

# policy

October 2014

## HARM REDUCTION UNIT COSTING TOOL

*User Guide*

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## ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
EHRN	Eurasian Harm Reduction Network
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HPP	Health Policy Project
NSP	needle and syringe distribution and/or exchange program
OST	opioid substitution therapy
PR	principal recipient
SR	sub recipient
SSR	sub-sub recipient
PWUD	people who use drugs
WHO	World Health Organization



# INTRODUCTION

The USAID-funded Health Policy Project (HPP), in collaboration with the Eurasian Harm Reduction Network (EHRN), developed the harm reduction unit costing tool to estimate in-country unit cost per client per year for opioid substitution therapy (OST) and needle and syringe exchange (NSP) services. The tool was created for use by civil society groups to advocate for increased funding for harm reduction as HIV prevention in Eastern Europe and Central Asia (EECA). The results will facilitate evidence-based decision making by filling a current data gap on the costs of providing harm reduction in different countries in the region.

The tools are important within the EHRN's implemented regional advocacy program "Harm Reduction Works—Fund It," funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The program aims to strengthen advocacy by civil society, including people who use drugs, for sufficient, strategic, and sustainable investments in harm reduction as HIV prevention in EECA. Under this goal, the regional program has defined two objectives to (1) build an enabling environment for sufficient, strategic, and sustainable public and donors' investments in harm reduction and (2) develop the capacity of the community of people who use drugs to advocate for the availability and sustainability of harm reduction services that meet their needs. To implement Objective 1 of the EHRN's regional program, HPP, in collaboration with EHRN, developed financial tools for undertaking harm reduction funding advocacy. This user guide details how to collect, enter, validate, and interpret data for the harm reduction unit costing tool.

## Purpose of Unit Costing

The tool was created to advocate for increased funding for NSP and OST programs. Civil society groups, including service providers and advocacy organizations, can use the results to raise awareness and advocate for funding commitments from potential or current funders. Users of the tool can also use data in the tool to conduct advanced analyses to inform program scale-up.

The harm reduction unit costing tool estimates in-country unit cost per OST and NSP client per year. The tool is forward-looking; it can be used to estimate the total cost of harm reduction by multiplying the unit cost by the number of clients reached. The unit costing tool informs decision making by projecting the budgetary needs to scale up harm reduction services for people who use drugs (PWUD).

The tool is meant to calculate the unit cost of providing high-quality harm reduction services that meet the minimum standards set by the World Health Organization (WHO) or the country. Therefore, some of the tool's inputs should be based on recommendations or the need rather than the actual current situation. The tool can also estimate the cost of providing harm reduction activities that are not currently provided in-country, such as overdose prevention with naloxone. Therefore, the tool serves two purposes:

1. To calculate the unit cost of providing high-quality services based on the *current package* of services in country
2. To calculate the unit cost of providing high-quality services based on an *improved package* of services in country

The unit costing tool is part of a suite of Excel-based financial tools to be used for harm reduction advocacy.<sup>1</sup> The expenditure tracking tool is closely related to the unit costing tool, and some inputs may

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<sup>1</sup> The suite of harm reduction financial tools, which includes an expenditure tracking tool, unit costing tool, and funding gap tool, can be found on EHRN's website: <http://www.harm-reduction.org/projects/regional-program-harm-reduction-works-fund-it/act-locally>.

be the same in both tools. However, the tools serve different purposes. While the expenditure tracking tool monitors actual past expenditure for harm reduction, the unit costing tool estimates how much it costs on average to provide OST or NSP per client per year. Comparing the results of the two tools may reveal a large discrepancy in unit past expenditure and unit costs. Differences in unit cost and unit expenditure should be interpreted with caution, as the unit costing tool does not capture costs above the site level, unlike the expenditure tracking tool. Furthermore, the unit costing tool accounts for all inputs required to provide harm reduction services, whereas the expenditure tracking tool only accounts for the inputs purchased within the two years of analysis.

## Key Features of the Tool

The tool has standard definitions and descriptions to enable a cross-country comparison but is flexible to allow for different country contexts. A key cornerstone of the tool is the option for countries to choose which OST and NSP activities provided within the OST and NSP package of services are high, medium and low priority according to the in-country situation. These country-specific classifications should be based on consultations with the PWUD community and evidence showing that the activity is effective at reducing HIV and other serious health harms (see Step 3: Classify Activities).

The tool also shows the distribution of costs across several categories. The average annual unit cost for harm reduction services is disaggregated by

- Program (OST or NSP)
- High-, medium-, and low-priority activities
- Indirect versus direct cost
- Cost category (e.g., cost of staff, overhead, medical commodities, medical equipment, and non-medical equipment)

It is recommended that the user saves multiple versions of the tool to compare the average weighted unit cost across different service delivery scenarios and packages of services.

## DATA COLLECTION PROCESS

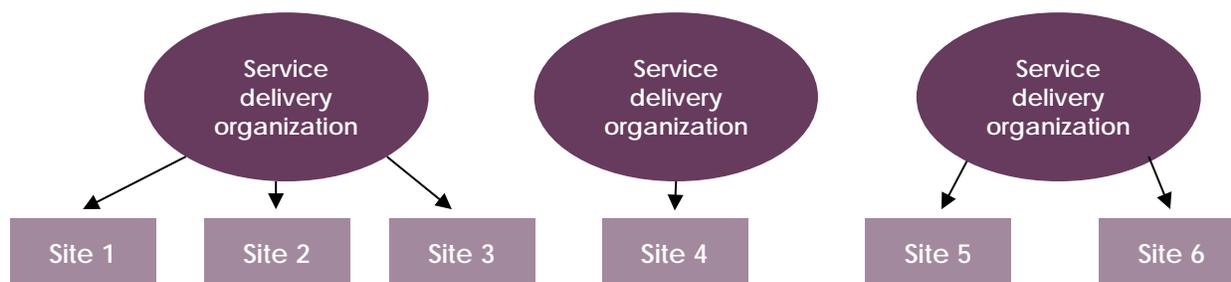
The data collection process is adaptable across multiple countries. This section provides general guidelines on data collection, including potential collection methods, sources, and data accuracy and quality.

### Organizational Structure of NSP and OST

Harm reduction provision includes service delivery organizations, which manage or supervise harm reduction service providers, and sites, which are the facilities that directly provide harm reduction services (see Figure 1). Service delivery organizations can include the government or nongovernmental organizations, and sites may include an OST clinic, HIV integrated clinic, NSP site, or mobile NSP site.

The tool is designed to capture harm reduction unit costs at the site level only. This includes all items used in direct service provision, even if they are centrally procured. Service delivery organization’s staff and overhead, however, will not be entered in the unit costing tool.

Figure 1: Basic Organizational Structure



The tool allows for data collection according to the Global Fund’s organizational structure, as NSP and OST programs are largely funded by the Global Fund in the EECA region (see Table 1).

Table 1: Global Fund Organizational Structure

Organization	Description	Classification
Sub-recipient (SR)	Manages SSR <b>and may also</b> provide NSP or OST services	Service delivery organization <i>(if manages SSR)</i> <b>or</b> site <i>(if provides services)</i>
Sub-sub-recipient (SSR)	Directly provides NSP or OST services	Site

### Cost Categories

The unit costing tool estimates the average annual unit cost for OST or NSP clients at the site level.

Site-level costs include those for

- Site staff
- Medical commodities
- Medical equipment
- Other direct costs not included under commodities and equipment
- Non-medical equipment
- Site overhead

Some harm reduction sites (primarily OST clinics) may offer other services outside the scope of harm reduction, especially if it is an integrated clinic. In this case, costs associated with harm reduction activities should be isolated from other costs (see Tool Format and Data Entry for more details).

## Types of Data Sources

Financial and program records from service delivery organizations and sites are required for filling in the tool. (For a complete list of data sources, see Table 2.) Financial and program records will include information on past expenditure on harm reduction and the number of people who receive NSP or OST services. Other pertinent information, such as what services are currently provided in-country and the number and type of staff for harm reduction, could also be derived from program records. If financial records are unavailable due to the sensitivity of sharing information, the interviewer or data collector must rely on information communicated informally. These data should be confirmed in writing or verbally.

**Table 2: Data Sources**

Data Source	Description	Purpose
Financial records	Financial record books, receipts, or any other documentation showing expenditures by service delivery organizations or sites	Used to estimate the cost of harm reduction activities
Program records	Physical or electronic records on clients reached, services provided, types of staff, staff time and attendance, etc.	Used to calculate the number of clients reached, time staff spend for each activity, etc.
Harm reduction guidelines	International guidelines (i.e., WHO guidelines) or national guidelines for NSP and OST programs	Can be used to calculate staff time
Interviews	Interviews with site staff or experts in-person, via phone, or via mail (filled-in questionnaire)	Can be used to calculate staff time or salaries and to estimate costs if in-country price is unknown
Time-motion studies	Third party observation of how much time different types of staff spend on each harm reduction activity	Can be used to calculate staff time
International price reference list or database	Source that has average international prices or prices from specific countries for harm reduction commodities, equipment, etc.	Used to estimate the cost of harm reduction activities if in-country price is unknown

National or international guidelines for NSP and OST, interviews with site staff and/or experts, and time-motion studies are recommended data sources for calculating staff time spent on harm reduction activities. Guidelines are the preferred source for calculating staff time, as the unit cost of providing harm reduction should be based on providing high-quality harm reduction services. If the current standard of service delivery is inadequate to meet the needs of PWUD or have a significant health impact, it is strongly recommended that the inputs in the unit costing tool be based on national or international guidelines.

If such guidelines are not available, interviews with staff or experts are other recommended data sources. Experts include human resources for health specialists within the Ministry of Health. When conducting interviews, the interviewer should ask permission to record and report all information and ensure that all information will be kept confidential. Furthermore, interviewers should impress the importance of collecting and ensuring the accuracy of this data, because it will be used to advocate for increased funding for harm reduction.

Countries may also conduct their own time-motion studies through direct observation of site-level staff. Time-motion studies are studies that observe and calculate how much time staff spend on certain activities throughout the day. For more information on conducting interviews and time-motion studies and how they can be applied to calculate staff time, see Annex 1.

If in-country data sources do not exist because the harm reduction activity is not currently provided in-country, international sources or data from neighboring countries may be used. The data collector should validate all data sourced from outside of the country based on in-country consultations with experts in the field. For instance, if naloxone is not currently provided in-country, the data collector may convene a consensus meeting among key pharmacists and program managers to arrive at the best point estimate for the price of naloxone using information from other countries and expert opinion.

## Data Collection

Data for NSP and OST are collected and entered separately. One person should ultimately be responsible for collecting, entering, and validating all data. The process of data collection depends on the number and spread of sites in-country.

All data should be collected and validated through site visits. An initial phone call or questionnaire can be sent to site managers in preparation of visits by the data collector. The data collection process may require multiple trips to sites and several different Excel files to track data. The data collector will compile all data and enter averages, as necessary, into one single version of the tool after data collection and validation (see “Data Validation”).

## Site Selection

It is strongly recommended that data be collected from all sites in-country, particularly if there are 15 sites or fewer. However, a sub-set of sites, herein called a sample, may be purposively selected for site-level data if there are geographic barriers to data collection, limited time, and/or a large number of sites in-country.

It is important to choose a mix of sites that will provide representative average costs that cover a broad enough spectrum of site types and situations. For instance, including outlier sites may provide insight on how costs can vary across different service delivery scenarios. Purposive sampling also allows for exclusion of some sites due to the difficulty in collecting data. For instance, it may be impossible to collect data from harm reduction sites within prisons.

### *Choosing the number of sites*

The recommended number of sites to sample is based on the number of sites countrywide and their similarity. Fewer sites need to be sampled if the sites are generally the same (i.e., homogeneous). Data should be collected from all sites if a country has 10 or fewer sites, and all service delivery organizations in the country should be represented in the sample. Refer to Table 3 for sample size guidelines.

**Table 3: Sample Size Guidelines**

Number of Sites in Country	Sample Size (homogeneous sites)	Sample Size (heterogeneous sites)
1–10	Include all sites	Include all sites
11–30	10	12
31–50	12	20
51+	20	30

### Choosing the types of sites

Several criteria are important to consider when determining whether sites are generally the same (i.e., homogeneous) or vary significantly on several characteristics (i.e., heterogeneous). Refer to Table 4 for a list and description of these characteristics.

**Table 4: Criteria for Determining Heterogeneity of Sites and Site Selection**

Criteria	Questions to Consider	Homogeneity/Heterogeneity	Site Selection
Funding/revenue sources	Are sites funded primarily through the national government, the Global Fund, or another source?	<b>Homogeneous:</b> Most sites are funded by the same source <b>Heterogeneous:</b> Most sites are funded by different sources	Include sites from all funding sources in-country
Location	Are sites in urban or rural areas? How many sites are in each administrative region?	<b>Homogeneous:</b> Most sites are in same region or type of area <b>Heterogeneous:</b> Mix of urban and rural sites; most sites are in a few regions	Include sites from diverse locations
Site experience	How many years have sites been in operation? How many clients do they reach?	<b>Homogeneous:</b> Most sites are around the same age and reach similar numbers of clients <b>Heterogeneous:</b> There is a large range in number of years in operation and number of clients reached	Choose new and old sites and sites with wide ranges in number of clients reached
Types of services	What and how many harm reduction services are provided at the sites? Who receives these services? Are other services outside of harm reduction provided?	<b>Homogeneous:</b> Most sites provide the same types of services <b>Heterogeneous:</b> There is a large range in the types and number of services provided by sites	Choose sites to represent all OST and NSP services currently provided in county
Quality of services	What is the proportion of staff to clients? How do PWUD rate the quality of services at the sites? What are sites' lost-to-follow-up or stock-out rates?	<b>Homogeneous:</b> Most sites provide the same quality of services <b>Heterogeneous:</b> There is a large range in the quality of services provided by sites	Choose sites that differ on quality measures

The determination of heterogeneity may require both qualitative and quantitative analysis. For example, the range of values across sites on quantitative indicators, such as the number of clients reached, can be compared to determine whether most sites have similar characteristics. If there are large ranges in the site-level indicators, this may reveal that sites are generally heterogeneous. Sites can also vary significantly on subjective measures that cannot be quantitatively analyzed, such as perceptions of service quality; and these factors should also be considered through consultations with program managers and experts. It is recommended that countries form a small team to evaluate the heterogeneity of sites based on a site mapping exercise before selecting the sites to sample.

### Data Validation

Some data validation components are already included in the tool. For example, data on the unit cost of commodities cannot be entered unless the activity that uses the commodity is selected from the drop-down menu. Furthermore, cells with formulas are locked to avoid data entry errors. However, additional checks are needed, particularly to ensure the quality of the data entered.

Three main guiding principles for data validation are

1. **Logic:** Are all data inputs reasonable? Do they make sense?
2. **Accuracy:** Was information from financial and program records properly mapped and copied to cells within the tool? Are the calculations mathematically accurate?
3. **Consistency:** Are the inputs consistent across similar sites?

The designated person ultimately responsible for all data entered into the tool should use data triangulation, mathematical checks for accuracy, and logical tests to validate the data. Data triangulation refers to using multiple sources to ensure data accuracy. For example, interviews with staff can be corroborated with time-motion studies to determine the percentage of time each type of staff spends on certain harm reduction activities. The user of the tool should also perform random checks to ensure that the amounts entered into the tool are mathematically correct and are the properly weighted averages of all sites. The user should conduct logic tests to ensure the data are generally consistent as well. For instance, time-use should never exceed 100 percent. Lastly, all suspicious or unusual data points should be confirmed by sites. Information given verbally needs to be confirmed via a follow-up visit or through email.

## TOOL FORMAT AND DATA ENTRY

This section reviews the data inputs and sources required for each section of the unit costing tool. All data can be entered in local currency. Total and unit cost calculations may be converted into U.S. dollars or another currency following data entry and validation.

Data entry is separate for NSP and OST services; the segments in green are for NSP data entry, while the portions in orange are for OST data entry. Data may not be entered in cells that are shaded grey, as these cells are locked and have formulas or text that must remain.

If a country is using a sample of sites rather than conducting a census, all data entered into the tool should be based on the sample of sites. There are no instances where information for all sites in the country is required.

The data entry process is outlined below. Screenshots of the tool are provided to show how data should be filled in. The data shown are dummy data; therefore, users should not compare the data to their own. In instances where the data process for OST and NSP are the same, screenshots may only show the process for one of the programs.

### Step 1: Review the Menu

This sheet is a clickable menu that helps the user navigate to different parts of the tool. The menu also includes the purpose of the tool. The user should identify which currency will be used when inputting unit cost data. The same currency should be used for all data entry. It is also required that the user select from a drop-down menu whether data will be entered for activities not currently provided in the country.

<h1>Harm Reduction Unit Costing Tool</h1> <p>Developed by the USAID  Health Policy Project (April 2014)</p>	
<p><b>Purpose:</b> To estimate in-country unit cost per OST and NSP client per year. The tool allows for variations in unit cost based on different coverage and service delivery scenarios and shows the major cost drivers in OST and NSP. This tool can be used to find an optimal way to use Global Fund indicative funding for harm reduction (or national funding planned) and to estimate full expression of demand.</p>	
<p><b>Menu:</b></p> <ul style="list-style-type: none"> <li><a href="#">Definitions of harm reduction activities</a></li> <li><a href="#">Classification of harm reduction activities</a></li> <li><a href="#">Indirect vs. direct expenditures</a></li> <li><a href="#">Staff cost- OST</a></li> <li><a href="#">Staff time- OST</a></li> <li><a href="#">Staff unit cost- NSP</a></li> <li><a href="#">Commodities- OST</a></li> <li><a href="#">Commodities- NSP</a></li> <li><a href="#">Medical equipment- NSP &amp; OST</a></li> <li><a href="#">Other direct expenditures- NSP &amp; OST</a></li> <li><a href="#">Non-medical equipment- NSP &amp; OST</a></li> <li><a href="#">Overhead- NSP &amp; OST</a></li> <li><a href="#">Overall unit costs</a></li> </ul>	<p><b>Currency*:</b> U.S. Dollars</p> <p><i>*Enter currency used for data entry</i></p> <p><b>Costing based on:</b></p>

## Step 2: Review the Activity Definitions

This sheet is a glossary that defines each harm reduction activity to ensure comparability across countries. The user should review the list of activities and their respective definitions before classifying their harm reduction activities as high, medium, or low priority. Definitions may not be changed.

### Definitions of Harm Reduction Activities

*Informational- no input required*

NSP		OST	
Activity (Service provided to NSP recipients)	Definition	Activity (Service provided to OST recipients)	Definition
Needle and syringe distribution and/or exchange	Daily distribution and/or exchange of needles, syringes, condoms, informational materials, and other commodities (e.g., swabs, sterile water, disinfectant, etc.) required for basic NSP service package that supports safe injection practice, as per international guidance and regional best practice.	Provision of methadone or buprenorphine	Daily provision/dispensing of medication (liquid or powdered).
Social work and counseling	Includes counseling for risk reduction and referral to OST or other treatment, social assistance. Does NOT include legal services.	Take-home dosing	When dose of medication for several days is given to patient at one time to reduce need for daily visit, or encourage a patient (contingency management).
HIV test and pre- and post- test counseling	At least once a year test and pre and post test counselling with a trained person (medical professional or other).	Short-term off-site dosing services	To deliver appropriate dose of medication at home, or at hospital due to health condition of a OST client. For hospital stays, etc.
TB screening and diagnosis	Provision of a TB screening with relevant lab. controlled assessments, including X-ray examinations prescribed and performed by medical doctor for early detection of TB infection and future management. For PLHIV, standard screening should be with GeneXpert rather than clinical screening	Case management	Management of individual cases by social worker, to improve the outcome of a treatment, help client into resocialization (help with employment, communication skills and other) and improvement of health condition.
TB DOT	Dispensing TB medication to NSP clients and other activities to assure TB treatment adherence	Regular clinical assessments	Performed by doctor to monitor health condition of a patient, sometimes some lab examinations are prescribed as well.
STI diagnosis	This means provision of STI tests with relevant lab. controlled assessments prescribed and performed by infectious diseases specialist. Includes syndromic diagnosis (in use in some countries) and lab-based diagnosis.	HIV test and pre- and post- test counseling	At least once a year test and pre and post test counselling with a trained person (medical professional or other).

### Key Definitions

**High priority**—A service without which a harm reduction program cannot effectively prevent HIV or other serious health harms.

**Medium priority**—A service that significantly improves a harm reduction program’s ability to prevent HIV or other serious health harms, but if absent, the program can still run.

**Low priority**—A service that is beneficial to NSP or OST clients and may improve a harm reduction program’s ability to attract or retain clients, but it does not directly aid in the prevention of HIV or other serious health harms.

## Step 3: Classify the Activities

The user selects activities conducted in-country from a drop-down menu and classifies them as high, medium, or low priority based on pre-set definitions.

NSP Activity	OST Activity	
<b>1. High priority (select from dropdown)</b>	<b>1. High priority (select from dropdown)</b>	<b>2. Enter percentage of all OST patients in country who receive each activity</b>
Needle and syringe distribution and/or exchange	Provision of methadone or buprenorphine	100%
HIV test and pre- and post- test counseling		
<b>Medium priority (select from dropdown)</b>	<b>Medium priority (select from dropdown)</b>	<b>Enter percentage of all OST patients in country who receive each activity</b>
Social work and counseling	Gender-sensitive services for women	10%

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

The user should rank interventions based on health impact, likelihood of future funding for the particular activity, and whether the activity can be replaced by another intervention. The classification of activities should be defined in close cooperation with and through extensive consultations with PWUD community groups. It is strongly recommended to use the Service Monitoring Group methodology within the “Harm Reduction Works—Fund It” regional program to organize the consultation process with the community.

Needle and syringe distribution and/or exchange and provision of methadone or buprenorphine must be classified as high-priority activities. Not all activities need to be selected, and the same activity cannot be selected more than once.

A country may select activities not currently provided in-country. This is recommended to estimate the cost of an activity that is a priority to PWUD or is planned to be provided in the future. Multiple versions of the tool can be saved with different classification of activities. Costs can then be compared across different packages of services to reveal the incremental cost of introducing a new harm reduction activity.

### ***Percentage of OST clients who receive each service***

The percent of OST clients who receive each activity needs to be entered. This should be based on program records or national/international standards for service delivery. For instance, in-country clinical standards may mandate that 100 percent of OST patients receive HIV testing and counseling. Even though fewer people may receive this service in actuality, the user should use this assumption to enter data into the tool in order to cost for the need of HIV testing and counseling.

If guidelines do not exist and program data are collected from sites, the percentage of clients who receive a service can be calculated by adding the number of OST clients who receive each service across sites and dividing by the total number of OST clients reached. All OST patients (100%) should receive methadone or buprenorphine.

### ***Number of OST and NSP clients per year***

The user should enter the number of people who receive high-, medium-, and low-priority NSP and OST services each year and the total number of OST and NSP clients. If a sample is used to collect data, the number entered should be based on the number of clients reached at the sample sites rather than the total number of people reached in-country. These data should be for the most recent year where data are available.

3. NSP Recipients		
Number of people receiving NSP services in country	1000	
Number of NSP recipients who receive high priority activities	1000	100.00%
Number of NSP recipients who receive medium priority activities	700	70.00%
Number of NSP recipients who receive low priority activities	500	50.00%

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

The number entered can also be the projected number of clients for the year based on recent trends at the site level. The country can project the future number of clients based on a linear trend or moving average that takes seasonality into account.

The number of clients accessing NSP or OST services should not be confused with the number of client contacts or needles and syringes distributed. The number of clients should be based on the following definitions of a client.

#### Key Definitions

**NSP client**—Person who received the NSP minimum standard package of services once a month in the last 12 months. The minimum standard package can vary by country.

**OST patient**—Person who receives OST treatment at a specified date. The basic OST treatment may include a baseline assessment done by a doctor and/or nurse, including tests regulated by country-specific medical protocols; and receipt of at least one dose of medication.

If the number of clients is tracked monthly and the annual number of clients is unknown, the following calculations may be used to estimate the total number of clients reached per year, in order from least to most rigorous:

- **Simple average:** Add the number of clients reached each month in a year and divide by 12
- **Cumulative estimate:** Baseline number of clients (first month recurring clients) plus new clients each month for 12 months
- **Cumulative estimate accounting for loss to follow-up:** Baseline number of clients (first month recurring clients) plus new clients each month minus clients lost to follow-up each month for 12 months

When collecting and entering data, the data collector should ensure that the sites have comparable definitions of NSP or OST clients that match the definitions in the tool. Expert opinion may be used to adjust numbers to match definitions, as necessary.

If sites track which services each client receives, the data collector may directly enter the number of clients who receive at least one high-, medium-, or low-priority service into the tool. If this client count is unknown, the highest number of clients who receive a specific service within the high-, medium-, or low-priority categorization may be used to estimate the number of clients who receive at least one high-,

medium-, or low-priority service. See Table 5 below for an example. In this case, the number of clients who receive at least one medium-priority service could be estimated at 155 out of 250 total clients reached.

**Table 5: Sample Data for Clients Who Receive at Least One Medium Priority Activity**

Sites	Total number of OST clients	Medium Priority Activities		
		Number who receive HIV test and pre- and post- test counseling	Number who receive TB DOT	Highest number by site
Site 1	100	75	60	75
Site 2	150	45	80	80
<b>TOTAL</b>	<b>250</b>	<b>120</b>	<b>140</b>	<b>155</b>

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

The percentage of clients who receive high-, medium-, and low-priority OST and NSP services will be automatically calculated based on the input number of clients for each type of activity. In the example above, it is estimated that 62 percent of clients receive at least one medium-priority service (155 divided by 250). All clients (100%) should receive the high-priority services, as provision of methadone or buprenorphine and needle and syringe distribution and/or exchange will always be classified as high priority.

### Step 4: Review the Definitions of Indirect and Direct Costs

This is an informational tab showing definitions and some examples of direct and indirect costs. Countries cannot choose which costs are direct or indirect; this calculation is automatic. Definitions cannot be changed.

Definitions and Examples of Direct and Indirect Expenditure	
<i>Informational- no input required</i>	
<b>Definitions:</b>	
<b>Direct</b>	Costs that are directly related to specific harm reduction activities
<b>Indirect</b>	Costs that are indirectly related to service provision and cannot be readily identified with a particular activity
<b>Examples (not a comprehensive list):</b>	
	<b>NSP</b>
	<b>OST</b>
<b>Direct expenditures</b>	<b>Commodities:</b> Syringes, needles, swabs, disinfectants, naloxone, condoms, HIV tests, STI tests, pregnancy tests, vein ointments, scarificators, eppendorf, HBV, vitamins, bandages, etc.
	<b>Staff salaries (and bonuses) and staff training for direct service provision:</b> Outreach worker, social worker, counsellor, physician, nurse, psychologist, lawyer
	<b>Medical equipment:</b> Fridge, lab furniture (chairs and table), VCT table, pipette, medical cupboard, medical waste disposal <b>Other direct costs:</b> Informational/educational materials, hygienic materials, monetary incentives, hand sanitizer, rental space for training, expenses related to case management
<b>Indirect expenditures</b>	<b>Commodities:</b> Methadone, buprenorphine, cups, dispensers, gloves, vaccinations, drug screening tests, disinfectants, condoms, HIV tests, STI tests, hepatitis tests, water, naloxone, antidepressants, etc.
	<b>Staff salaries (and bonuses) and staff training for direct service provision:</b> Physician, nurse, social worker, psychologist, head of department, pharmacist, etc.
	<b>Medical equipment:</b> Fridge, dosimeter, alcohol tester, BP monitor, water dispensers, scales, bottle for dosimeter <b>Other direct costs:</b> Informational/educational materials, food packages, conference costs rental space for training
<b>Indirect expenditures</b>	<b>Staff salaries (and bonuses) and staff training for indirect service provision:</b> Security staff, cleaner, driver, program director, program coordinator, program assistant, accountant, logistics staff, M&E specialists <b>Non-medical equipment:</b> Computers, printers, scanners, telephones, air conditioner, office furniture, washing machine
	<b>Staff salaries (and bonuses) and staff training for indirect service provision:</b> Security staff, cleaner, driver, program director, program coordinator, program assistant, accountant, logistics staff, M&E specialists <b>Non-medical equipment:</b> Computers, printers, scanners, telephones, air conditioner, office furniture, video recorder, safebox
	<b>Central program and site overhead:</b> Utilities (water, heat, electricity), office supplies (pens, pencils, markers, badges, printer ink), building maintenance (rent, security), transportation (car maintenance and fuel), taxes

## Step 5: Enter the OST Staff Costs

The tool uses different methodologies for estimating staff costs for OST and NSP. For each type of direct OST staff in-country, the user must enter the average annual salary prior to taxes and inclusive of average benefits and the average training cost per year. The average annual salary can be calculated by adding the salaries of each type of staff and dividing by the total number of each type of staff. Data from the expenditure tracking tool can be used for this calculation, although the data collector should use the data from the most recent year available.

If the cost of benefits or trainings is not known for each staff type, there are two ways to approximate the cost. The method chosen should reflect what is perceived as the most accurate method after consulting with a site manager.

1. **Assuming benefits and training costs are the same per staff member:** Estimate the benefits paid per type of staff by dividing the total amount of benefits paid by the total number of staff who received benefits. Exclude any staff who do not receive benefits or training from this calculation.
2. **Benefits and training costs proportional to salaries paid:** Estimate the benefits paid and training costs per type of staff based on the proportion of total salaries paid for each type of staff. For example, if total benefits paid to staff are \$10,000 and nurses' salaries account for 20 percent of all site-level staff expenditures, the total benefits paid to nurses would be \$2,000. This amount should then be divided by the total number of nurses to yield the average annual benefits cost per nurse.

For direct staff (i.e., staff that directly provide harm reduction services), the user must also enter the number of hours worked per week and weeks worked per year. This information is used to calculate a cost per minute for each type of direct staff. Most frequently, the number of hours worked per week will be 40 and the number of weeks worked per year will be 52. The time worked per each type of staff should not exceed national labor standards, and any overtime included should also be accounted for in the average staff salary.

For indirect staff, the user must enter the total salaries paid, inclusive of benefits paid, and training costs for each type of staff. These data should come from the most recent year of data in the expenditure tracking tool. The benefits paid and training costs per each type of worker can be estimated using the same methods as above for direct staff.

Type of OST Staff	Definitions	Enter average annual salary (inclusive of average benefits)	Enter average annual training costs per person	Enter number of hours worked a week	Enter number of weeks worked per year	Cost per minute
<b>Staff involved in direct provision of services</b>						
Head of department/OST site coordinator	May be a chief doctor of narcology unit, manages OST site	50,000.00	500.00	40	52	0.40
Physician/Narcologist	Medical doctor responsible for daily management of medication, performs assessment of patient and prescription of appropriate dose of medication.	45,000.00	1,000.00	40	52	0.37

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

## Step 6: Enter the OST Staff Time

For each type of OST staff that directly provide harm reduction services, enter the number of minutes spent on each harm reduction service in-country. These data can be based on national or international service delivery guidelines, interviews with site-level staff, or time-motion studies.

These data sources are substitutes for one another, meaning that the country does not need to use all three sources. However, data from multiple sources can be compared to arrive at the best estimate for the average number of minutes spent on each activity.

If the user conducts interviews with site-level staff, s/he should conduct at least one interview with each type of staff for two or more sites. The data collector should take the average response reported across each type of staff. If the same type of staff report large differences in time spent on the same activity, the data collector should investigate why there is this discrepancy and conduct interviews with additional staff at other sites for validation.

For more information on what questions to ask and how to calculate staff time for OST, see Annex 2.

OST Activity	1. Enter number of visits per patient per year	2. Enter time (in minutes) each direct staff member spends per activity per patient per visit								
		Head of department/ OST site coordinator	Physician/ Narcologist	Psychologist	Social worker	Case manager	Nurse	Pharmacist	Other (specify)	Other (specify)
<i>High priority activities</i>										
Provision of methadone or buprenorphine	365		5				10	5		

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

## Step 7: Enter the OST Staff Costs

For each type of direct NSP staff in-country, the user must enter the average annual salary prior to taxes and inclusive of benefits and the average training cost per year. The average annual salary can be calculated by adding the salaries of each type of staff and dividing by the total number of each type of staff in-country. The most recent data available should be used for these calculations.

If the value of benefits or training is unknown, use either of the methods explained in the previous section on OST staff cost to estimate these costs.

For direct staff (i.e., staff that directly provides harm reduction services), the data collector must also enter the number of each type of staff who provide or are trained in high-, medium-, or low-priority activities for all sites in the sample. The same staff member can be counted across the three categories if s/he is trained and provides high-, medium-, and low-priority services. This information can come from interviewing site managers or human resources for health experts.

NSP Staff (Direct Service Provision)	Definitions	Enter average annual salary (inclusive of benefits)	Enter average annual training costs per person	Enter total number of staff in program who provide and are trained in...			Enter average percent of time (not to exceed 100%) spent on...				Unit cost		
				High priority activities	Medium priority activities	Low priority activities	High priority activities	Medium priority activities	Low priority activities	All activities	High priority activities	Medium priority activities	Low priority activities
Social worker/case manager	Distributes commodities and informational materials on or off site. This is certified person who has diploma of social worker. But in some cases this position is the same as outreach worker, the person who is ex-drug user and knows the community well.	30,000.00	1,000.00	30	20	0	95%	5%	0%	100%	883.50	44.29	0.00

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

The user must also enter the average percent of time each type of staff spends on high-, medium-, and low-priority activities. Similar to OST staff time, this percentage can be based on national or international service delivery guidelines, interviews with staff, or time-motion studies. If the data collector conducts interviews, s/he should interview at least one person for each type of staff for at least two sites in the sample. For more information on what questions to ask and how to calculate this percentage for NSP staff, please see Annex 3.

For indirect staff, the user must enter the total salaries, inclusive of benefits paid, and training costs for each type of staff. These data should come from the most recent year of data in the expenditure tracking tool. The benefits paid and training costs per each type of worker can be estimated using the same methods as direct staff.

NSP Staff (Indirect Service Provision)	Definitions	Enter total annual salary (inclusive of benefits)	Enter total annual training costs per person	Unit cost		
				High priority activities	Medium priority activities	Low priority activities
Sub coordinator	Coordinator of sub-sub-contract project, manages NSP site and its activities	35,000.00	500.00	33.81	1.69	0.00

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

## Step 8: Enter the Commodities Costs

Commodities are medical items used in direct service provision that have a lifespan of less than a year. Commodity costs are considered direct costs. There are separate sheets to enter costs for OST and NSP commodities.

Commodity costs are calculated differently for items given directly to patients versus items used in direct service provision. For instance, while syringes are given directly to clients, disinfectants and gloves are not.

To calculate the unit cost for each type of commodity given directly to clients, the user must first select from a drop-down menu the type of activity and which specific activity uses the commodity. If more than one activity uses the commodity, select “multiple” from the drop-down menu. For commodities not given directly to clients but are used in direct service provision, select “yes” or “no” from the drop-down menu based on whether the commodity is used for high-, medium-, or low-priority activities. The user will not be allowed to enter cost data unless these drop-down selections are made.

The purpose of each commodity used should not vary across service delivery organizations or sites, meaning that commodities can be mapped to the same activity across all service delivery organizations and sites. The data collector can collect this information from organizations outside of the country or the service delivery organizations that procure, store, and distribute commodities on behalf of sites. If sites directly purchase their commodities, the data collector must collect data from those sites.

The tool requires the user to enter the in-country unit price for each type of commodity based on the definition of one unit provided or defined by the user. If the country’s pack size is different than the definition provided, the data collector should change the definition to match the in-country pack size. Furthermore, the unit price should be based on expenditure within the past year or current market prices. For commodities not currently provided in-country, the data collector can use price data from neighboring countries or an international source.

The unit price of the commodity needs to include the cost of commodity procurement, storage, and transportation. A proxy formula can be used if these costs are unknown for each type of commodity. For instance, a certain percentage of the unit price can be added to the unit cost to account for procurement, storage, and transportation. This can be based on the cost of procurement, storage, and transportation in-country within the last year or information from neighboring countries.

For items given directly to clients, the user must also enter the percent of all OST and NSP clients who receive each commodity and the frequency of receipt per person per year based on the definition of one

unit. This information can be based on site-level records or guidelines. For example, sites may report procuring and distributing 100 1 ml syringes, 50 2 ml syringes, and 50 5 ml syringes to NSP clients. In this case, the percent of clients who receive 1 ml syringes could be estimated at about 50 percent (100 divided by 200). For example, the frequency of receipt per person per year could be 200 for each type of syringe based on WHO guidelines and the definition of one unit as one syringe.

1. NSP commodities given to patients	Definition of one unit of commodity	Select if commodity is used for High, Medium or Low Priority OST activities (from dropdown)	Select specific NSP activity which uses commodity (from dropdown)	Enter in country unit price of commodity	Enter percent of all NSP recipients who use commodity	Enter frequency of use per recipient per year	Unit cost
Syringes- 1ml	One syringe	NSP_High	Needle and syringe distribution and/or exchange	3.50	50%	200	350
Syringes- 2 ml	One syringe	NSP_High	Needle and syringe distribution and/or exchange	2.95	50%	200	295

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

For items not given directly to clients but are used in direct service provision, the user must enter the total quantity needed per year in-country or for the sample of sites, based on the definition of one unit. This calculation will be estimated based on assumptions. For instance, if a bottle of disinfectant usually lasts for one month and one is needed per site, the total number needed per year will be 12 times the number of sites in the sample.

2. NSP commodities used in direct services	Definition of one unit of commodity	Is the commodity used for... (select Yes or No from dropdown)			Enter in-country unit price of commodity	Total quantity needed per year	Total cost
		High priority activities	Medium priority activities	Low priority activities			
Gloves	One pair of gloves	Yes	No	No	1.25	10920	13650

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

## Step 9: Enter the Medical Equipment Costs

Medical equipment refers to items used in direct service provision that have a lifespan greater than one year. For instance, laboratory furniture, scales, and refrigerators are medical equipment. All medical equipment costs are considered direct costs.

Medical equipment data are entered in the same sheet for NSP and OST. For each type of equipment purchased, select “yes” or “no” from the drop-down menu for whether the equipment is used for high-, medium-, and/or low-priority activities. The user then enters the in-country unit price for each piece of equipment used according to past expenditure or current market rates. The user will not be able to enter this information unless s/he specifies which activities require the use of the equipment. The user also inputs the average lifespan in years for each piece of equipment based on past experience, equipment warranty, or international databases on equipment lifespan. These data are used to automatically calculate the annual depreciated price for each piece of equipment used in-country. The tool assumes linear depreciation.

Finally, the number of equipment needed in-country should be entered for each piece of equipment. This can be based on national or international standards, past programmatic experience, or expert opinion. Approximates can be used based on the number of sites or people reached in a year. For instance, each site may need two medical refrigerators on average. If there are 100 sites in the country, then 200 refrigerators are needed. The number of refrigerators needed could also be based on the number of people reached; if sites, on average, need one refrigerator for every 25 clients reached and the total number of clients reached is 100, the number of refrigerators needed is 4. The total number needed rather than the rate should be entered into these cells.

Medical Equipment	1. Is the equipment used for... (select Yes or No from the dropdown menu)			2. Enter the in-country unit price of equipment	3. Enter equipment life span in years	Depreciated annual unit price	4. Enter quantity needed for program	Total cost
	High priority Activities	Medium priority activities	Low priority activities					
<b>NSP</b>								
Fridge	Yes	No	No	2500	5	500	15	7500

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

## Step 10: Enter the Other Direct Costs

Other direct costs are costs related to direct service provision at the site level that are not medical commodities or equipment. For example, educational materials, rental space for NSP or OST client trainings, and materials for recreational works are other direct costs. Data for both NSP and OST are entered in the same sheet.

This sheet follows a similar format to the commodities sheet. The user must first enter the definition of one unit for each of the other direct costs used in-country. For example, one unit for educational materials may be one pamphlet. Prior to entering unit cost data, the user must choose the specific activity that utilizes the item from a drop-down menu. The items used for each activity should not vary across service delivery organizations or sites. If more than one activity uses the item, select “multiple” from the drop-down menu.

There are two options for entering the cost data based on whether the item is given directly to clients. For example, educational materials are distributed directly to clients, but rental space is not.

For items directly given to clients, such as educational materials, the user must enter the in-country unit price of the item based on the definition of one unit in-country. These data can be sourced from past expenditure records or current market rates. The user must also enter the percentage of patients who use the item by type of activity (i.e., high, medium, or low priority). This information is based on program records, guidelines, and in-country standards for activities. For example, some countries may require that all NSP clients receive educational materials each time a needle is distributed. Therefore, the percentage of NSP clients reached through high-priority services who receive educational materials is 100 percent. The user must also enter the number of items required per patient per year. This information can be based on national or international guidelines and program records. As in the example above, if all NSP clients must receive educational materials each time a needle is distributed, then the number of educational materials needed per patient per year should equal the number of needles distributed per patient per year.

Activity Type	1. Definition of one unit	2. Select specific activity which uses item (from dropdown)	3. If item can be given to clients (ex: educational pamphlet, hygienic materials, money, recreational works):			
			Enter the in-country unit price of item	Enter percent of recipients who use item by activity group (high, medium, low)	Enter number of items per patient per year	Unit cost
<b>NSP High Priority Activities</b>						
Information/education materials	1 pamphlet	Needle and syringe distribution and/or exchange	3	100%	200	600

For items not given directly to clients, such as bicycles, the user must enter the aggregate annual expenditure on each item based on past expenditure records and the number of people who receive or benefit from the item for each type of activity (i.e., high, medium, or low priority). The expenditure data can be sourced from the expenditure tracking tool. The number of clients who receive or benefit from the item may be based on program records of number of clients served or guidelines. For example, if bicycles will be used for needle and syringe distribution and outreach in some NSP sites in your sample, the

number of people who receive or benefit from the item would be the number of NSP clients who receive high-priority services from those specific sites.

Activity Type	1. Definition of one unit	2. Select specific activity which uses item (from dropdown)	4. If item cannot be given to clients (ex: rental space for training):		
			Enter total annual expenditure on item in-country by activity type	Enter number of people who receive or benefit from item within each activity group (high, medium, low)	Unit cost
<b>NSP High Priority Activities</b>					
Bicycles	1 bicycle	Needle and syringe distribution and/or exchange	5000	1000	5

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

Be mindful to not overestimate the unit cost due to entering aggregate data more than once for high-, medium-, and low-priority activities.

### Step 11: Enter the Non-Medical Equipment Costs

Non-medical equipment refers to items with a lifespan greater than one year that are not used in direct service provision. All non-medical equipment costs are indirect costs. Data on non-medical equipment costs for OST and NSP are entered in the same sheet.

For each type of non-medical equipment required at the site level, enter the in-country unit price based on past expenditure or current market rates. The unit price is the price for one piece of equipment. The user must also enter the equipment lifespan in years. Similar to medical equipment, this information can be based on past experience or the equipment warranty and is used to calculate an annual depreciated price for each piece of equipment. The tool assumes linear depreciation.

Lastly, the user must enter the quantity of equipment needed in-country or for the sample of sites for each type of equipment. This can be based on national/international standards or past programmatic experience. Approximates can be used based on the number of sites, staff, or people reached in a year. For instance, if each site should have a computer, the total number of computers needed would be the number of sites in the sample. Even if only a few sites have a computer, the user may want to assume that each site will need a computer, as the unit costing should be guidelines-based and reflect the need to provide high-quality harm reduction services. Only numbers (not rates) can be entered into these cells.

	1. Enter in-country unit price of equipment	2. Enter equipment life span in years	Depreciated annual price	3. Enter quantity needed in program (e.g., 1 per site or employee)
<b>NSP Non-Medical Equipment</b>				
Computers	1500	5	300	30
Printers	500	5	100	10

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

### Step 12: Enter the Site-Level Overhead Costs

Site-level overhead refers to the costs related to maintaining the site, including expenditure on utilities, transportation, rent, office supplies, and taxes. Site-level overhead data are collected and entered by site. Data for both OST and NSP are entered in the same sheet and can be sourced directly from the most recent year of the expenditure tracking tool.

If the site does not pay rent because the building is owned or provided in-kind, the site should calculate the estimated value of rent. This is different from the expenditure tracking tool methodology because the purpose of the unit costing tool is to estimate the true cost of providing harm reduction services rather than just the financial cost paid. Rent can be calculated by multiplying the square footage of the site space by the average rental price per square footage in the city where the site is located.

NSP	1. Enter annual expenditure by NSP site					
	Office supplies	Utilities	Transportation	Construction	Rent	Site taxes
<b>NSP Organization 1</b>						
Site 1	750	5500	32000		85000	10000
Site 2	650	10000	14500	3000	25000	10000

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

OST sites may not be able to easily disaggregate OST-related overhead from non-OST-related overhead. Therefore, there is an option to enter the aggregate overhead by site and the percentage of all patients at the site who receive OST to determine the proportion of overhead allocable to OST services. The proportion of all patients who receive OST can be taken from the ratio column of the “Service Providers” tab of the expenditure tracking tool.

OST	2. If expenditures cannot be separated for OST only: Enter total annual expenditure by site						
	Percent of all people at site who receive OST	Office Supplies	Utilities	Transportation	Construction	Rent	Site taxes
<b>OST Organization 1</b>							
Site 1	95%	750	5500	32000		85000	10000
Site 2	80%	650	10000	14500	3000	25000	10000

Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

### Step 13: View the Results

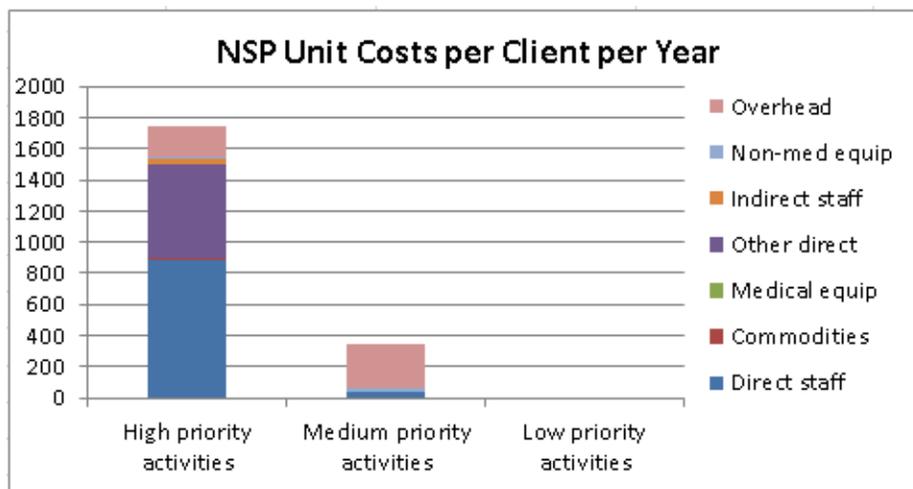
The final section is a summary sheet that does not require any inputs and is locked to avoid errors. The summary sheet shows the overall weighted average unit cost per OST and NSP client per year based on the percentage of NSP or OST clients who receive or should receive each package of services (high, medium, or low priority) and the unit cost of each package. The unit cost per client per year is also calculated for high-, medium-, and low-priority activities. These unit costs can be used to estimate the total cost of harm reduction in-country based on the need (PWUD population size) and programmatic coverage (percent of PWUD reached). Therefore, the annual cost of providing OST or NSP would be the average weighted cost per OST or NSP client multiplied by the number of OST or NSP clients reached in one year.

<b>NSP unit costs per client per year</b>				
	<b>Percent of all NSP recipients receiving activities</b>	<b>Direct unit cost</b>	<b>Indirect unit cost</b>	<b>Total unit cost</b>
<b>High priority activities</b>	100.00%	1502.2	240.9	1743.0
<b>Medium priority activities</b>	70.00%	44.3	295.9	340.2
<b>Low priority activities</b>	0.00%	0.0	0.0	0.0
<i>Weighted overall unit cost per client per year</i>		<b>1,981.1</b>		

Note: The results shown here are not reflective of actual costs or patient numbers. The numbers are based on dummy data, meaning that these amounts should not be compared to actual data. This is just an example of what the sheet will look like when data are filled in.

Multiple versions of the tool should be saved to show the variations in cost based on different service delivery scenarios. In particular, comparisons can be made between the cost of the recommended package of services, which may include activities not currently provided in-county, and the cost of the current package of services provided in-county.

The proportion of the unit costs attributable to direct vs. indirect costs and cost category (e.g., staff, medical equipment, etc.) are shown to identify cost drivers within the country. Two graphs will auto-populate based on the data entered. These graphs show the average unit costs by activity type and cost category.



Note: All data used are hypothetical and for demonstration only. Do not use for analysis.

The results should be interpreted with caution. Results may not be comparable across countries due to the different classification of activities, activity inputs, and standards of service delivery. Furthermore, the true cost of harm reduction provision is likely higher than the amount estimated in the unit costing tool due to the exclusion of central program management costs above the site level.

## USING THE RESULTS FOR HARM REDUCTION ADVOCACY

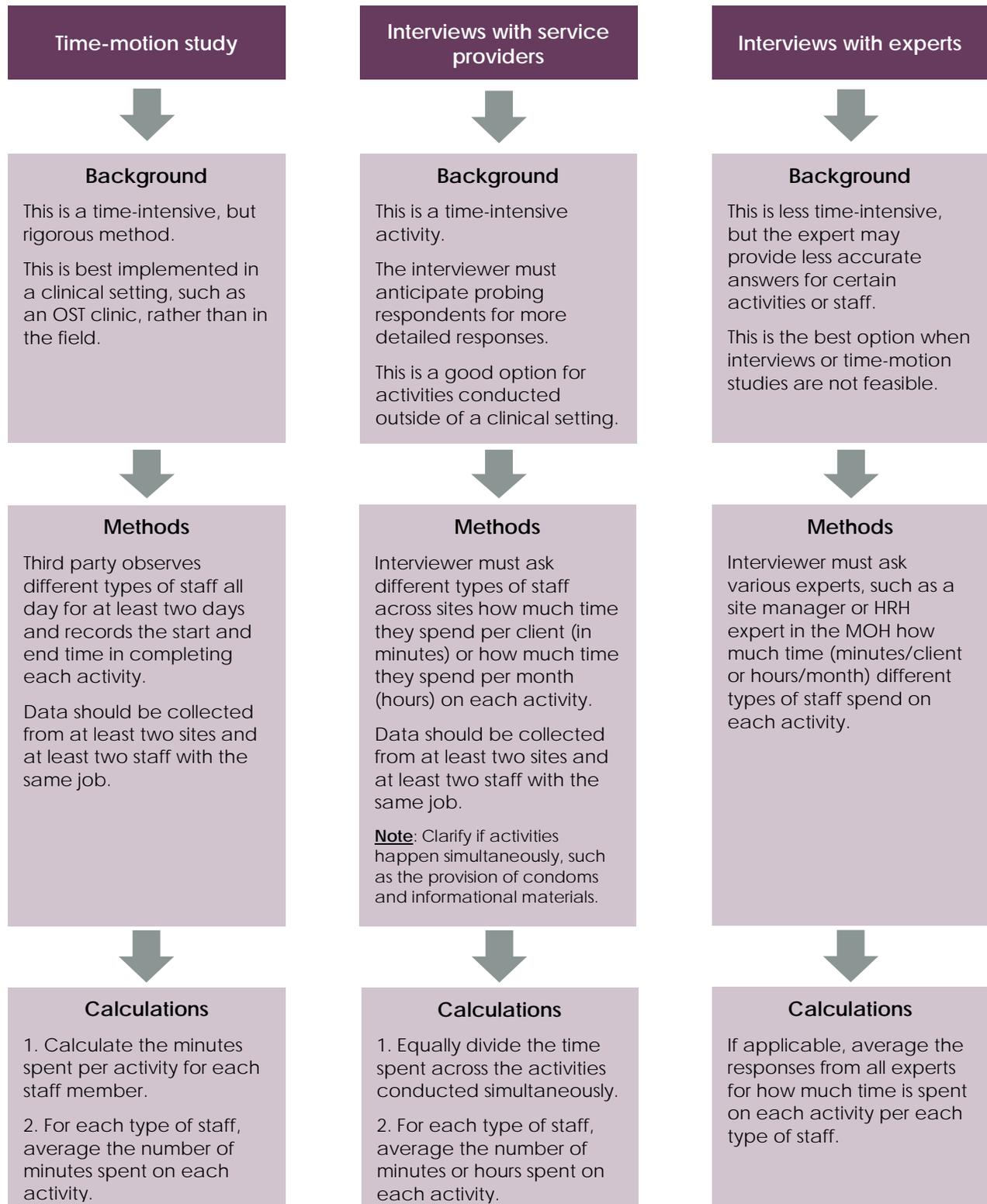
The unit costing tool can be used to advocate for resource mobilization for harm reduction programs. The results of the tool may be used to estimate the financial resources needed per year for OST and NSP in-country by multiplying the weighted average unit cost per NSP or OST client by the estimated annual number of clients reached. In particular, the results can be used to estimate the resources needed for scaling up services to reach more people in need, taking into account the total number of PWUD in the country. This information is vital to policymakers and potential funders, who need to know how much money should be allocated for harm reduction in order to meet the needs of PWUD and reduce health harms.

The unit cost results can also be used in additional analyses to show the cost-benefit or cost-effectiveness of harm reduction interventions. For instance, a cost-effectiveness analysis could show the cost of averting one HIV infection or death. A cost-benefit analysis could compare the cost of providing NSP or OST services to the cost savings in terms of HIV treatment for all new infections averted.

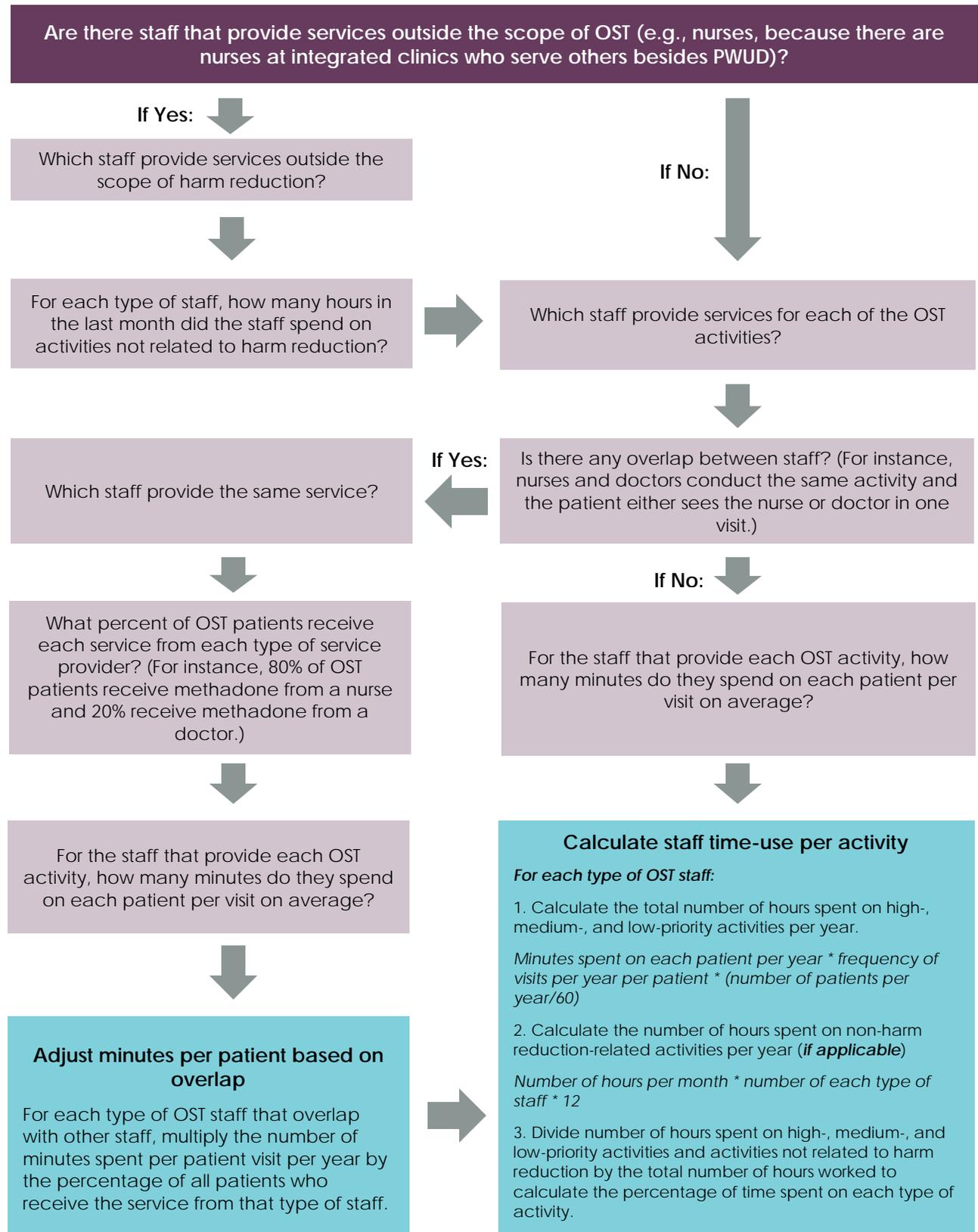
Furthermore, the unit costing tool can be used to show how changes in service delivery, such as task shifting or procuring lower-cost commodities, allows for more PWUD to be reached at the same overall cost and quality. Showing how harm reduction services can be cost-efficient is a compelling argument for policymakers to invest in harm reduction. Additionally, the unit costing tool may be used for cost optimization, in which countries provide the highest-quality package of services to as many PWUD for the lowest unit cost possible. Countries can optimize costs by experimenting with service delivery characteristics, classification of activities, and numbers of PWUD reached and comparing total costs to total resources available.

Lastly, the tool can show the incremental cost per person for providing harm reduction services not currently provided in-country. The incremental cost can be compared to the incremental effects on health outcomes to decide if the provision of the new service and additional investment is cost-effective.

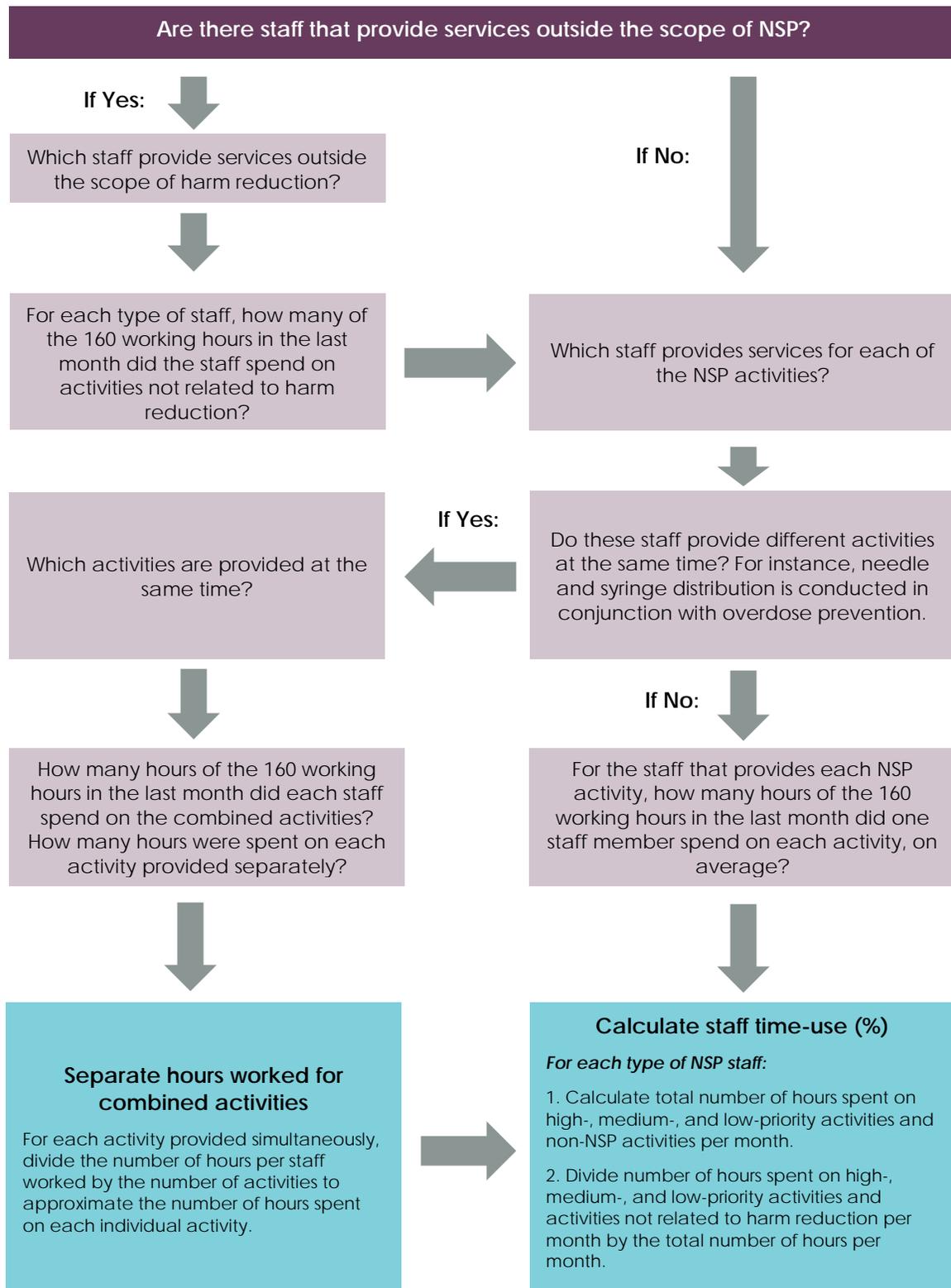
# ANNEX 1. DATA SOURCES FOR STAFF TIME IN MINUTES OR HOURS



## ANNEX 2. QUESTIONS FOR CALCULATING OST STAFF TIME



## ANNEX 3. QUESTIONS FOR CALCULATING NSP STAFF TIME



## GLOSSARY

**Benefits:** Indirect and non-cash compensation paid to staff.

**Direct costs:** Costs that are directly related to specific harm reduction activities and can be readily allocated to a specific harm reduction activity.

**Fiscal Year:** A year as reckoned for taxing or accounting purposes. A fiscal year may or may not align with the calendar year.

**Harm reduction activity:** A service provided to clients of a needle and syringe distribution and/or exchange program (NSP) and opioid substitution therapy (OST), including but not limited to needle and syringe distribution and/or exchange, provision of methadone or buprenorphine, overdose prevention with naloxone, STI diagnosis, HIV testing and counseling, social work and counseling, and medical consultation.

**Headquarters:** A central location in-country for the service delivery organizations providing harm reduction services. This may be the headquarters for the principal recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) or the government.

**High-priority activity:** A service without which a harm reduction program cannot effectively prevent HIV or other serious health harms. Needle and syringe distribution and exchange and provision of methadone or buprenorphine must be classified as high-priority activities, regardless of specific country or local context. A full list of high-, medium-, and low-priority activities for the country and local context should be defined in close cooperation with and through extensive consultations with community groups of people who use drugs (PWUD). It is strongly recommended to use the Service Monitoring Group<sup>2</sup> methodology to organize the consultation process with the community.

**Indirect costs:** Costs that are indirectly related to service provision and cannot readily be identified with a particular harm reduction activity. However, they are nonetheless necessary for undertaking harm reduction activities. Examples include furniture and staff who do not directly provide harm reduction services, such as accountants.

**Low-priority activity:** A service that is beneficial to NSP or OST clients and may improve a harm reduction program's ability to attract or retain clients, but it does not directly aid in the prevention of HIV or other serious health harms. A full list of high-, medium-, and low-priority activities for the country and local context should be defined in close cooperation with and through extensive consultations with PWUD community groups. It is strongly recommended to use the Service Monitoring Group methodology to organize the consultation process with the community.

**Medical commodities:** Medical items with a short lifespan (less than one year) and usually given directly to NSP or OST clients.

**Medical equipment:** Items with a long lifespan (at least one year) that are directly related to service provision.

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<sup>2</sup> The Service Monitoring Group is a technical working group under EHRN's Global Fund-supported regional advocacy program "Harm Reduction Works—Fund It!" This group is conducting a survey of PWUD to incorporate PWUD's opinions on harm reduction programming and policy in countries.

**Medium-priority activity:** A service that significantly improves a harm reduction program's ability to prevent HIV or other serious health harms, but if absent, the program can still run. A full list of high-, medium-, and low-priority activities for country and local context should be defined in close cooperation with and through extensive consultations with PWUD community groups. It is strongly recommended to use the Service Monitoring Group methodology to organize the consultation process with the community.

**Non-medical equipment:** Items with a long lifespan (at least one year) that are indirectly related to harm reduction service provision.

**NSP client:** A person who received the NSP minimum standard package of services once a month in the last 12 months. The minimum standard package can vary by country; however, it should at least include distribution of needles and syringes, condoms, and informational materials; and a consultation with an outreach worker.

**OST patient:** A person who receives OST at a specified date. Basic OST may include a baseline assessment done by a doctor and/or nurse, including tests regulated by country-specific medical protocols, and the receipt of at least one dose of medication.

**Overhead:** The costs of running the organization or site, including but not limited to expenditure on office supplies, transportation, utilities, and building maintenance.

**Salary:** A fixed amount of money or compensation paid to staff, usually expressed in an annual sum.

**Service delivery organization:** An overarching organization providing OST or NSP in-country that supervises or manages sites. Some sites may manage themselves, meaning that not all sites must be managed by an overarching organization. Organizations based outside of the country that may fund harm reduction programs in-country are not included.

**Site:** A facility or location of service delivery, such as an OST clinic, integrated clinic, NSP site, or NSP mobile site.

**Staff:** Paid personnel or consultants who provide or conduct work on harm reduction services.

**Time-motion studies:** Studies that track through observation how much time employees spend on certain activities.

**Training costs:** Costs of teaching staff a particular skill or type of behavior directly or indirectly related to undertaking harm reduction activities.



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