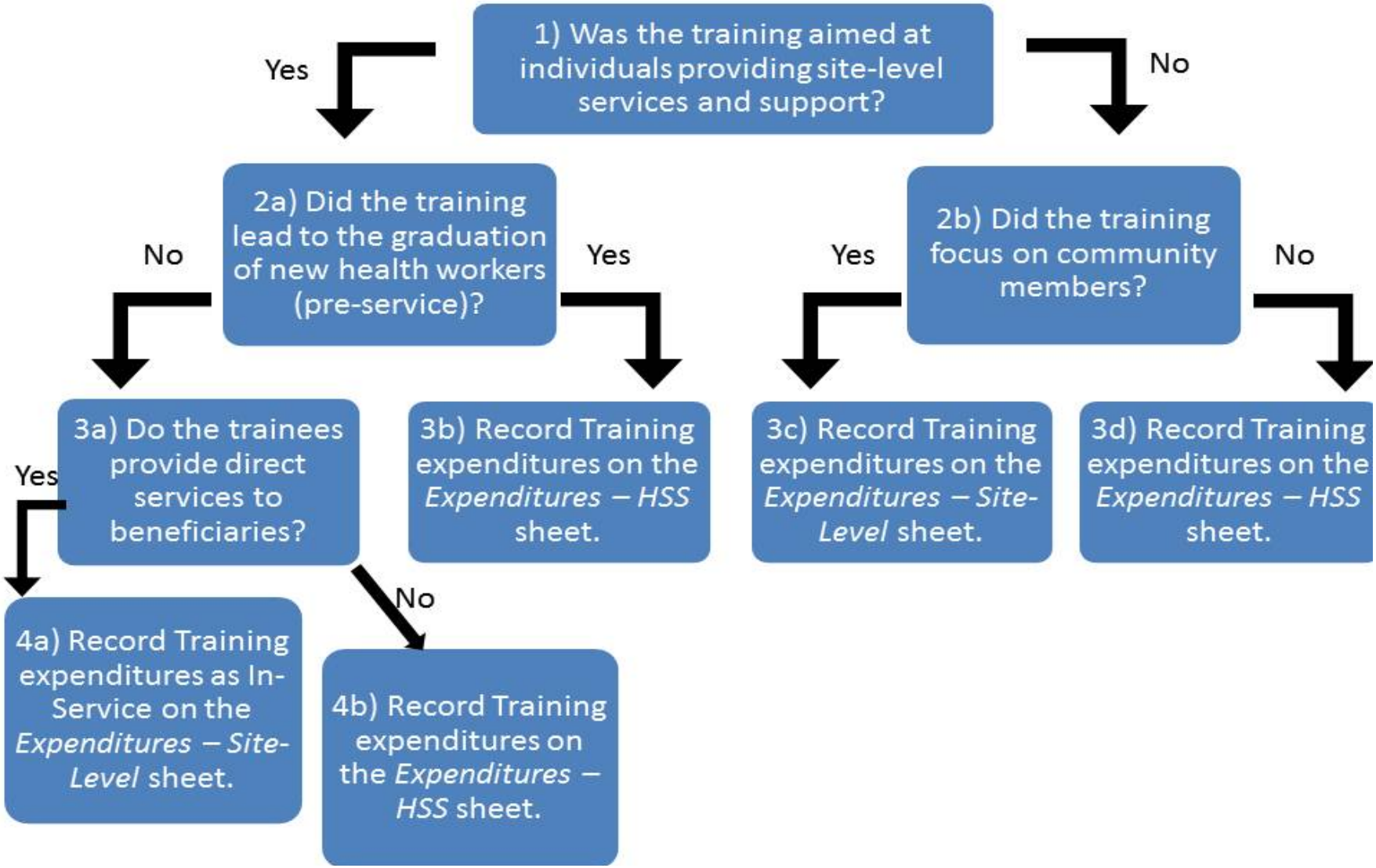
Categorizing and Allocating Training Expenditures in EA

- Training expenditures can be challenging for partners to classify in EA

- While difficult to classify, training comprises a large portion of the overall PEPFAR effort and incorrectly classifying a large training activity by location or program area could skew the EA results

- To accurately capture training, you are highly encouraged to refer to the decision tree in the EA Guidance

Decision Tree for Allocating Training Expenditures



Outline

- Introduction to EA
- EA Methods– The Basics
- EA Methods – Categorizing and Allocating Expenditures
- **What's New for 2015**
- EA Results & Analysis
- Data Use

What's New: Central Initiative Funding

- PEPFAR central funding that directly supports the field through central initiatives, "plus-up funds", or other special initiative funding should be reported
  - Often one-time disbursements and are intended to fill critical programmatic gaps
  - Including but not limited to: Key Populations Challenge Fund, ACT, VMMC Reserves, DREAMS, Gender Challenge Fund, PMTCT Acceleration, etc.
  - HOP funding should not be included in EA 2015
  - More detailed guidance on which funds should be included is forthcoming

What's New: Changes to Categorization

- New OVC sub-categories
  - Health Access & Health Promotion
  - Educational Support and Early Childhood Development (ECD)
  - Economic Strengthening
  - Psychosocial Support
  - Nutrition & Food Security
  - Child Protection
  - Case Management

- New HSS HRH functional area sub-categories
  - Pre-service training
  - In-service training systems support and institutionalization
  - HRH performance support/quality
  - HRH policy, planning and management

What's New: Other Changes

- Renaming of Other Vulnerable Population Prevention (OVP-PREV) to Priority Population Prevention (PP-PREV)

- Removal of disaggregation under General Population Prevention (GP-PREV)

- Program Information for Facility-Based Care, Treatment, and Support (FBCTS) now on Site-Level Expenditures tab of EA Template in FBCTS (rather than it's own separate tab)

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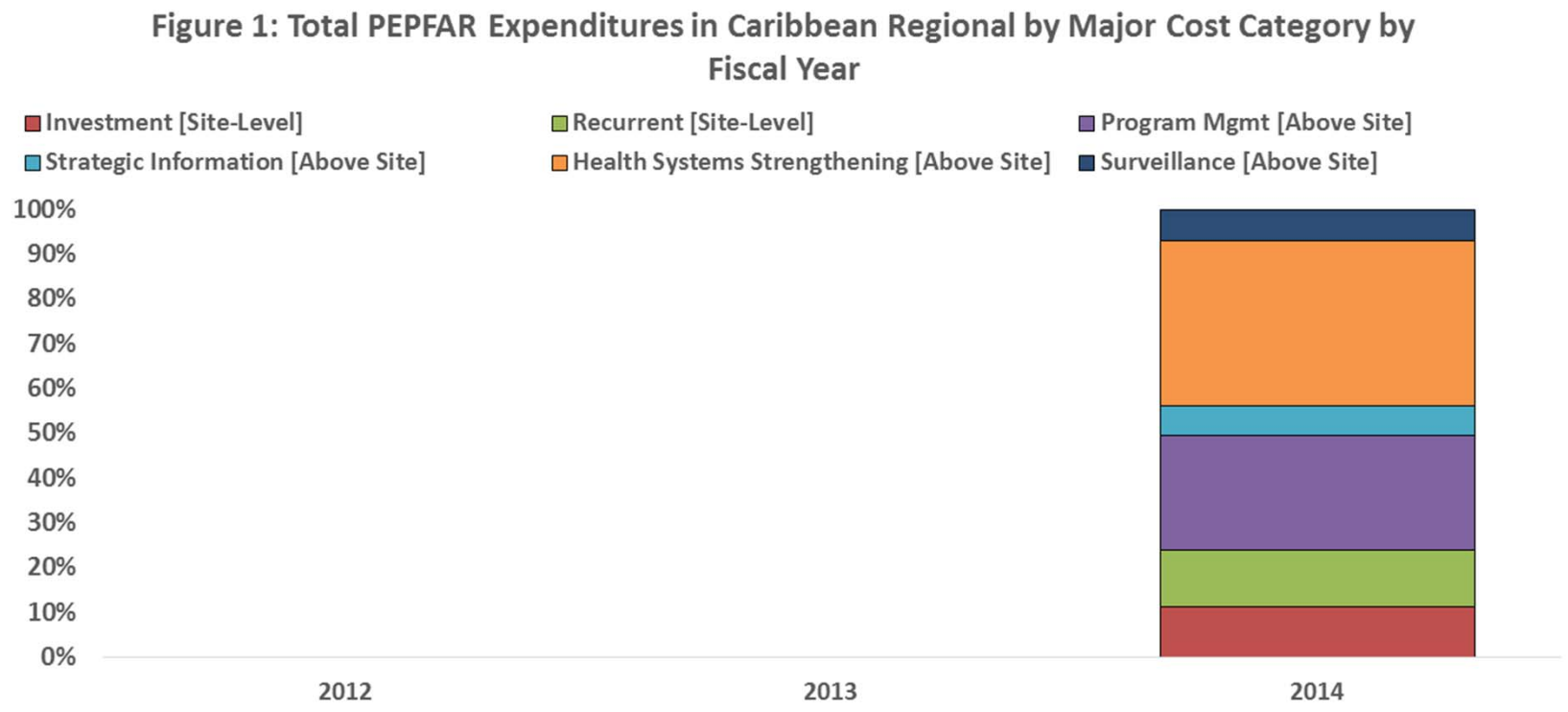
EA Analysis & Results

- Our EA methodology dictates the way we analyze data and display our expenditure results

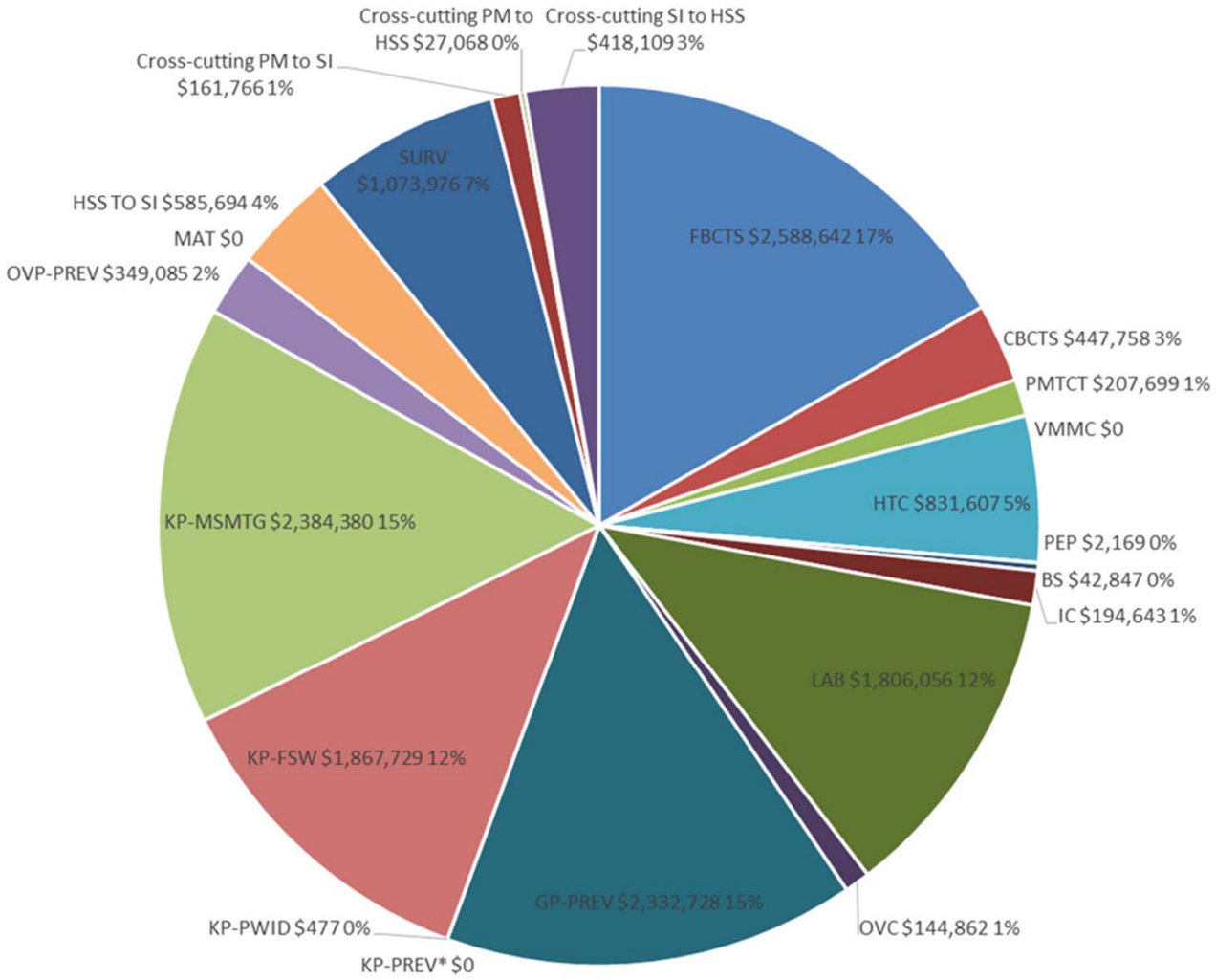
- EA data by program area, cost category, and geography…accordingly, we can look at our data through any one of those lenses (or a combination)

Total Expenditure by Major Cost Category



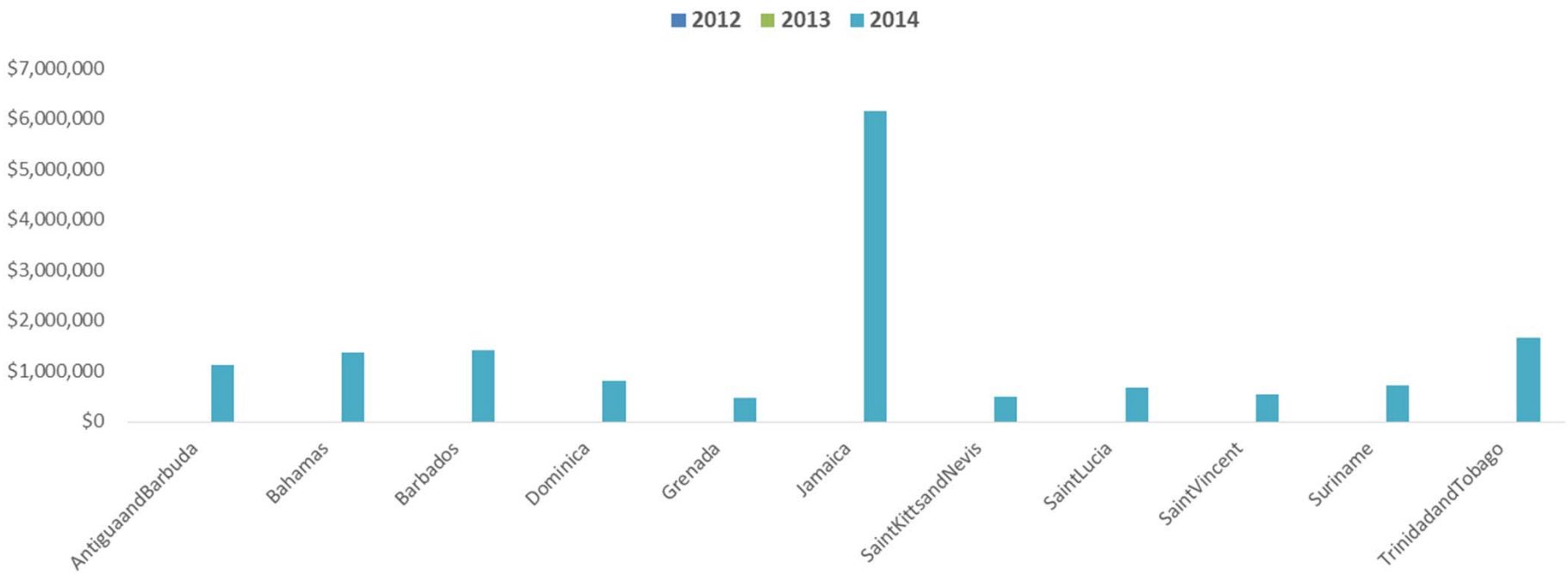
Total Expenditure by Program Area

Figure 4: Total PEPFAR Expenditures in Caribbean Regional by Program Area in Fiscal Year 2014



Total Expenditure by Geographic Level

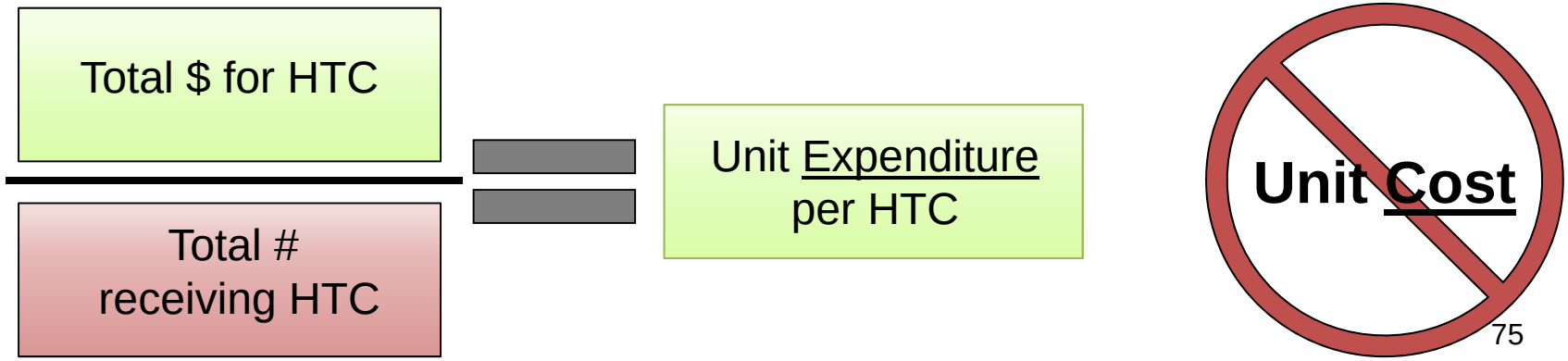
Figure 5: Total PEPFAR Expenditures in Caribbean Regional by Sub National Unit and Fiscal Year



What is a “unit expenditure”?

When possible, we also link our expenditures to indicators to calculate an expenditure per output, or unit expenditure

- **Only PEPFAR expenditures are captured**
- **PEPFAR results do not reflect differing partner inputs**
- **Cash basis doesn’t amortize one time investments such as constructions or bulk ARV procurements**
- **Missing other critical factors such as quality, linkage, retention, etc.**

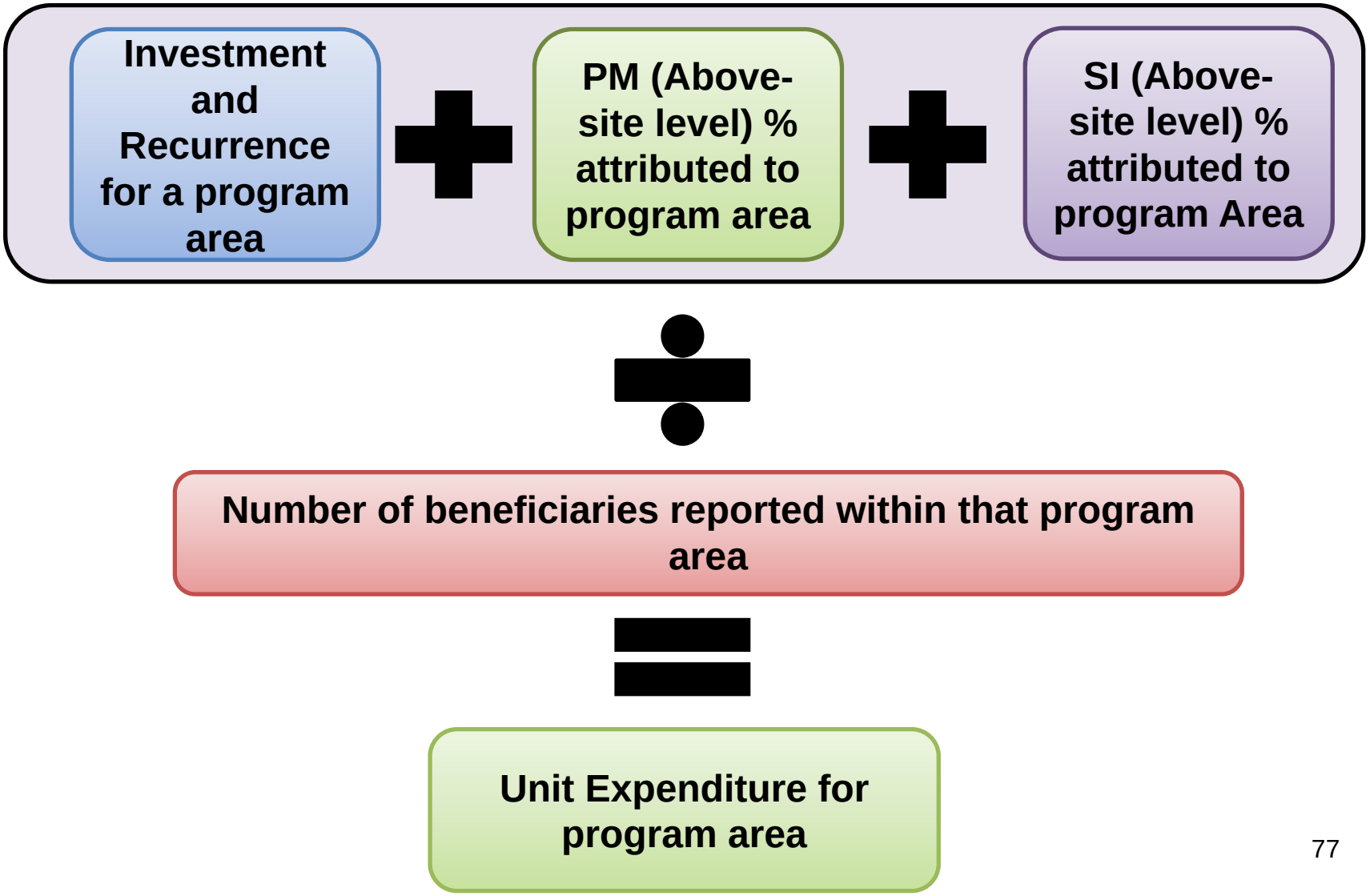


What's in a Unit Expenditure?

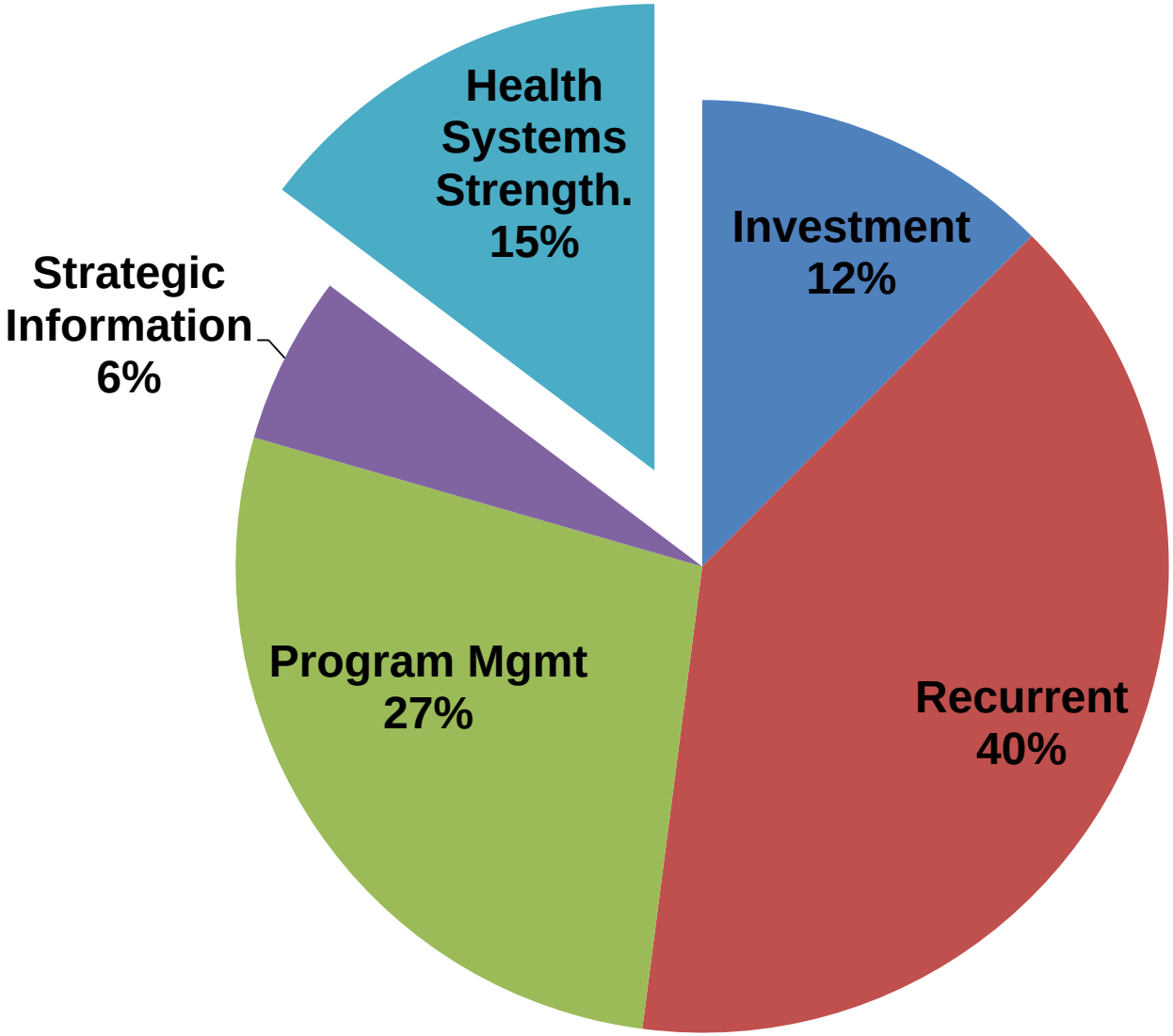
- **Numerator = all expenditures attributed to output (result)**
  - **Investment expenditures (e.g. vehicles)**
  - **Recurrent expenditures (e.g. personnel)**
  - **Program management allocated to program area**
  - **Strategic information allocated to program area**

- **Denominator = output taken from APR results (from DATIM)**

Calculating the Unit Expenditure

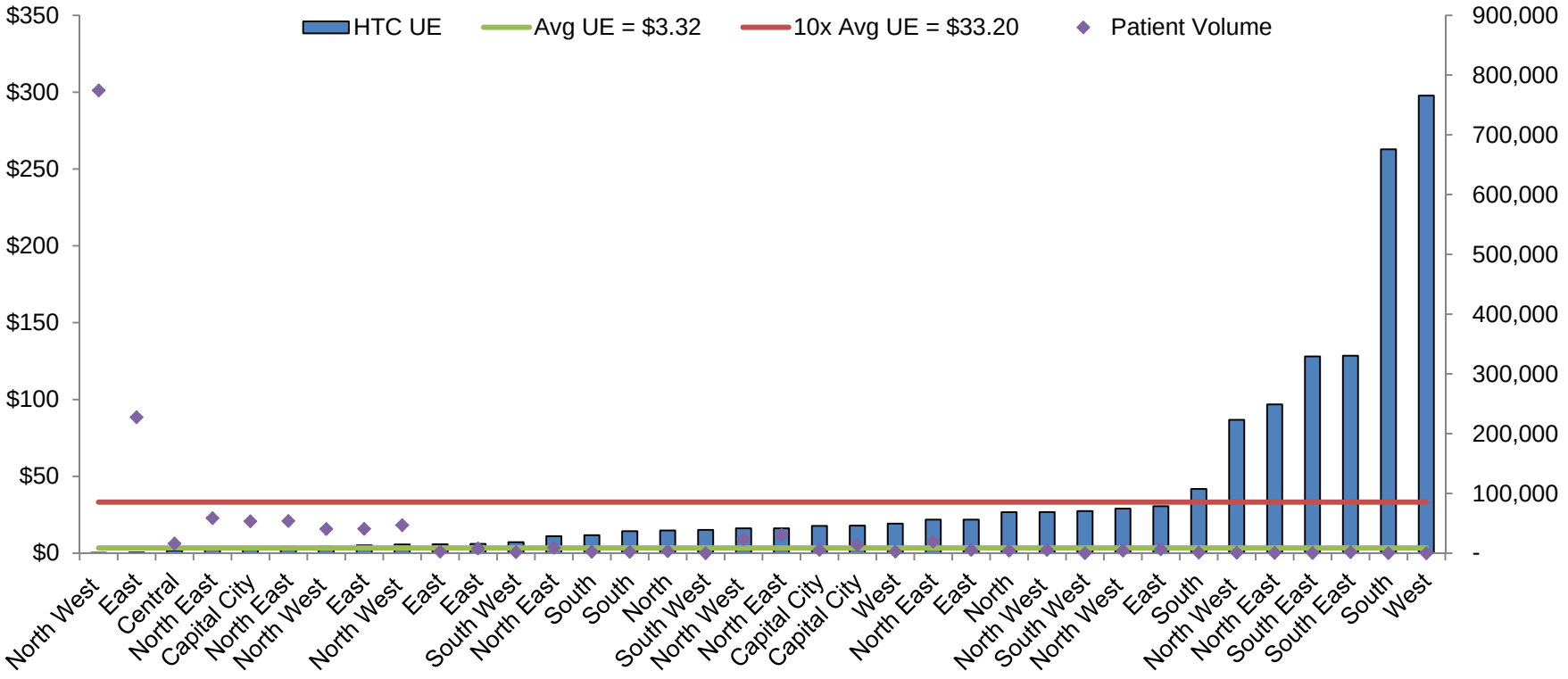


What's NOT in a Unit Expenditure?



IM-SNU Unit Expenditure - Graph

Figure 15: PEPFAR Unit Expenditures for HTC by Mechanism and Sub National Unit in PEPFARaway in Fiscal Year 2014



Interpreting Unit Expenditures

When interpreting UE graphs, there are a number of contextual and other factors that should be considered, including:

- Epidemiology (number of PLHIV, new infections, population type)
- Geographic structural factors (e.g., ease and cost of physical access to the location, population density)
- Differences in share of PEPFAR versus other funding streams
- Differences in service delivery models (e.g., type of personnel used, integration with other services, resource intensity)
- Differences in scope of IMs' activities (e.g., an IM that provides both system support and direct service delivery versus an IM that provides only direct service delivery)
- Differences in quality of services provided
- Differences in efficiency of service delivery
- Differences in program maturity
- Data Quality (both expenditures and indicators)

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How can EA data be used?

- **Budgeting**
- **Implementing Partner Management**
- **Share data with host-national governments**
- **Combine with other program data to help inform resource allocations and program prioritization**

Contact Information

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