policy

October 2014

HARM REDUCTION EXPENDITURE TRACKING TOOL

User Guide

This publication was prepared by Catherine Barker, Arin Dutta, Dasha Ocheret, and Nora Kriauzaite.

USAID FROM THE AMERICAN PEOPLE
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EURASIAN HARM REDUCTION NETWORK ЕВРАЗИЙСКАЯ СЕТЬ СНИЖЕНИЯ ВРЕДА
HEALTH POLICY PROJECT

Suggested citation: Barker, C., A. Dutta, D. Ocheret, and N. Kriauzaite. 2014. *Harm Reduction Expenditure Tracking Tool: User Guide*. Washington, DC: Futures Group, Health Policy Project; and Vilnius, Lithuania: Eurasian Harm Reduction Network.

ISBN: 978-1-59560-051-6

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). It is implemented by Futures Group, in collaboration with Plan International USA, Futures Institute, Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

"Harm Reduction Works—Fund It" is a three-year (2014–2017) regional advocacy program funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. The program is implemented by the Eurasian Harm Reduction Network and 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 the region of Eastern Europe and Central Asia (EECA).

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[1] Futures Group, [2] Eurasian Harm Reduction Network

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ACKNOWLEDGMENTS

This user guide was produced through a joint collaboration between the Eurasian Harm Reduction Network (EHRN) and the Health Policy Project (HPP). HPP developed the harm reduction expenditure tracking tool based on technical insights and review from EHRN. The authors wish to acknowledge the valuable contributions (both knowledge and time) of staff from EHRN and other organizations working in the field. In particular, we would like to thank Sergey Votyagov, Executive Director of EHRN, and Irma Kirtadze, Senior Researcher of Alternative Georgia.

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
PWUD	people who use drugs
SR	sub-recipient
SSR	sub-sub-recipient

INTRODUCTION

The USAID-funded Health Policy Project (HPP), in collaboration with the Eurasian Harm Reduction Network (EHRN), developed the harm reduction expenditure tracking tool to assess total and unit expenditure in-country over two fiscal years for needle and syringe exchange programs (NSPs) and opioid substitution therapy (OST). 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. The results will facilitate evidence-based decision making by filling a current data gap on expenditure levels for harm reduction 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 at strengthening advocacy by civil society, including people who use drugs, for sufficient, strategic, and sustainable investments in harm reduction as HIV prevention in the region of Eastern Europe and Central Asia (EECA). Under this goal, the regional program has defined two objectives to (1) build an enabling environment for sufficient, strategic, and sustainable public and donor 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 expenditure tracking tool.

Purpose of Expenditure Tracking

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 utilize the data to conduct advanced analyses to inform program scale-up.

The specific purpose of the expenditure tracking tool is to calculate the total amount spent on OST and NSP programs in-country over a two-year period. Tracking expenditure on harm reduction may reveal underinvestment in NSP and OST programs in-country and identify specific sub-interventions that need additional funding. In particular, cross-country comparisons in unit expenditure on harm reduction may highlight the need for increased allocations for harm reduction in certain donor and government budgets.

The tool is part of a suite of Excel-based financial tools to be used for harm reduction advocacy.[1] The expenditure tracking tool is closely related to the unit costing tool, and some inputs may be the same in both tools. However, the tools serve different purposes. While the expenditure tracking tool monitors actual past expenditure on 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 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.

[1] 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.

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 people who use drugs (PWUD) and evidence showing that the activity is effective at reducing HIV and other serious health harms.

The tool also shows the distribution of expenditure across several categories. Total expenditure on harm reduction can be divided by

- Year
- Program (OST or NSP)
- Funding source (Global Fund, national government, or other)
- High-, medium-, and low-priority activities
- Indirect versus direct expenditure
- Cost category (e.g., expenditures on staff, overhead, medical commodities, medical equipment, and non-medical equipment)

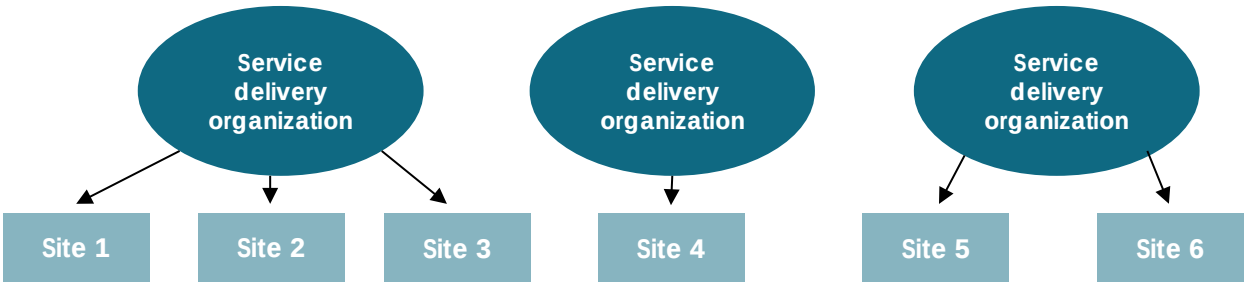
DATA COLLECTION PROCESS

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

Organizational Structure of NSP and OST

The tool is designed to capture harm reduction expenditures from multiple funding sources and service delivery levels. The two levels of service delivery include (1) service delivery organizations, which manage or supervise harm reduction service providers; and (2) 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.

Figure 1: Basic Organizational Structure



The tool aims to estimate aggregate in-country expenditure on harm reduction, so expenditure by organizations based outside the country does not need to be captured. However, the tool allows data from outside organizations to be entered in the expenditure tracking tool if countries want to capture a portion of the organization's overhead attributable to harm reduction provision in-country for advocacy reasons.

The tool allows for data collection according to the Global Fund organizational structure, as NSP and OST programs are largely supported by the Global Fund in Eastern Europe and Central Asia (see Table 1). If both the principal recipient (PR) and sub-recipient (SR) are based in-country and manage the sub-sub-recipient (SSR), expenditure should be captured for both organizations (see Step 4 for instructions).

Table 1: Global Fund Organizational Structure

Organization	Description	Classification
Principal recipient	Manages SR and SSR; some countries will not have a PR based in-country	Service delivery organization *(if based in-country)*
Sub-recipient	Manages SSR **and may also** provide NSP or OST services	Service delivery organization *(if manages SSR)* **or** site *(if provides services)*
Sub-sub-recipient	Directly provides NSP or OST services	Site

If the PR is based outside the country, data should only be collected for the SR and SSR. However, a country can include PR expenditures for principal recipients based outside the country if desired (see section Step 4 for instructions). A certain percentage of the PR's overhead may be added to the overall indirect expenditures for harm reduction in-country. This percentage would be determined based on consultations with the PR on the proportion of resources allocated to harm reduction in-country compared to resources allocated to other activities.

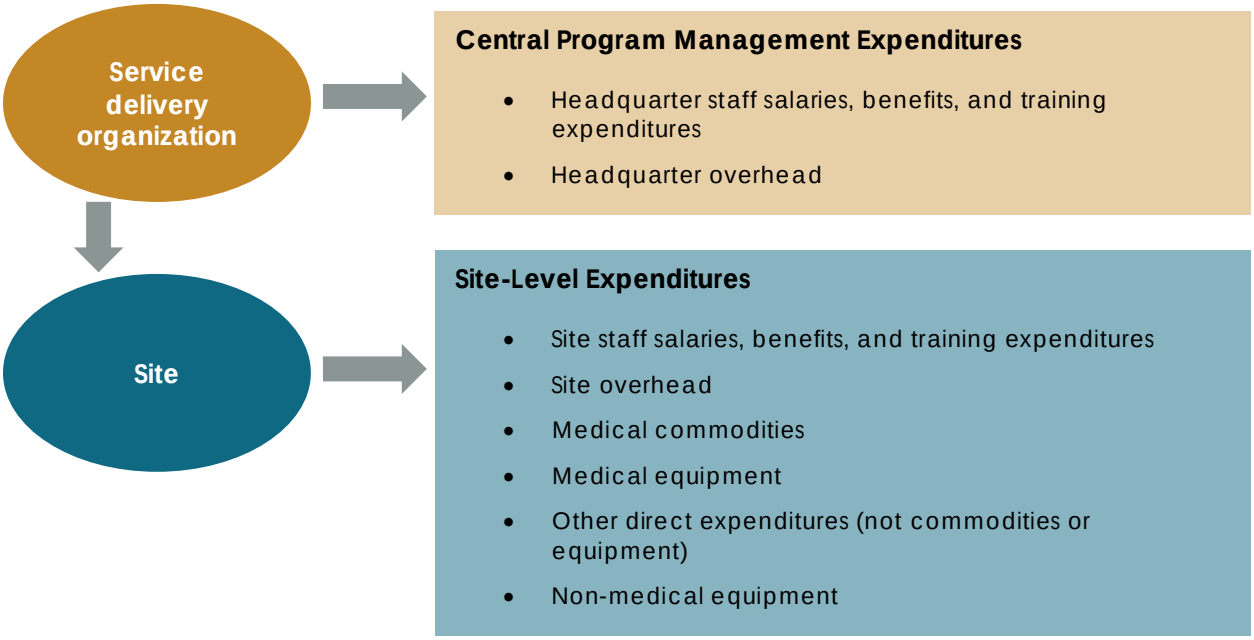
Assumptions

The tool assumes that no service delivery organizations manage both OST and NSP sites and no more than 20 sites are managed by the same service delivery organization. The tool allows data entry for seven service delivery organizations. Some sites may manage themselves, and in which case, there will be no service delivery organization above them.

Expenditure Categories

Two main types of expenditures are captured in the tool: (1) central program management expenditures, which include the expenditures from the service delivery organization's headquarters and (2) site-level expenditures, which include all the expenses incurred for direct service provision. Figure 2 shows the key costs included under each type of expenditure. If local organizations function as sites and are not managed by another service delivery organization, their site management costs should be captured under site-level staff and overhead sheets.

Figure 2: Central Program Management and Site-Level Expenditures



Data should be collected from both service delivery organizations and sites for

- Staff salaries, benefits, and training expenditures
- Overhead expenditures (e.g., office supplies, utilities, building maintenance, etc.)

Data should also be collected from sites for

- Medical commodities
- Medical equipment
- Other direct expenditures not included under commodities and equipment
- Non-medical equipment

Some harm reduction sites (chiefly OST) may offer other services outside the scope of harm reduction, such as an integrated clinic. In this case, expenditures associated with harm reduction activities should be

isolated from other expenditures, which can be done by service delivery organization (if known) or based on the ratio of harm reduction clients to non-harm reduction clients (see Step 4 for more about this ratio).

Types of Data Sources

Financial and program records from service delivery organizations and sites are required for filling in the tool. These data sources will include information on actual expenditure on harm reduction and the number of people who receive NSP or OST services, among other pertinent information required. Budgets should not be used to fill in the expenditure tracking tool. There might be large discrepancies between budgetary allocations and actual expenditures, and the purpose of the tool is to evaluate spending levels for harm reduction services. For a complete list of data sources and their purposes, see Table 2.

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 enter expenditure on 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 number of clients reached, time staff spend on each activity, etc.
Harm reduction guidelines	International guidelines (i.e., World Health Organization 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
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

When collecting financial records, the user should avoid double counting expenditures at the central program management and site levels. This can be avoided by carefully reading the data entry instructions and communicating with the service delivery organizations and sites when collecting financial records. Some financial records held by the service delivery organization could be site-level expenditures. For instance, a service delivery organization may pay for the procurement and storage of medical commodities and equipment that are used at the site level. These expenditures should be reflected in the site-level portion of the tool only.

National or international guidelines for NSP/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. 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 this data, as it will be used to advocate for increased funding for harm reduction. Countries may conduct their own time-motion studies through direct observation of site-level staff if such studies do not exist. For more information on conducting interviews and time-motion studies and how they can be applied to calculate staff time, see Annex 1.

Collecting Data

Since countries may not have both OST and NSP programs and different organizations oversee these programs, all data for NSP and OST are collected and entered separately in the tool. 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 the country.

It is strongly recommended that all data 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 compile data. Data can be entered directly into the tool, or the data collector can set up separate tables in a different Excel file to be used for calculating averages, if necessary. 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 section titled “Data Validation”).

Site Selection

Data should be collected from all sites, particularly if there are 15 sites or fewer in-country. A census of all sites will yield actual aggregate past expenditure on harm reduction in the country.

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. The results from the sample can be extrapolated to estimate aggregate past expenditure on harm reduction countrywide.

It is important to choose a mix of sites that will provide representative average expenditures 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 of 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 how many there are and their similarity. Fewer sites need to be sampled if the sites in-country 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-country should be represented in the sample. Please 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 (i.e., heterogeneous). Refer to Table 4 for a list and description of relevant site 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?	**Homogeneous:** Most sites are funded by same source **Heterogeneous:** 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?	**Homogeneous:** Most sites are in the same region or type of area **Heterogeneous:** 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?	**Homogeneous:** Most sites are around the same age and reach similar numbers of clients **Heterogeneous:** There is a large range in the number of years in operation and number of clients reached	Choose new and old sites and sites with wide ranges in the 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?	**Homogeneous:** Most sites provide the same types of services **Heterogeneous:** 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 quality of services at sites? What are the sites' lost-to-follow-up or stock-out rates?	**Homogeneous:** Most sites provide the same quality of services **Heterogeneous:** 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 instance, 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 accounted for 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 a sample.

Data Validation

Some data validation components are already included in the tool. For instance, expenditure data on commodities cannot be entered unless the activity that uses the commodity is selected from the drop-down menu. However, additional checks are needed, particularly to ensure that high-quality data are entered.

The three main guiding principles for data validation are

1. **Logic:** Are all data inputs reasonable, meaning they follow a logical pattern and 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 activities?

The designated person ultimately responsible for all data entered into the tool should use data triangulation, mathematical checks for accuracy, and logic tests to validate the data. Data triangulation refers to using multiple sources to ensure data accuracy. For instance, 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 make sure 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, and the data collector should document that the visit took place on a certain date.

TOOL FORMAT AND DATA ENTRY

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

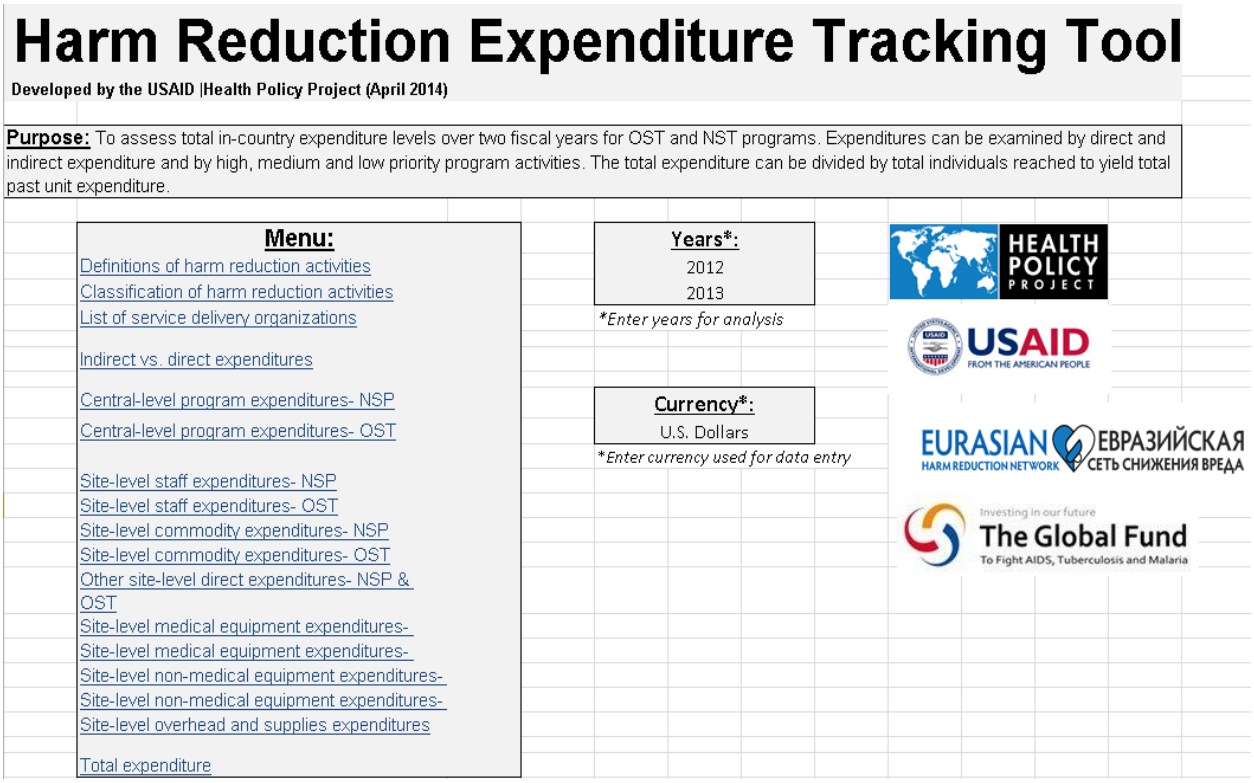
Data entry is separate for NSP and OST; the segments in green are for NSP data entry, while the portions in orange are for OST data entry. Data may not be entered in cells that are shaded grey, as they have formulas or text.

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, except in the "Service Providers" tab, which requires inputting the total number of clients reached through OST and NSP in the country.

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. The data entry process for OST and NSP are the same. Thus, 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 the different parts of the tool. The menu includes the purpose of the tools and requires the user to enter the two fiscal years for analysis. Countries should follow their own fiscal calendars when inputting the years. The user should also identify which currency will be used when inputting expenditure data. The same currency should be used for all data entry.



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 the harm reduction activities in-country 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 peron (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 treament, help client into resocialization (help with emplyment, communication skills and other) and imporvement of health condition.
TB DOT	Dispensing TB medication to NSP clients and other activities to assure TB treatment adherhence	Regular clinical assessments	Performed by doctor to monitor health condition of a patient, sometimes some lab examinations are perscribed 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 peron (medical professional or other).

Step 3: Classify the Activities

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.

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			OST		
High priority (select from dropdown)	Medium priority (select from dropdown)	Low priority (select from dropdown)	High priority (select from dropdown)	Medium priority (select from dropdown)	Low priority (select from dropdown)
Needle and syringe distribution and/or exchange			Provision of methadone or buprenorphine		

The user should rank interventions based on health impact, PWUD preferences, likelihood of future funding for the service, and whether the activity can be replaced by another. 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. The user should not select an activity that is not currently being provided in-country.

Step 4: Enter the Information on Service Providers

The user records the names of service delivery organizations and their respective sites, the number of NSP or OST clients by site, and the total number of people served at each site in this sheet.

NSP Service delivery organization	Primary funding source	Enter number of NSP clients by site		Enter number of all clients by site		Ratio	
		2012	2013	2012	2013	2012	2013
NSP Organization 1	**Global Fund**	80	95	80	95	100%	100%
Site 1	Global Fund	50	60	50	60	100%	100%
Site 2	Global Fund	30	35	30	35	100%	100%

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

If data are collected using a sample of sites, the total number of NSP and OST clients reached from all sites in-country must be entered by year. These figures can be estimates and are used to approximate aggregate annual expenditure for the entire program.

*If taking a **sample** of sites, enter:*		
	Total number of NSP clients reached in program	Total number of OST patients reached in program
2012	100	300
2013	150	305

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

Name entry

Do not enter the name of a site or service delivery organization more than once. If more than one service delivery organization in-country oversees the same set of sites (for instance, the Global Fund's PR and SR

are based in-country and oversee the SSR), enter both service delivery organizations' names in separate lines, but only include the SSR sites under the SR to avoid double-counting site-level expenditures.

For organizations based outside the country, enter the organization's name and the percentage of overhead agreed on for NSP and OST in-country under "Ratio" for each year of analysis. This percentage is based on consultations between the data collector and the organization and is dependent on the following factors:

- How many other countries are receiving resources from the organization
- How many organizations/sites in-country are managed by the organization
- The time and resource-intensity required to oversee harm reduction in-country

For example, a large organization working in 20 countries that provides minimal oversight to harm reduction in-country may decide that no more than 5 percent of its overhead should be allocated to harm reduction expenditure in-country.

For each service delivery organization and site, select from the drop-down menu the primary funding source. Although an organization or site may have multiple funding sources, select the source that provides the most financial support.

Number of NSP or OST clients by site

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.

The number of people who receive NSP or OST services within the fiscal year needs to be entered by site. The number of clients accessing NSP or OST should not be confused with the number of client contacts or needles and syringes distributed. The number of clients should be based on pre-set definitions.

If the same person accesses NSP or OST services in both years, s/he should be included in the client counts for both years. If a client is lost to follow-up during the fiscal year, s/he should still be included in the client count.

This information should come from site-level program records. If program records are incomplete for the year, the user must estimate the total number of NSP or OST clients per site per year. Previous years' data should not be used. Rather, a linear month-to-month trend may be used to fill gaps in the average number of clients reached per month.

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

1. **Simple average:** Add the number of clients reached each month in a year and divide by 12
2. **Cumulative estimate:** Baseline number of clients (first month recurring clients) plus new clients each month for 12 months

3. **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 an NSP or OST client. Expert opinion may be used to adjust numbers if necessary.

Number of all patients by site

The total number of people reached by each site, including those who are NSP or OST clients and those who do not receive NSP or OST services, need to be entered. For example, if an integrated clinic provides antiretroviral treatment to non-OST patients, the all-patient total count would be the number of people receiving treatment plus the number of OST patients. The all-patient count can include others besides PWUD. This information should come from site-level program records or interviews with a site manager.

Step 5: Review the Definitions of Indirect and Direct Expenditure

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

Definitions and Examples of Direct and Indirect Expenditure

Informational- no input required

Definitions:

Direct	Costs that are directly related to specific harm reduction activities
Indirect	Costs that are indirectly related to service provision and cannot be readily identified with a particular activity

Examples *(not a comprehensive list)*:

	NSP	OST
Direct expenditures	**Commodities:** Syringes, needles, swabs, disenfectants, naloxone, condoms, HIV tests, STI tests, pregnancy tests, vein ointments, scarificators, eppendorf, HBV, vitamins, bandages, etc.	**Commodities:** Methadone, buprenorphine, cups, dispensers, gloves, vaccinations, drug screening tests, disinfectants, condoms, HIV tests, STI tests, hepatitis tests, water, naloxone, antidepressents, etc.
	Staff salaries (and bonuses) and staff training for direct service provision: Outreach worker, social worker, counsellor, physician, nurse, psychologist, lawyer	**Staff salaries (and bonuses) and staff training for direct service provision:** Physician, nurse, social worker, psychologist, head of department, pharmacist, etc.
	Medical equipment: Fridge, lab furniture (chairs and table), VCT table, pipette, medical cupboard, medical waste disposal	**Medical equipment:** Fridge, dosimeter, alcohol tester, BP monitor, water dispensers, scales, bottle for dosimeter
	Other direct costs: Informational/educational materials, hygienic materials, monetary incentives, hand sanitizer, rental space for training, expenses related to case management	**Other direct costs:** Informational/educational materials, food packages, conference costs rental space for training
Indirect expenditures	**Staff salaries (and bonuses) and staff training for indirect service provision:** Security staff, cleaner, driver, program director, program coordinator, program assistant, accountant, logistics staff, M&E specialists	**Staff salaries (and bonuses) and staff training for indirect service provision:** Security staff, cleaner, driver, program director, program coordinator, program assistant, accountant, logistics staff, M&E specialists
	Non-medical equipment: Computers, printers, scanners, telephones, air conditioner, office furniture, washing machine	**Non-medical equipment:** Computers, printers, scanners, telephones, air conditioner, office furniture, video recorder, safebox
	Central program and site overhead: Utilities (water, heat, electricity), office supplies (pens, pencils, markers, badges, printer ink), building maintenance (rent, security), transportation (car maintenance and fuel), taxes	**Central program and site overhead:** Utilities (water, heat, electricity), office supplies (pens, pencils, markers, badges, printer ink), building maintenance (rent, security), transportation (car maintenance and fuel), taxes

Step 6: Enter the Central Program Management Expenditures

Data entry for central program management expenditures—the headquarter-level expenditures for each service delivery organization in-country—is the same for OST and NSP programs. Data are collected and entered by service delivery organization. All central program management expenditures are indirect expenditures.

If the organization only provides NSP or OST services **or** the organization provides other services but knows its NSP or OST-only expenditures, enter data in the "NSP/OST ONLY" column. If the organization provides services outside the scope of NSP or OST **and** does not know how much is

specifically spent on NSP or OST, enter data in the "TOTAL (NSP/OST ONLY UNKNOWN)" column. For organizations based outside the country, enter all data under the "TOTAL (NSP/OST ONLY UNKNOWN)" column. Data from the service delivery sheet (i.e., the ratio of NSP or OST patients to the overall number of patients served at the sites under the service delivery organization) will be used to separate NSP or OST expenditures from overall expenditures.

		1. NSP ONLY		2. TOTAL (NSP ONLY UNKNOWN)	
Central Program Management Costs	Definitions	Enter Staff (Total salaries paid only) and Overhead Expenditures		Enter Staff (Total salaries paid only) and Overhead Expenditures	
		2012	2013	2012	2013
NSP Organization 1					
Staff					
Program director	Director of Sub-program that deals with several sub-sub contractor organizations (NSP sites). Responsibilities include: strategic planning, controlling the process of implementation and realization of the	$ 40,000.00	$ 40,000.00		
Coordinator	Controls the process of data collection from NSP, VCT and PDI; prepares monthly reports; oversees mobile lab work, outreach work; etc.	$ 35,000.00	$ 35,000.00		
Program assistant	Work includes scheduling, dealing with correspondence, documentation and archiving all office related work, includes work with data base to cross check the data provided from SSRs.	$ 25,000.00	$ 25,000.00		
Financial manager	Makes financial calculatiuons. Controls flow of funding and all the reports received from SSRs and prepares monthly reports for PR.	$ 35,000.00	$ 35,000.00		

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

There are two overarching headquarters expenditures that need to be entered: staff salaries and overhead. Based on the definitions provided, enter the aggregate salaries paid to each type of staff prior to taxes.

If the aggregate salaries for each type of staff are unknown, use the following formula to estimate total expenditure:

S = A*N, where:

S = Aggregate annual salary, A= Average annual salary, and N= number of type of staff employed at headquarters

Aggregate training and benefits expenditures for all headquarters staff should be entered by service delivery organization.

	NSP ONLY				TOTAL (NSP ONLY UNKNOWN)			
	3. Enter NSP headquarter staff training expenditure by year		4. Enter NSP headquarter expenditure on staff benefits paid by year		5. Enter NSP headquarter staff training expenditure by year		6. Enter NSP headquarter expenditure on staff benefits paid by year	
Organization	2012	2013	2012	2013	2012	2013	2012	2013
NSP Organization 1	$ 3,000.00	$ 2,500.00	$ 4,000.00	$ 5,000.00				

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

Central program expenditures also encompass overhead expenditures at the headquarters. Overhead expenditures should not duplicate site-level expenditures entered in other sheets. For instance, commodity procurement, storage, and distribution costs should be reflected in the site-level commodities sheet, even if the headquarters is responsible for procuring consumables for sites.

Furthermore, the user does not need to enter data for each overhead category. If the service delivery organization does not pay rent because the building is owned or provided in-kind, the organization should leave this cell blank.

Step 7: Enter the Site-Level Staff Expenditures

Site-level expenditure on staff is entered by service delivery organization. Data can be collected from the service delivery organization and/or sites.

Based on the definitions provided, enter the aggregate salaries paid to each type of staff prior to taxes.

If aggregate salary information is unknown, aggregate expenditure on staff can be estimated using the same formula as central program management staff, assuming staff salaries do not vary significantly across sites:

S = A*N, where:

S = Aggregate annual salary, A= Average annual salary, and N= number of type of staff employed at all sites managed by the service delivery organization.

There are both direct and indirect staff expenditures. Expenditures on staff that directly provide harm reduction services, such as physicians, nurses, and outreach workers, are considered direct expenditures, whereas expenditures on staff that support service provision indirectly, such as accountants and drivers, are considered indirect expenditures.

For each type of staff who directly provides services, enter the percentage of time the staff spends on high-, medium-, and low-priority activities. This will vary by country based on the country's activity classification. Time-use can be based on international or national guidelines for how much time staff should spend per patient per visit, interviews with site-level staff, or time-motion studies that observe how much time staff spend on activities. If the service delivery organization's sites provide services outside the scope of harm reduction (e.g., an integrated clinic that provides HIV services to the general population), the user must estimate, on average, how much time is spent on non-OST or NSP activities for each type of staff. Time-use data are ideally collected from every site and averaged across all sites. However, data from interviews with each type of staff from at least two sites can be used to fill in time-use for the entire program. 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. Time-use data are not needed for indirect staff. For more on how to calculate staff time-use, see Annexes 2 and 3.

		1. Enter NSP Staff Salaries		2. Enter Time-Use (%) for Each Type of Staff				
Site Staff	Definitions	2012	2013	Non-NSP activities	High priority NSP activities	Medium priority NSP activities	Low priority NSP activities	Total time use (should equal 100%)
NSP Organization 1								
Staff involved in direct provision of services								
Social worker/case manager	Distributes commodities and informational materials on or off site. This is certified person who has diploma of social worker in most cases.	$ 40,000.00	$ 42,000.00	0%	35%	30%	35%	100%
Social assistant	In some countries there is no such position and duties performed by a social worker. This person is responsible for social assistance to accompany client to receive off site services.							0%
Outreach worker	Distributes commodities and informational materials out of NSP site, performs the same job as a social worker but is not certified "social worker", in most of cases this person is ex-drug user and knows the community well, has ability to recruit drug users into services.	$ 30,000.00	$ 30,000.00	0%	75%	10%	15%	100%

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

For each service delivery organization, enter the annual aggregate expenditure on staff trainings and benefits.

Organization	3. Enter NSP staff training expenditure by year		4. Enter NSP staff benefits expenditure by year	
	2012	2013	2012	2013
NSP Organization 1	$ 900.00	$ 1,100.00	$ 3,000.00	$ 4,000.00

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

Step 8: Enter the Commodities Expenditures

Commodities are medical items used in direct service provision that have a lifespan of less than a year. Expenditure on commodities is considered direct expenditure.

The tool requires the user to enter aggregate expenditure on each type of commodity for the entire NSP or OST program in-country. The commodities used for each activity should not vary significantly across service delivery organizations or sites, meaning that a commodity can be mapped to a specific activity for all sites. The data collector can collect this information from service delivery organizations that procure, store, and distribute commodities on behalf of sites. If sites directly purchase their own commodities, the user must collect data from those sites.

To enter aggregate expenditure for each type of commodity, the user must select the primary funding source; the type of activity it is used for (high, medium, or low priority); and, from a drop-down menu, which specific activity uses the commodity. If more than one activity uses the commodity, select "multiple" from the menu.

Aggregate expenditure on each commodity needs to include expenditures on commodity procurement, storage, and transportation. If these expenditures are unknown for each type of commodity, disaggregate the total expenditure on procurement, storage, and transportation based on the ratio of expenditure per commodity to the overall commodity expenditure. For instance, if syringes account for 25 percent of all expenditure for NSP commodities and the total expenditure on commodity procurement, storage, and transportation for all commodities is $1,000, the procurement, storage, and transportation expenditure allocated to syringes would be $250.

NSP Commodity	1. Select primary funding source of commodity in country	2. Select if commodity is used for high, medium or low priority NSP activities	3. Select specific NSP activity which uses commodity (from dropdown)	4. Aggregate expenditure	
				2012	2013
Syringes	Global Fund	NSP_High_Priority	Needle and syringe distribution and/or exchange	$ 5,000,000.00	$ 5,550,000.00
Needles	Global Fund	NSP_High_Priority	Needle and syringe distribution and/or exchange	$ 1,000,000.00	$ 1,500,000.00

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

Step 9: Enter the Other Direct Expenditures

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

This sheet follows a similar format to the commodities sheets. The total expenditure on each other direct expenditure is entered for the entire NSP or OST program in-country. The items used for each activity should not vary across service delivery organizations or sites. Prior to entering aggregate expenditure, the user must choose for each item the primary funding source; the type of activity it is used for (high, medium, or low priority); and, from a drop-down menu, which specific activity uses the item. If more than one activity uses the item, select "multiple" from the menu.

Other Direct Expenditures	1. Select primary funding source of commodity in country (from dropdown)	2. Select if item is used for high, medium or low priority activities (from dropdown)	3. Select specific activity which uses item (from dropdown)	4. Aggregate expenditure	
				2012	2013
NSP					
Information/education materials	Global Fund	NSP_Low_Priority	Peer education	$ 1,500,000.00	$ 2,000,000.00

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

Step 10: Enter the Medical Equipment Expenditures

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 purchases are considered direct expenditure.

Medical equipment data are entered in separate sheets for NSP and OST services. Data on medical equipment expenditures must be collected and entered by site. For each site, select the equipment purchased by the site within the past two years. Only the equipment purchased during the two years of analysis should be included. If a site uses equipment that was purchased in prior years, do not select the equipment from the drop-down menu.

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 must also select whether the equipment is used for services outside the scope of harm reduction for sites that may provide non-OST or NSP services. The user then enters the aggregate annual expenditure for each type of equipment. The user will not be able to enter expenditure data unless all drop-down selections are made.

Site	Equipment 1 (select from dropdown)	Select if equipment is used for the following activities (Yes or No)				Aggregate expenditure	
		High priority	Medium priority	Low priority	Non-NSP activities	2012	2013
NSP Organization 1							
Site 1	Fridge	Yes	No	No	No	$2,000.00	
Site 2	Medical cupboard	Yes	No	No	No		$200.00

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

Step 11: Enter the Non-Medical Equipment Expenditures

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 purchases are indirect expenditures. Data on non-medical equipment for OST and NSP are entered in separate sheets.

Similar to the section on medical equipment, data on non-medical equipment expenditures are collected and entered by site. For each site, select the equipment purchased by the site within the past two years. Only the equipment purchased during the two years of analysis should be included. If a site uses equipment that was purchased in prior years, do not select the equipment from the drop-down menu. For each type of equipment purchased, enter the annual aggregate expenditure.

Site	Equipment 1 (select from dropdown)	Aggregate expenditure		Equipment 2 (select from dropdown)	Aggregate expenditure	
		2012	2013		2012	2013
NSP Organization 1						
Site 1	Computers	$10,000.00	$ 2,000.00	Combo - printer-scanner-copier		$12,000.00
Site 2	Copier		$ 8,000.00	Wall board -magnetic	$ 25.00	

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

Step 12: Enter the Site-level Overhead Expenditures

Site-level overhead refers to the expenditures 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.

If the site does not pay rent because the building is owned or provided in-kind, the site should leave this cell blank.

Site	Utilities		Office supplies		Transportation		Rent		Site taxes	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
NSP										
NSP Organization 1										
Site 1	$ 5,000.00	$ 5,500.00	$ 700.00	$ 750.00	$25,000.00	$32,000.00	$80,000.00	$85,000.00	$10,000.00	$10,000.00
Site 2	$ 6,000.00	$10,000.00	$ 800.00	$ 650.00	$15,000.00	$14,500.00	$20,000.00	$25,000.00	$10,000.00	$10,000.00

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. The summary sheet shows the distribution of expenditure by program, year, indirect vs. direct expenditure, cost category, funding source, and type of activity (high, medium, or low priority). The average past unit expenditure per client is also calculated.

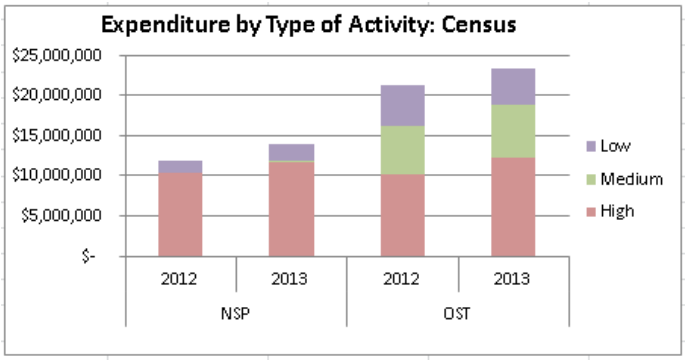
The user should either refer to the results for a sample of sites or for a census of sites, as results for total expenditure will differ based on the methods used. If a census of sites was undertaken, the aggregate expenditure per year is the actual expenditure in-country on harm reduction. If a sample of sites were selected, aggregate expenditure is estimated by multiplying the average unit expenditure per client per year by the total number of clients reached in-country per year. The proportions of expenditure on direct and indirect costs and by high-, medium-, and low-priority activities are used to estimate annual aggregate expenditure by those categories.

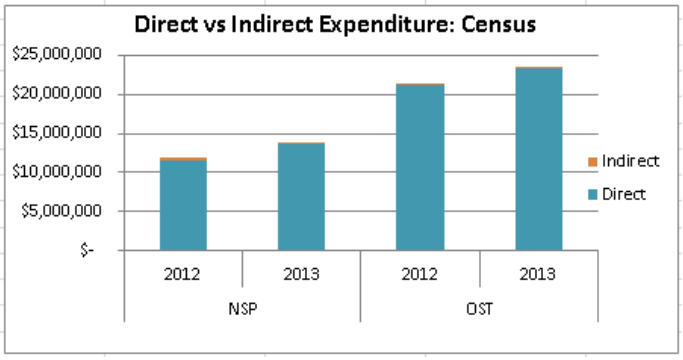
Census of sites:				
	NSP		OST	
	2012	2013	2012	2013
TOTAL	$ 11,942,400	$ 13,903,650	$ 21,340,527	$ 23,433,163
Patients	80	95	35	40
Exp per patient	$ 149,280	$ 146,354	$ 609,729	$ 585,829
Direct vs. Indirect Expenditure				
Direct	$ 11,627,900	$ 13,567,750	$ 21,197,610	$ 23,199,830
Indirect	$ 324,525	$ 357,900	$ 143,192	$ 233,681
Expenditure by Activity Type				
High	$ 10,318,812	$ 11,760,790	$ 10,115,878	$ 12,169,561
Medium	$ 16,278	$ 18,716	$ 6,123,086	$ 6,649,108
Low	$ 1,613,335	$ 2,145,445	$ 5,101,228	$ 4,614,012
Expenditure by Primary Funding Source				
Global Fund	$ 9,850,600	$ 11,537,550	$ 6,000,000	$ 6,500,000
Government	$ 50,000	$ 70,000	$ 10,509,035	$ 12,623,355
Other	$ 2,000,000	$ 2,250,000	$ 5,000,000	$ 4,500,000

Census of sites:			
	NSP	OST	Both
Grand total	**$ 25,846,050**	**$ 44,773,690**	**$ 70,619,740**
Exp per patient	$ 147,817	$ 597,779	

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.

Two graphs will auto-populate based on the data entered. These graphs show expenditure by activity type and for indirect vs. direct expenditure for each year and program. Only refer to the graphs for "sample" if a sample of sites was used.





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

Final results should be interpreted with caution. The past annual unit expenditure per OST or NSP client is not reflective of the actual cost of providing harm reduction services per client per year. The unit costing tool accounts for all items and staffing needs to provide the standard quality of care to PWUD. Expenditure by high-, medium-, and low-priority activities is not necessarily comparable across countries due to in-country classification of priority activities. Furthermore, expenditure by funding source is an estimate, as the user only selects the *primary* funding source for each input.

USING THE RESULTS FOR ADVOCACY

The results can be used in advocacy campaigns by civil society groups to inform harm reduction policy and evidence-based decision making. Through continuous use of the tool, the knowledge and data gap related to harm reduction expenditures in Eastern Europe and Central Asia will close. Countries will be able to track harm reduction expenditures over an extended period of time, which will reveal patterns in expenditure for OST and NSP services provided in-country.

The tool could be used to raise awareness of harm reduction services in-country and the need to systematically record and collect pertinent data, such as the number of clients reached by site. Users of the tool can share the results with other civil society organizations and train staff on how to collect, record, and use the data.

The results of this tool could also influence budget allocations for NSP and OST. Aggregate expenditure can be compared to the total estimated cost to show the gap in current spending and financial resources needed. By tracking expenditure by funding source, countries could use the results to advocate for increased funding from particular funders.

Lastly, the tool may inform the scale-up of NSP and OST in countries. The results may reveal that different models of service delivery are more cost-efficient based on the number of clients reached and expenditure for certain types of sites. Also, the results could identify the programmatic gap based on current expenditure levels. For instance, experts can approximate how many people receive specific services or commodities based on the current expenditure levels and compare that number to national targets.

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

Time-motion study

Background

This is a time-intensive, but rigorous method.

This is best implemented in a clinical setting, such as an OST clinic, rather than in the field.

Methods

Third party observes different types of staff all day for at least two days and records the start and end time in completing each activity.

Data should be collected from at least two sites and at least two staff with the same job.

Calculations

1. Calculate the minutes spent per activity for each staff member.

2. For each type of staff, average the number of minutes spent on each activity.

Interviews with service providers

Background

This is a time-intensive activity.

The interviewer must anticipate probing respondents for more detailed responses.

This is a good option for activities conducted outside of a clinical setting.

Methods

Interviewer must ask different types of staff across sites how much time they spend per client (in minutes) or how much time they spend per month (hours) on each activity.

Data should be collected from at least two sites and at least two staff with the same job.

Note: Clarify if activities happen simultaneously, such as the provision of condoms and informational materials.

Calculations

1. Equally divide the time spent across the activities conducted simultaneously.

2. For each type of staff, average the number of minutes or hours spent on each activity.

Interviews with experts

Background

This is less time-intensive, but the expert may provide less accurate answers for certain activities or staff.

This is the best option when interviews or time-motion studies are not feasible.

Methods

Interviewer must ask various experts, such as a site manager or HRH expert in the MOH how much time (minutes/client or hours/month) different types of staff spend on each activity.

Calculations

If applicable, average the responses from all experts for how much time is spent on each activity per each type of staff.

ANNEX 2. QUESTIONS FOR CALCULATING OST STAFF TIME

Are there staff that provide services outside the scope of OST (e.g., nurses, because there are nurses at integrated clinics who serve others besides PWUD)?

If Yes:

Which staff provide services outside the scope of harm reduction?

For each type of staff, how many hours in the last month did the staff spend on activities not related to harm reduction?

If No:

Which staff provide services for each of the OST activities?

Is there any overlap between staff? (For instance, nurses and doctors conduct the same activity and the patient either sees the nurse or doctor in one visit.)

If Yes:

Which staff provide the same service?

What percent of OST patients receive each service from each type of service provider? (For instance, 80% of OST patients receive methadone from a nurse and 20% receive methadone from a doctor.)

If No:

For the staff that provide each OST activity, how many minutes do they spend on each patient per visit on average?

For the staff that provide each OST activity, how many minutes do they spend on each patient per visit on average?

Adjust minutes per patient based on overlap

For each type of OST staff that overlap with other staff, multiply the number of minutes spent per patient visit per year by the percentage of all patients who receive the service from that type of staff.

Calculate staff time-use per activity

For each type of OST staff:

1. Calculate the total number of hours spent on high-, medium-, and low-priority activities per year.

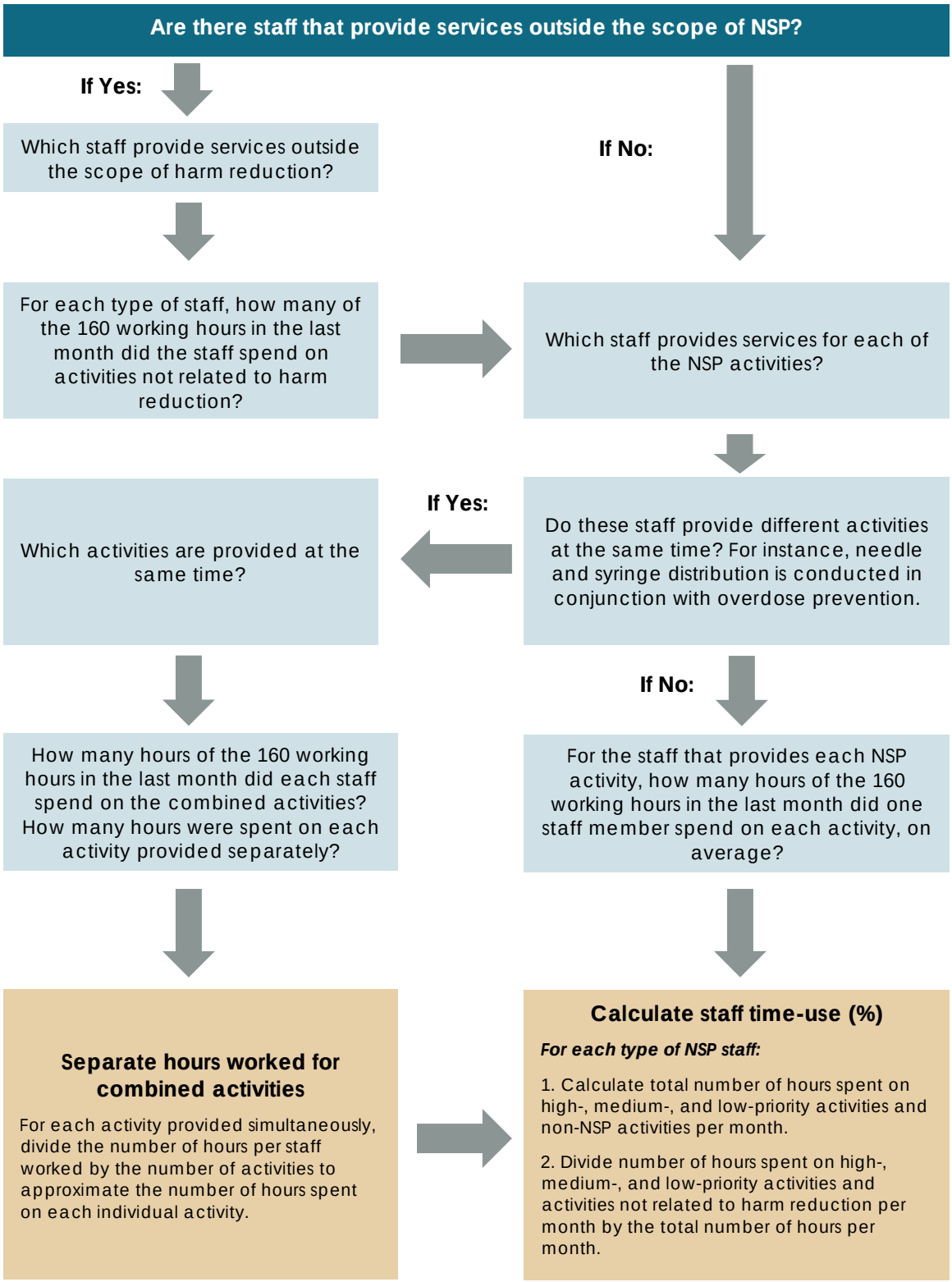
*Minutes spent on each patient per year * frequency of visits per year per patient * (number of patients per year/60)*

2. Calculate the number of hours spent on non-harm reduction-related activities per year (***if applicable***)

*Number of hours per month * number of each type of staff * 12*

3. Divide number of hours spent on high-, medium-, and low-priority activities and activities not related to harm reduction by the total number of hours worked to calculate the percentage of time spent on each type of activity.

ANNEX 3. QUESTIONS FOR CALCULATING NSP STAFF TIME



GLOSSARY

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

Central program management expenditures: Program expenditure at the headquarters level for every service delivery organization in the country.

Direct expenditure: Expenses 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: Central location in-country for the service delivery organizations providing harm reduction services. This may be the headquarters for the Global Fund to fight AIDS, Tuberculosis and Malaria principal recipient 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[2] methodology to organize the consultation process with the community.

Indirect cost: 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 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.

[2] 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 their opinions on harm reduction programming and policy in countries.

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

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 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.

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

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; however, it should at least include the distribution of needles and syringes, condoms, and informational materials; and a consultation with an outreach worker.

OST patient: 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: 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: 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 expenses: Expenditure on teaching staff a particular skill or type of behavior directly or indirectly related to undertaking harm reduction activities.

For more information, contact:

Health Policy Project
Futures Group
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
www.healthpolicyproject.com